

SUPERVISING to OUTCOMES

Client-Centered Supervisor Training

for

*Providers of
Adult Mental Health
Services in California*

with



California Institute for Mental Health
2125 19th Street, 2nd Floor • Sacramento, CA 95814 www.cimh.org

Client-Centered Supervisor Training

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Rick Goscha, MSW
Dianne Asher, LSCSW, CADCI

Provided through a partnership of
The Kansas Department of Social and Rehabilitation Services
and

University of Kansas School of Social Welfare
Lawrence, Kansas | (785) 864-4720



TRAINING AGENDA

DAY ONE

SECTION 1

Client-centered Supervision: Principles for Practice (9:00 AM – 10:30 AM)



- What are the principles of client-centered supervision?
- How does client-centered supervision differ from other forms of management practice?

SECTION 2

Performance Planning: In Search of Excellence (10:45 AM – Noon)



- What are the outcomes we should focus on?
- What are ways we can bring meaning to numbers?
- How do we set a performance goal that is meaning to our agency?
- How do we break this goal down into discrete, achievable steps so we can see our progress taking place?

SECTION 3

Strengths Assessment: Amplifying Wellness in the Midst of Problems and Challenges (1:00 PM – 2:30 PM)



- What do we mean when we talk about “strengths”?
- What is a Strengths Assessment and how does it differ from the typical “psychosocial assessment”?
- How do you conduct a strengths-based assessment?

SECTION 4

Group Supervision: Creativity Unleashed (2:45 PM – 4:00 PM)



- How does an effective group supervision differ from a more traditional “client staffing”?
- How does group supervision reinforce the tools and practices of the strengths model?

DAY TWO

SECTION 5

Integrating the Strengths Assessment into Practice (9:00 AM – 10:30 AM)



- How is the strengths assessment used as a pro-active tool in daily practice?
- How can the supervisor use a quality review process as a means of ensuring quality service provision and enhancing professional development?

SECTION 6

Field Mentoring: Supporting Staff in their Work (10:45 AM – Noon)



- When should I provide field mentoring for staff?
- *What are the multiple ways of using field mentoring to give staff feedback on their work with client?*

SECTION 7

Client-Centered Feedback: Brining Everyone Along (1:00 PM – 2:15 PM)



- How can I give effective feedback to staff who are struggling to incorporate the strengths model in practice?
- How do I develop a plan for improved staff performance?

SECTION 8

Rewards-based Environment: Motivating Excellence (2:30 PM – 3:15 PM)



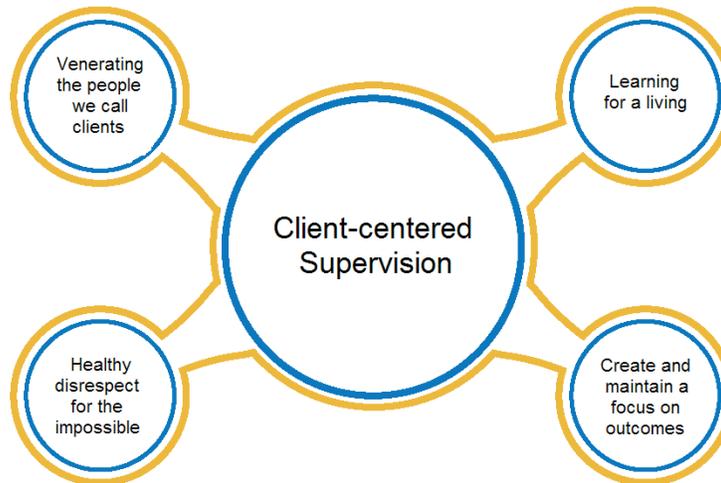
- How can I positively motivate my staff to incorporate the tools of strengths practice into their work?
- How can I contribute to a positive, learning work environment?

CLOSING

Wrap-up: Discussion/Q&A (3:15 PM – 4:00 PM)

Section One

Client-centered Supervision: Principles for Practice



Alice: “Would you tell me, please, which way I ought to go from here?”

Cat: “That depends a good deal on where you want to get to.”

Alice: “I don’t much care where...”

Cat: “Then it doesn’t matter which way you walk.”

- *Alice in Wonderland*

“I would argue that changing “systems” is the easy part. Changing ourselves and becoming vulnerable enough to be transformed through our relationships with consumer/survivors-now that is the hard part. It is only when we can profoundly embrace those people whom we are called to serve are, indeed, human beings with whom we share a common humanity,-only then do we begin to be transformed and to change.”

– *Patricia Deegan*

Typical Management Styles

1. Managing by problems (“What is the crisis of the day?”)

“Good management is the art of making problems so interesting and solutions so constructive that people can’t wait to get to work to deal with them.”

2. Managing by rules and regulations (“We can’t do that.”)

“A ship in a harbor is safe but that is not what ships are built for.”

“There is *nothing* so useless as doing efficiently that which should not be done at all.”

– Peter Drucker

3. Managing by budget (“We don’t have money for that.”)

“The budget evolved from a management tool to an obstacle to *management*.”

4. Managing by happy constituents (“Is everyone satisfied?”)

“*Anyone can hold the helm when the sea is calm*”

5. Managing by outcomes

Services are tools; a means to an end.

We should continuously ask ourselves, “How does this benefit the people *receiving* our services?”

People tend to stay motivated when they see value in the things they are *asked* to do.

Four Assumptions of Client-Centered Management

1. Clients are the focus of all of our activities
2. Ultimate criterion of organizational performance is improving client outcomes.
3. Managerial performance is identical to organizational performance.
4. Primary role of supervisor is to help staff do their job more effectively and efficiently.

The Four Principles of Client-Centered Supervision

#1. Venerating the people we call clients.

Key point:

Helping people recover and reclaim their lives is the focus of all our activities.

One example:

Supervisor establishes the expectation that team members will not refer to clients by labels such as “schizophrenic, borderline, or chronics.”

Your examples:

Ways that you currently support venerating the people we call clients or ways that you are planning to do this.

#2. Learning for a Living

Key point:

The moment you stop learning, you stop improving. When you are through improving, you are through.

One example:

Supervisor takes time during the week with each case manager to continue the development of their practice skills through a combination of field mentoring, review of practice tools, and feedback on performance.

Your examples:

Ways that you currently support learning for a living or ways that you are planning to do this.

#3. Healthy Disrespect for the Impossible

Key point:

Our stance should be, “How can we make it happen,” rather than getting stuck by seemingly glaring obstacles or challenges. Viewing challenges as opportunities unleashes creativity.

One example:

Supervisor creates a monthly award for the staff who accomplished something that month that took extreme persistence and creativity.

Your examples:

Ways that you currently support a healthy disrespect for the impossible or ways that you could do this in the future.

#4. Create and Maintain a Focus on Outcomes

Key points:

The ultimate criterion for organizational performance is improving client outcomes.

One example:

Each month the entire team looks at program outcome data and celebrates individual and collective efforts in making progress.

Your examples:

Ways that you currently focus on outcomes or ways that you could do this in the future.

Principles of Client-Centered Supervision Exercise

1. Venerating the people we call clients.

Strategies I learned from other supervisors:

#2. Learning for a Living

Strategies I learned from other supervisors:

#3. Healthy Disrespect for the Impossible

Strategies I learned from other supervisors:

#4. Create and Maintain a Focus on Outcomes

Strategies I learned from other supervisors:

Section Two

Performance Planning: In Search of Excellence



Managing Information

Select the information that is important and essential for improving client outcomes.

Give the information/data directly to staff on a regular basis.

Teach staff how to question, understand and make use of the information.

Give the data relevance – find ways to help staff go beyond the numbers.

Make sure concrete action steps follow any review of information/data.

Use Data to:

Reward

Help people set goals

Evaluate staff and team performance

Learn and Improve

Take action

Performance Planning

1. Choose an outcome area where you would like to see improvement:
 - Pick an outcome area that holds some passion or excitement for you or your staff.
 - Pick an outcome area that fits with your current role in the agency or where you might have some ability to impact.
2. Write a goal for the outcome area chosen.
Standards for goal writing:
 - Increase/decrease
 - Single measurement
 - Time frame (by when?)

Examples:

- 1) Increase the number of people competitively employed by 10% (10 people) by December 2006.
- 2) Decrease the number of people requiring inpatient psychiatric hospitalization by six people next quarter (December 2006)
- 3) Increase the number of people who move from homeless to independent living by 10 people by next quarter (December 2006).

---"If it is to be, it is up to me."---

PERFORMANCE PLAN

CMHC:

SUPERVISOR: Ann

DATE: 7/1

Behavior:

Increase the number of people in vocational activity by 10% (10 people) by next quarter 12/06

Behavioral Short-Term Goals/Tasks Toward Achievement	Responsibility	Date to be Accomplished	Date Accomplished	Comments
Review program data with team and set goal to increase activity	Ann	7/10	7/10	Current vocational activity is at 12% (14 people). Team set goal of 20% (24 people) by December 2006.
Ask each case manager to identify two people on his/her caseload who have expressed interest in work, but are not currently employed.	Ann/Case Managers	7/10	7/10	Case managers will have list to me by 7/14.
Have case managers update strengths assessments for people on list.	Case Managers	7/17 for consumers to be presented on 7/17. 7/24 for all others	7/17	
Present three people on list at group supervision in order to generate ideas for moving toward employment	Ann/Case Managers	7/17	7/17	Will do follow-up field mentoring session with Jamie to offer support
Hold two-hour training session on use of motivational interviewing in helping people process decisional conflict around employment.	Ann and Mary	7/24	7/24	Will use field mentoring and role play to help support skill development
Conduct chart review of consumers identified by case managers for employment	Ann	7/26		From chart review determinate possible group supervision presentations or field mentoring opportunities

Set up appointment times to give case managers individual feedback on vocational activity with consumers.	Ann	7/26		
Talk to Sandy (executive director) about increasing flexible funds for consumers going back to work	Ann	7/26		
Go out with Jamie for field mentoring session	Ann/Jamie	7/27		
Present on three more consumers at group supervision	Ann/Case Managers	7/31		
Set up meeting with Cyndi at Voc Rehab to discuss strategies for getting more consumers employed	Ann	8/1		Include Mike, supported employment specialist
Set up focus group with consumers to talk about vocational aspirations and possible obstacles people might be facing	Ann	8/1		Include Mike
Meet with each case manager to discuss individual employment goals for performance evaluation.	Ann	8/30		
Search for articles on best practices in improving vocational outcomes	Ann	8/30		
Create award for case manager who has had the most vocational activity for the quarter	Ann	8/30		

Section 3

Strengths Assessment: Amplifying Wellness in the Midst of Problems and Challenges



“All people possess a wide range of talents, abilities, capacities, skills, resources, and aspirations. No matter how little or how much may be expressed at one time, a belief in human potential is tied to the notion that people have untapped, undetermined reservoirs of mental, physical, emotional, social, and spiritual abilities that can be expressed.

– *Charles Rapp*

“In my psychiatric residency that followed medical school, I glibly applied the terminology of physical disease to the “disorders” of the mind. I became so immersed in pathology that I no longer even used the word healthy. Instead, I conceived of health as the absence of illness and referred to people who were well as “asymptomatic.” In retrospect, the worst offender was the term “unidentified” as if the only way I could know a person was by his or her sickness.”

– *S. J. Wolin*

“If you are not depressed when you come in for a typical psycho-social assessment, you probably will be by the time you leave.”

– *Anonymous consumer advocate*

Types Of Strengths

1. Qualities/Personal Characteristics
2. Talents
3. Environmental Strengths
4. Interests/ Aspirations



Qualities/Personal Characteristics	Skills/Talents	Environmental Strengths	Interests/ Aspirations
<ul style="list-style-type: none"> • honest • caring • hopeful • hard working • kind • patient • sensitive • talkative • friendly • willing to help • stands up for the underdog 	<ul style="list-style-type: none"> • good card player (Spades) • good at math and tracking money • works on cars • can put up drywall • arranges flowers • knows all about baseball cards • computer wiz • knows a lot about classic rock music • great memory 	<ul style="list-style-type: none"> • has a safe home that he/she really likes • big brother • her dog Max is her best friend • gets \$535 SSI each month • was part of a local faith community 2 years ago • Sweat Lodge - cultural healing tradition 	<ul style="list-style-type: none"> • wants to be a rock star • loves to fish • loves to watch old movies on TV • likes to go to coffee shop and "hang out" • wants to spend more time with niece • hopes to have his own car one day soon

Strengths Assessment

Consumer's Name

Ann P.

Case Manager's Name

Rick G.

Current Status: What's going on today? What's available now?	Individual's Desires, Aspirations: What do I want?	Resources, Personal Social: What have I used in the past?
Life Domain/Daily Living Situation		
<ul style="list-style-type: none"> • 27 yrs old. • Lives in 2-bedroom apartment with 2-year-old son. • Nicely decorated with paintings (landscapes) she did. • Ann uses public transit —likes to cook, keeps apartment tidy. • SRS involved re: welfare of son. 	<ul style="list-style-type: none"> • I want to stay out of the state hospital. • I want to keep my son. • I want to have “some time to myself” away from child care duties. 	<ul style="list-style-type: none"> • Has been in the hospital 2 times in past. Longest admission 6 months. • Has lived in current apt. for 5 months. • Previously lived with family. • Lived with father of child for 2 years in San Francisco.
Financial/Insurance		
<ul style="list-style-type: none"> • Has ADC—Food Stamps. • SSI (\$202.00 per month). • Section 8 apartment. • Medical card. • Family helps out occasionally. • No child support. 	<ul style="list-style-type: none"> • I want to increase my monthly income. • I would consider applying for SSDI. 	<ul style="list-style-type: none"> • Used to earn “good money” as a waitress (see vocational).
Vocational/Educational		
<ul style="list-style-type: none"> • Not presently employed. • Days are devoted to child care. This is her primary role now and Ann states that “sometimes I don’t know how to handle him.” • Has GED. 	<ul style="list-style-type: none"> • I would like to attend art classes. • I want to be a “better parent.” 	<ul style="list-style-type: none"> • Worked as a waitress for “a couple of years” before onset of illness; she did not like “having to put up with customers’ complaints.”
Social Supports		
<ul style="list-style-type: none"> • Son is very important to her. • Family (parents, 2 older sisters) live nearby—some support but “they want to take my son” and “they don’t believe me when I tell them things.” 	<ul style="list-style-type: none"> • I want to keep my son. • I want to make more friends. • I want my family to “understand” me and “believe” me. 	<ul style="list-style-type: none"> • Used to “have a lot” of friends. • Used to enjoy dancing and painting - was a source of support. • Her last case manager “really helped”; was very supportive. • Used to go to church.

Strengths Assessment

The Strengths Assessment is designed to capture a broad range of people's strengths in an efficient but thorough manner. The information gathered should be detailed, specific, and thorough.

The lists on the following pages are sample questions that can be used to explore each life domain. These lists are not exhaustive or prescriptive and should NOT be used as an interview or interrogation of the person. When completing the strengths assessment, the process should be conversational, in your own style, not intrusive, and at the person's own pace.

By no means should you, in one sitting, go through these questions in a linear manner. The examples are only meant to stimulate ideas of areas to be explored for a richer assessment. The most important aspect of the Strengths Assessment is getting to know the strengths, resources and aspirations of the person you are working with in a relaxed and positive way!

5 Critical Components of the Strengths Assessment

- Thorough, detailed and specific
- On-going process/updated on regular basis
- Conducted in conversational manner
- Consumer paced
- Consumer language used

Areas to Explore through the Strengths Assessment

Daily Living

Current Status

- Where do you live (your address)? How long have you lived there?
- Do you live with anyone else?
- What is good about where you live? What do you like about where you live? (e.g., quiet neighborhood, close to grocery store, near bus route)
- How do you get around (car, bike, bus, or walk)?
- Do you have pets or animals?
- What personal assets related to daily living does the person have? (e.g., a phone, cable, TV, dishwasher, washer/dryer) Note: This can help identify wants - does the person wish he/she had a vacuum cleaner?
- Are there details, special attributes about the home that the person is proud of or enjoys? (e.g., collects things, paintings, is very tidy, embroiders, has aquarium)
- What does the person enjoy doing or is good at doing in terms of daily living tasks, if anything? (e.g., cooking, cleaning, doing errands, grocery shopping)

Desires/Aspirations

- Do you like where you live? Where else would you like to live?
- Do you like living alone? With other people?
- If you could change one thing about your living situation, what would it be?
- What would your ideal living situation be? (e.g., living on a farm, buying a home, etc.)
- Is there anything you would want to make your living situation easier? (e.g., a vacuum, day care for kids, a care, a way to get to the shopping center more, etc.)
- What is most important to you in your living situation? (e.g., feeling safe, near friends, near business, having a pet, etc.)

Resources

- Where have you lived in the past (list each)? With whom? For how long? What was the type (e.g., apartment, group home, house, nursing facility) and location?
- Are there things you really liked about any of the past living situations?
- What was your favorite living situation? Why?
- Are there things you had in a past living situation that you do not have now but you would like to have again?

Financial/Insurance

Current Status

Income (type and amount)

- SSI/SSDI
- Income from work
- Family/friends loans/assistance

Program Assistance

- Food stamps
- Section 8/HUD
- PASS Plan
- Homestead
- TANF

Insurance

- Medicare/Medicaid
- Insurance Company
- Spend-down information (amount)

Money Management

- Do you have a bank account? What kind?
- Payee? Name & address
- How do you budget & manage your money
- How do you pay your bills?
- Do you have extra spending money each week? How much?

Desires/Aspirations

- What would you like to be different with regard to finances? How?
- What is important to you regarding your finances? (e.g., I want extra money each week to go out to eat; I want to be able to rent movies; I wish I had a savings account, etc.).
- Are there benefits the person is entitled to, but is not getting?

Resources

- What was the person's income in the past? From what sources? (e.g., has the person worked in the past? Did they get benefits they do not receive now?)
- Did the person use/have any resources in the past that they are not using now? (e.g., payee, taking a financial management class, was an accounting major in college, used to have a savings/checking account, etc.)

Vocational/Educational

Current Status

- What is the person doing with regard to productive activity? Include type, where, and amount of time. (e.g., Junior College classes in art one class per semester).
- Activities that could be included in this category: competitive employment, volunteer work, school, odd jobs, helping others, work in the CSS program, job search, involvement in vocational services and/or vocational program, parenting, taking care of sick or elderly friend or relative, etc.
- Highest level of education (e.g., GED, high school, 22 hours of undergraduate work, B.A., etc.)
- What do you like about your current job, activities, etc.?
- What is important to the person about what they are doing? (e.g., "I like the extra money," "Helping people," "Being around people," "Being in charge of something," etc.)
- Particularly if the person is not doing anything in this area, what are their interests, skills, abilities related to productive activity? (e.g., "I'm very mechanical," "I enjoy playing with kids," "Art is my passion," etc.)

Desires/Aspirations

- Do you have any desire to work? Go to school? Volunteer? Earn extra money?
- If so, what would that be doing? What do you enjoy doing? What do you have experience doing? (e.g., "I'd like to get a nursing degree," "I like to work outside and with my hands," "I like helping people," etc.)
- If you could be or do anything you wanted (career-wise), what would that be? What is it about that that interests you?
- If the person is doing some type of activity currently, is the person satisfied with what they are doing? Is there anything about what they are doing they would like to change? Is there other activity they would like to do in addition?

Resources

- What type of activity (e.g., work, school, volunteer work, training, etc.) have you done in the past? For how long? When? Where? What did you like or not like about it?
- What kind of vocational services have you received in the past?
- Have you been/are you on any work incentive programs?
- What work situations have you found most enjoyable and why?

Social Supports

Current Status

- Who do you spend time with? Who are your friends? Who do you feel close to? Who makes you feel good when you're around them?
- What organizations, clubs, groups, or do you participate in? (e.g., church, AA/NA, CSS, softball league, neighborhood groups, etc.)
- Do you have anybody that comes to visit you or that you spend time with? What kinds of things do you do together?
- Do you have a pet? Would you like one?
- Do you visit with any members of your family? Are the visits pleasant or stressful? Do you rely on any members of your family for support?
- What is it you like and dislike about being with other people?
- Where, outside of your home, do you feel most at ease?

Examples of Social Supports

- | | | |
|---|---|--|
| <input type="checkbox"/> Family | <input type="checkbox"/> Friends | <input type="checkbox"/> Mental Health Workers |
| <input type="checkbox"/> School | <input type="checkbox"/> Compeer | <input type="checkbox"/> People at work |
| <input type="checkbox"/> Pets | <input type="checkbox"/> Spiritual (church, minister) | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Acquaintances | <input type="checkbox"/> Significant Other | <input type="checkbox"/> Self-help/ Consumer-run organizations |
| <input type="checkbox"/> Social service workers | | |
-

Aspirations/Desires

- Is there anything that you would like to be different in your social life?
- Are there any areas of you life you would like to have more support in? (e.g., spirituality, better relationship with family, more friends, someone to go camping with, etc.)
- Are there organizations, groups, clubs that you do not currently belong to, but would like to? (e.g., church, rotary club, book club, astrology club, etc.)

Resources

- Have there been important people in your life (e.g., friends/family) that you have felt supported by in the past but currently do not spend time with? Who?
- Are there places you used to hang out/people you used to hang out with that you do not currently? Describe who and where.
- In the past, did you belong to any groups, clubs, and/or organizations? What were they? Did you enjoy them? What did you enjoy about them?

Health

Current Status

Psychiatric

- Psychiatrist currently seeing
- Medications
- Do you experience symptoms of your illness? What are they like? What kinds of things do you do to cope with or manage your symptoms?
- What produces stress for you? What do you do to manage stress?

Physical

- Medical Doctor currently seeing
- Dentist
- Description of physical health
- Diet and eating habits
- Do you exercise? What type?
- Pharmacy and Pharmacist
- Use of over the counter medications
- Birth control
- Smoking habits

Desires/Aspirations

- Are there things you are working on or would like to work on with regard to your physical or mental health? (e.g., losing weight, managing symptoms, smoking less, drinking less, etc.)
- What is important to you in this area? Is there anything you would like to learn more about, improve, or change in this area?

Resources

- Address resources used in the past for any of the areas mentioned in current status.
- Patterns of hospitalization: When was your last hospitalization? Was it state or private? How often do you typically go into the hospital? What happens before you go in (precipitating factors)? Are the hospitalizations usually voluntary or involuntary?
- Were any of the resources used in the past (doctors, hospitals, exercise activities, medications, diets, symptom management techniques, etc.) particularly helpful?

Leisure/Recreation

Current Status

- What do you do for fun?
- What are your hobbies?
- What do you do to relax and enjoy yourself?

↳ Example Areas of Leisure/Recreational Activities

- | | | |
|---|---|--|
| <ul style="list-style-type: none">▪ Sports activities:
Basketball, football, softball, tennis, swimming▪ Individual entertainment:
Listening to the radio, TV, people watching, listen to music▪ Meditative Pursuits
Prayer, yoga, bible study | <ul style="list-style-type: none">▪ Outdoor - Nature Activities:
Hiking, fishing, canoeing, picnics, hunting, camping▪ Intellectual Pursuits
Reading, lectures, non-credit classes, going to library▪ Trips, Excursions, Vacations
Shopping | <ul style="list-style-type: none">▪ Social pursuits:
Parties, visiting, table games, talking on the phone, shopping▪ Cultural/Artistic
Instruments, painting, crafts, visiting museums, art class, concerts, movies▪ Cooking, Baking, or Knitting |
|---|---|--|
-

- Do you ever go out and do things on weekends? If so, what do you usually do?
- Do you have a TV? Would you like one? What is your favorite TV show? Do you like movies? What kind? Who is your favorite actor?
- Do you like to read? Who is your favorite author? Do you go to the library?
- Do you like to cook? What is your favorite meal? Do you like to go out to eat?
- If you could do anything you wanted for one day, what would you do?
- When do you get bored? What do you do when you get board?

Desires/Aspirations

- What fun things do you like to do, but are not doing currently?
- Have you ever wanted to try something that sounded like fun, but you never have done?
- Explore desires listed in current status.

Resources

- Explore past involvements, interests, activities listed in current status. Where did the person do the activities? With whom?
- What activities did you most enjoy in the past? What was it about the activities you enjoyed?

Spirituality

Definition

Spirituality refers to any set of beliefs and/or practices that give a person a sense of hope, comfort, meaning, purpose in their life, or a connection to the greater universe.

For some people this may have to do with God and some type of organized religion, for others it may be an individual relationship with a higher power, for others it may not be specifically defined. Religion is not necessarily synonymous with spirituality.

Do not limit the definition to only an institution, church, or denomination. Also, do not impose your own thoughts or beliefs on the person.

Examples

- | | | |
|---------------------|--------------------------|---------------------|
| ▪ 12-step | ▪ Meditation | ▪ ARrt |
| ▪ Community Service | ▪ Temple | ▪ Music |
| ▪ Nature | ▪ Organized Religion | ▪ Rituals |
| ▪ Altruism/giving | ▪ Fellowship with others | ▪ Political Justice |
-

Possible Approaches to Talking About Spirituality

- Is there anything in your life that brings you a sense of comfort, meaning, or purpose in your life?
- What gives you the strength to carry on in times of difficulty?
- What do you believe in?
- What do you have faith in?

This topic can also come up within other life domains, such as social support. Often times, spirituality is linked with connection to others in a social context.

Quality Review of Strengths Assessment

Consumer's Name _____ Date Reviewed _____

Case Manager's Name _____

- | | | | |
|-----|----------|----|--|
| Yes | Somewhat | No | Complete and thorough - each life domain has rich and detailed information. |
| Yes | Somewhat | No | Individualized and specific – gives a clear picture of who this person is. (Here's a good test. Blank out the name and make copies for everyone on the team. Team members should be able to readily identify this person by the information provided.) |
| Yes | Somewhat | No | Clear indication of the person's involvement in the assessment – signature, person's comments, information written by person, written in person's own words, etc. |
| Yes | Somewhat | No | Used in an on-going manner – updated regularly upon meeting with person (weekly for first few meetings, at least monthly after that). |
| Yes | Somewhat | No | Includes natural resources (as opposed to only formal resources) in <u>each</u> area. |
| Yes | Somewhat | No | The individual's wants and desires are listed, prioritized and written in person's own language (vs. professional jargon). |
| Yes | Somewhat | No | Reflects cultural, spiritual, ethnic, and/or racial information that holds meaning for the person. |
| Yes | Somewhat | No | Reflects person's skills, talents, accomplishments and abilities – what they know about, care about, have a passion for in each life domain. |

Section 4

Group Supervision: Creativity Unleashed



“No idea is so outlandish that it should not be considered with a searching but at the same time steady eye.”

– *Winston Churchill*

“It is better to have enough ideas for some of them to be wrong, than to be always right by having no ideas at all.”

– *Edward de Bono*

“If at first the idea is not absurd, then there is no hope for it.”

– *Albert Einstein*

“To think creatively, we must be able to look afresh at what we normally take for granted.”

– *George Kneller*

“Synergy is the highest activity of life; it creates new untapped alternatives; it values and exploits the mental, emotional, and psychological differences between people.”

– *Stephen Covey*

Group Supervision: Process Description

Group supervision is the fuel that keeps strengths model practice alive and strong on a team level. The structure is designed to keep the team focused on generating creative strategies, rather than digressing into venting or rehashing of problems. Group supervision consists of six steps; each is distinct and critical to the success of the process. Each discussion of a client situation should take no more than 20-30 minutes so that four or five clients can be covered during a typical two-hour group supervision.

Step 1: Hand out Strengths Assessments – The presenting staff person makes copies of a strengths assessment for every team member and hands them out. The process will NOT work unless each team member has his or her own copy of the strengths assessment for the person being presented.

Step 2: What do I need? – The presenting staff person states very precisely what he or she needs from the team (i.e., I need ideas on how to engage with Mary; I need help on how to assist Joe to reach his goal, etc.). This keeps the provider and team focused on what is to be accomplished in this meeting.

Step 3: Thumbnail sketch – The presenting staff person gives a one to two minute description of the situation and a few things that have already been tried.

Step 4: Questions only – For five to ten minutes the team asks questions of the presenting staff person to further clarify things written on the strengths assessment or other relevant information. For example, “It says here that the grandmother is supportive. Tell me more about her role in the person’s life?” No advice can be given in this section, only questions that will help with brainstorming in the next section.

Step 5: Brainstorming – For five to ten minutes the team brainstorms ideas. The presenting staff person (or other designated person) **MUST** write down every idea without speaking (i.e., no evaluation of the ideas or “yes, buts”). For example, “The client could ask the grandmother to call her every Saturday to see how she is doing.” The list should include approximately 20 to 40 ideas.

Step 6: Clarification of Ideas – The presenting staff person reviews the ideas and asks for any additional information if needed to carry out the suggestions. For example, “You mentioned this community service; do you know who the contact person there is?”

Step 7: Next Steps – The presenting staff person states what they will do based on the suggestions received. The plan should be stated as specifically as possible. For example, “I will meet with John on Friday and I will have him do a pro/con list regarding going back to work.”



Social History Ideas

Ideas generated:

What types of ideas were generated?

Group Supervision Ideas

Ideas generated:

What types of ideas were generated?

What was reinforced?

What was different about the process?

The Role of the Supervisor in Group Supervision

It is up to the supervisor to make group supervision a positive and powerful experience for staff. Here are some ways for the supervisor to make most effective use of group supervision time:

- 1) Help staff prepare for group supervision. If they do not have an updated strengths assessment, have them do this before presenting. Meet with the staff person to help them clarify what type of help they will be asking from the group
- 2) Hold group supervision in a place that minimizes distractions. Hold calls and messages until after supervision is over (except for emergencies).
- 3) Start group supervision on time. Make it a team expectation that everyone is present and ready to go.
- 4) Keep staff on track with the process. There is a reason for each step and it maximizes the help the presenting person will receive. Don't allow staff to jump too quickly into suggestions before adequate time for questions of clarification from the strengths assessment.
- 5) Follow-up with the presenting staff person to see if they need additional help from you in carrying out the suggestions brought up in group supervision. A supervisor might offer to do a role play with the staff person, provide field mentoring, or give them ideas on how to implement the suggestions with the consumer.
- 6) Use group supervision time to celebrate successes from previous group supervision sessions. Nothing encourages staff to present more than to see that it is making a difference.
- 7) Help staff to see cross-application for working with other consumers besides the one being presented. For example, "Jill, you are also working with someone who just had a relapse. Some of these ideas presented might be helpful to you as well."



Group Supervision – What’s It Going to Take?

What SPECIFIC steps would you need to take to accomplish your first group supervision in the next month?

What specific steps did you learn from other supervisors?

Section 5

Integrating the Strengths Assessment into Practice



Many case managers once becoming skilled at completing the strengths assessment may still find it difficult using this tool in a pro-active, purposeful manner in daily practice. The supervisor can help case manager build their skills in using the strengths assessment through regular review of consumer charts and giving staff specific feedback on how to incorporate the strengths assessment into practice. Here is an example of how a supervisor might conduct this review and feedback process.

- 1) Have each case manager pick one or two people on their caseload to use for the review process.
- 2) Have the case manager complete a strengths assessment on the person(s) they have chosen. Rather than expecting staff to start using a newly learned tool with every person they are working with and do a mediocre job, have them practice doing high quality strengths assessment on one or two people. These skills can be transferred to working with other people over time.
- 3) Give the case manager feedback on the strengths assessment he/she has completed asking them questions to see if any of the information can be made more specific or useful. For example, “You put down his sister as a source of support. What are the specific ways the sister is a support for him?” or “You mention these three previous jobs the person has held in the past. Any specific skills they possess in doing these jobs? These are strengths that could be added to the assessment.”

-
- 4) With the completed strengths assessment in front of you, review progress notes from the previous two months with the case manager. Have the case manager talk where he/she sees themselves going with the person and what his/her plan is for future visits. Give suggestions on how to build upon information currently in the strengths assessment or what areas might need to be further explored.
 - 5) Continue to meet with the case manager regularly to review weekly progress, using both the strengths assessment and the progress notes to guide discussion. Look for opportunities where a case manager might need further skills training to enhance their practice (e.g., motivational interviewing, medication education, stage-wise interventions for persons with substance abuse problems, or engagement skills).
 - 6) Offer field mentoring.

Section Six

Field Mentoring: Supporting Staff in their Work

Field mentoring is a supervisory tool used to help staff further develop and refine their use of skills and/or tools in actual practice. The environment for field mentoring should be one of mutual learning and professional development rather than micro-management. There should be an expectation that all staff continue in their professional development throughout the year, and the role of the supervisor is to support the enhancement of their professional skills.

The following are some examples of ways to provide field mentoring.

Field Mentoring Interventions

<p><u>Intervention #1</u></p> <p>Observe ↓ Provide Feedback ↓ Role Play ↓ Discuss</p>	<p><u>Intervention #2</u></p> <p>Model ↓ Discuss ↓ Observe ↓ Provide Feedback</p>
<p><u>Intervention #3</u></p> <p>Observe ↓ Prompt Skills ↓ Model Skills ↓ Discuss/Provide Feedback</p>	<p><u>Intervention #4</u></p> <p>Role Play ↓ Provide Feedback ↓ Observe ↓ Provide Feedback</p>

Intervention #1 – Here the case manager takes the lead role in working with the consumer with minimal involvement from the supervisor. After the session, the supervisor and case manager discuss what worked well and what did not. Using role play, the supervisor models as the case manager and presents alternative ways the session might have been conducted. The role play is discussed, along with possible switching of roles for further practice.

Intervention #2 – Here the supervisor takes the lead role in working with the consumer for the purpose of modeling how to use a specific skill or tool. The supervisor and case manager discuss the session afterwards. On a subsequent session, the supervisor observes the case manager using the skill or tool. Afterwards, they discuss the session.

Intervention #3 – Here the case manager takes the lead role in working with the consumer and will try using a new skill or tool. If needed the supervisor might intervene during the session and assist by modeling the skill or tool. Afterwards the supervisor and case manager discuss the session.

Intervention #4 – Here the supervisor and case manager role play using a new skill or tool prior to meeting with the consumer. The supervisor gives the case manager feedback on using the skill or tool. The supervisor then goes out with the case manager to observe him/her using the skill or tool with an actual consumer. Afterwards, the supervisor provides feedback to the case manager.

Field Mentoring Checklist

Goal: _____

Specifics Skill/Area of Focus: _____

Feedback:

1. What were specific strengths observed during field mentoring?

2. What effective interventions/approaches were used?

3. Were there any obstacles encountered?

4. What alternative interventions/approaches could have been used?

5. In what areas would the case manager like further support in developing skills

Plan for Follow-up:

1. _____
2. _____
3. _____
4. _____

Field Mentoring Exercise

Scenario #1

Ted is new to the agency, but has a lot of enthusiasm for doing case management and has a positive view of clients. He has some knowledge of psychiatric disability and addictions, but has a low skill set in regards to strengths-based case management. He has a great attitude in team meetings, but you start to get the feeling that he is only positively reframing some of things that are going on with his clients and not much progress is occurring regarding his clients' recovery. He rarely presents at group supervision, because he says that "things are going pretty well with most of my clients".

Scenario #2

Jennifer has been with the agency for several years and has always received positive marks on her performance evaluation. She views herself as a highly competent practitioner. She has been resistant to using the strengths-based tools the agency is implementing saying that they do not work with most of the clients on her caseload. She does them, but only with minimal effort and from reviewing strengths assessments and personal plans it appears that she is doing these without any of the client's direct input.

Scenario #3

William initially embraced the strengths-based philosophy and the strengths assessment. His strengths assessments are among the best you have ever seen, gathering rich and detailed information. He loves to present at group supervision and long lists of ideas are always generated to give him help in the field. In reviewing his charts though, his progress notes do not seem to reflect that he is actually using any of the information he gathers on the strengths assessment or the ideas from group supervision. He still presents frequently at group supervision, but you sensing he is getting frustrated with his work.

Section Seven

Client-centered Feedback: Brining Everyone Along



One of the burdens of leadership is to be unpopular when necessary.

“My great concern is not whether you have failed, but whether you are content with your failure.”

– Abraham Lincoln

“I don’t know the key to success but the key to failure is trying to please everybody.”

– Bill Cosby

“It isn’t the people you fire who make your life miserable, it’s the people you don’t.”

– Unknown

“When you go in for a job interview, I think a good thing to ask is if they ever press charges.”

– Jack Handy

Minimal Conditions for Successful Feedback

- 1) Making standards for work clear
- 2) Create a learning environment
- 3) Believe that your staff can learn, grow and change!
- 4) Know and recognize the strengths of your staff
- 5) Seek feedback for yourself (role model) as well as giving it to your staff
- 6) Be specific

Assessing the Situation

Identify a specific staff member whom you have had a challenge supervising in the past. Fill out the following spaces related to a SPECIFIC ISSUE that has presented a problem.

- 1) What is happening that presents a problem (only the facts, no judgments)

- 2) What do you want? What are your expectations?

- 3) What are the person's strengths? What are they doing well? (Be specific.)

- 4) What do you think are some things you might be able to do to HELP?
(Brainstorming, not what you will do, but what you COULD do)

Process of Giving Feedback

Using the same staff you identified earlier, write out a “script” of how you might give feedback to him/her using the following five steps.

1) Identify the person’s strengths

(e.g., Rather than starting off by identifying the problem (step 2) you might say, “I wanted to meet with you to give you some feedback. First of all, you are doing a great job of discovering new resources like the food bank and new job leads for the team...”)

2) State the situation in behavioral terms

(e.g., Rather than, “You are not getting your paper work done” you might say “I was reviewing charts the other day and I found that three of your clients did not have strengths assessments completed.”)

3) Set the tone for the discovery process

(e.g., Rather than, “I would like you to get these completed by next week” you might say... “I am wondering if you could help me better understand why these strengths assessments are not being completed.”)

4) Brainstorm alternative strategies

(e.g., Rather than, “I am going to...” you might say... “I would like you to give me some suggestions as to what I could do to help you get your strengths assessments done in a timely manner.”)

5) Set a time frame and next steps

(e.g., Rather than, “Ok, we’ll see how it goes” you might say... “I would like to schedule a time to meet with you in two weeks to see how it is going. How about the 15th right after team meeting?”)

Section Eight

Rewards-based Environment: Motivating Excellence



“A leader takes people where they want to go. A great leader takes people where they don’t necessarily want to go, but ought to be.”

– *Rosalynn Carter*

“We cannot expect people to do the right thing unless they know the right thing to do.”

– Unknown

“If your actions inspire others to dream more, learn more, do more and become more, you are a leader.”

– John Quincy Adams

“A leader’s role is to raise people’s aspirations for what they can become and to release their energies so they can try to get there.”

– David R. Gergen

The Power of Positive Reinforcement

1) Reinforce specific behavior

“Joe, great job in team meeting today.” (General recognition)

“Joe, I was really impressed with the creative strategies you came up with for helping Mike reach his goal of getting a job with animals. Your active participation in group supervision shows your commitment to the recovery of the people we serve. (More specific recognition)

2) Use immediate reinforcement

Recognizing someone’s accomplishments at a scheduled staff meeting or annual performance review (delayed reinforcement)

“Rather than waiting to recognize someone at monthly staff meetings, Mary likes to recognize staff when they help a person get a job immediately by sending the staff person an email and copying it to her supervisor.

3) Reward small, incremental achievements

For staff who are assisting people move from group homes or nursing facilities into their own apartments, Nancy, the supervisor, will recognize efforts toward goal attainment in group supervision and not wait until the goal is successfully accomplished before acknowledging the case manager.

4) Use intermittent reinforcement

Curt, the program director, reviews strengths assessments weekly to access high fidelity, he then makes a list of all case managers with high fidelity strengths assessments and randomly draws one name from the list every few weeks to reward with movie passes.

Types of Rewards

1) Verbal praise

Examples:

2) Written praise

Examples:

3) Symbolic rewards

Examples:

Application of Rewards-based Environment

One thing you learned during the strengths training that made you think, “We need to be doing more of _____ with our team.”

Write down at least 3 ways that you could create a “rewards-based environment” that would support your staff in making progress toward this activity.

Strategies I learned from other supervisors:

APPENDIX A
Performance Plan

--- "If it is to be, it is up to me." ---

Performance Plan

Agency:

Name:

Date:

Goal:

Tasks to achieve goal	Responsibility	Date to be Accomplished	Date Accomplished	Comments

Tasks to achieve goal	Responsibility	Date to be Accomplished	Date Accomplished	Comments

APPENDIX B
Strengths Assessment

Strengths Assessment

Consumer's Name

Case Manager's Name

Current Status: What's going on today? What's available now?	Individual's Desires, Aspirations: What do I want?	Resources, Personal Social: What have I used in the past?
Daily Living Situation		
<p>Living in Transitional Living Apts. (I don't want to stay there, but its better than the shelter).</p> <p>Likes to cook hot dogs, corn dogs, mac & cheese, burritos, etc.</p> <p>Has bus card</p>	<p>I want a place of my own</p> <p>I want to learn how to cook more Mexican food</p> <p>I need new shoes!</p>	<p>Lived in Bellview group home (hated it!- could only watch TV until 9:00pm, they decided what you could watch and they told you when to go to bed)</p> <p>I have lived with parents</p>
Financial/Insurance		
<p>\$376 SSI (\$120 goes for rent) \$78 food stamps</p> <p>The County is my payee I get \$50 per week for spending money. They make me put the rest in savings (I don't need savings, I need food)</p>	<p>I want to be my own payee (They are messing with my money and it's not right)</p> <p>I want to have more money to do the things I want</p>	<p>Mom used to be payee until she got real sick. Transferred payeeship to Bellview. Mom used to give me extra money.</p>
Vocational/Educational		
<p>I go to classes at the psychosocial program: symptom management, money management, etc. (Those things don't help me at all)</p>	<p>I want a job</p> <p>I want out of day program</p>	<p>I used to sweep floors and clean bathrooms at ASH. I did a good job. Would sometimes wash dishes in the kitchen.</p>
Social Supports		
<p>Tony – roommate (He pays for cable, sometimes we put our money together and rent movies)</p> <p>“I don't like my other roommates. They're weirdos, something's really wrong with them.”</p>	<p>I wouldn't mind getting married. There is a girl here at the center I like. I'm going to ask her out when I get out of here.</p>	<p>Mom – she was always there for me. Never got along with my dad. Uncle (Bud) – we used to go fishing. He moved here to Wichita when I was a kid, but I don't know where he is now. Cousins</p>

Health		
<p>I'm in good health, but my teeth hurt.</p> <p>Medication (Seroquel) helps somewhat but I don't like the side effect, sometimes feel like I'm coming out of my head. I do better at night.</p>	<p>I need to get my teeth looked at. I think they might have to pull a couple.</p> <p>I want to stop taking medications. I don't like the side effects</p>	<p>I used to have asthma when I was a kid, but I do better now, as long as I don't try to run when it's cold outside</p>
Leisure / Recreational		
<p>I like to watch TV – old westerns, Vincent Price movies. I watch any movie that is on TV.</p> <p>Tony and I rent movies. He likes comedies, but I like action (It doesn't matter though)</p> <p>I know a lot about movies</p>	<p>I want my own TV for my room. I have enough in savings to get one, but they say I can't use it for that.</p> <p>I want a VCR</p>	<p>Used to go fishing a lot Used to have my own pole and tackle box.</p> <p>Used to go to the movie house when I was a kid, sometimes with mom, sometimes with friends</p>

What are my priorities?

- | | |
|--|--|
| <p>1. I want a job</p> <p>2. I want to be my own payee</p> | <p>3. I want out of psychosocial</p> <p>4. I want my own place</p> |
|--|--|

<p>Consumer's Comments:</p>	<p>Case Manager's Comments:</p> <p>Dean is a very funny guy. He tells great stories. I have also never met a person who knew so much about movies (knows who starred in just about every movie)</p>
<p>_____</p> <p>Consumer's Signature Date</p>	<p>_____</p> <p>Case Manager's Signature Date</p>

APPENDIX C

Treatment Summary for Dean

Client's Name: Dean

Age: 42

Axis I: 295.10 Schizophrenia: Disorganized Type

Axis II: 301.7 Antisocial Personality Disorder

Axis III: high blood pressure

Axis IV: illiteracy, unemployment

Axis V: GAF score: 20

Living Situation

Client has been living in Wichita for two years. Spent first five months living either in homeless shelters or on the streets. Now resides in the Sedgwick County Transitional Living Apartments with three other roommates. Does not interact much with roommates. Has been accused of taking food belonging to roommates. Becomes hostile when confronted.

Client came to Wichita via bus from Little Rock, Arkansas. Had been living in group home there for eight years. Ran away from group home to find an uncle who he thought lived here in Wichita. No record of uncle living in Wichita. Transported to shelter by police after trying to spend the night at bus station.

Psychiatric History

First psychiatric hospitalization at age 17. Mother committed him after he became threatening to her. Spent 14 years in Arkansas State Hospital. Discharged in 1978 to group home. Re-hospitalized 12 times between 1978 and 1986.

Vocational/ Educational History

Client attended public schools until 3rd grade. Was withdrawn by parents to be home schooled. Client has limited reading and writing skills. Has never held paid employment. Only vocational activity has been work crew units (janitorial) at Arkansas State Hospital.

Social History

Client's father died when he was 12. Mother died when client was 33. Client has no social support network here in Kansas. Has difficulty making friends. Client has never been married.

Financial

Client receives \$376 in Supplemental Security Income. Sedgwick County Department of Mental Health is client's payee. Is not able to manage money well.

Presenting Problem

Client currently attends day treatment program five days per week. Has been increasingly hostile during the past few weeks. Was suspended for one day last week for yelling at clerical staff when they refused to give him bus tickets. Client states that he does not want to be at day treatment and wants to go to work. He has been repeatedly calling Social Security telling them that Sedgwick County is stealing his money and that he wants to be his own payee. Client is currently being prescribed Resperidol, but may need to go back on injections. Client seemed to respond better to injections. May need to be re-hospitalized if further behavioral problems continue.

APPENDIX D

Blank Strengths Assessment & Goal Worksheet

Strengths Assessment

Consumer's Name

Case Manager's Name

Current Status: What's going on today? What's available now?	Individual's Desires, Aspirations: What do I want?	Resources, Personal Social: What have I used in the past?
Daily Living Situation		
Financial/Insurance		
Vocational/Educational		
Social Supports		

Health		
Leisure / Recreational		
Spirituality/Culture		

What are my priorities?

- 1. 3.
- 2. 4.

Consumer's Comments:	Case Manager's Comments:
<hr/> Consumer's Signature Date	<hr/> Case Manager's Signature Date

Goal Worksheet

For: _____ Case Manager: _____ Date: _____

Long-Term Goal (The "Passion Statement):

Measurable Short-Term Goals Toward Achievement (Tasks or Action Steps)	Responsibility	Date To Be Accomplished	Date Accomplished	Comments:

Consumer's Signature

Date

Case Manager's Signature

Date

Other

Date

APPENDIX E

Quality Review of Strengths Assessment

Quality Review of Strengths Assessment

Consumer's Name _____ Date Reviewed _____

Case Manager's Name _____

- | | | | |
|-----|----------|----|--|
| Yes | Somewhat | No | Complete and thorough - each life domain has rich and detailed information. |
| Yes | Somewhat | No | Individualized and specific – gives a clear picture of who this person is. (Here's a good test. Blank out the name and make copies for everyone on the team. Team members should be able to readily identify this person by the information provided.) |
| Yes | Somewhat | No | Clear indication of the person's involvement in the assessment – signature, personal comments, information written by person, written in person's own words |
| Yes | Somewhat | No | Used in an on-going manner – updated regularly upon meeting with person (weekly for first few meetings, at least monthly after that) |
| Yes | Somewhat | No | Includes natural resources (as opposed to only formal resources) in <u>each</u> area. |
| Yes | Somewhat | No | The individual's wants and desires are listed, prioritized and written in person's own language (vs. professional jargon). |
| Yes | Somewhat | No | Reflects cultural, spiritual, ethnic, and/or racial information that holds meaning for the person. |
| Yes | Somewhat | No | Reflects consumer's skills, talents, accomplishments and abilities – what they know about, care about, have a passion for in each life domain. |

APPENDIX F

Strengths Assessment – Example

Strengths Assessment

Consumer's Name

Case Manager's Name

Current Status: What's going on today? What's available now?	Individual's Desires, Aspirations: What do I want?	Resources, Personal Social: What have I used in the past?
Daily Living Situation		
- Lives with her two children (Abbey & Devin) - Lives on bus route - Laundry facilities available at apartment complex	"I would eventually like a house with a backyard" "The kids want to get a hamster, but I'm not sure if I'm ready for a pet right now"	- Lived w/ the kids' father for one year" - Lived with mom while going to tech school ("not the best place for me to live") - Used to have a car until it broke down (couldn't afford to get it fixed)
Financial/Insurance		
- Rent assistance through Section 8 - Received TANF and food stamps - Mom helps out financially sometimes	"I want to be able to provide for my kids" "Would like to earn some extra money for birthdays, Christmas, etc."	- Worked at a few fast food places in high school (didn't like pace) - Did data entry for a car dealership for about four months (I liked it, but my life was a mess at that time)
Vocational/Educational		
"Taking care of my kids and myself is a full-time job right now"	"I would like to go back to work when both of the kids are in school" "I might even consider going back to school at some point"	Completed GED in 2002 Completed year of tech school (clerical) - see financial section above
Social Supports		
- Mom is there to help with the kids - Susan has been my best friend since high school (I can call her anytime "My kids are my life"	"Susan is great, but I would like to get to know other moms with kids" "I would like to feel more comfortable in social situations"	"My grandmother was always there for me until she died "I had a few other friends in high school, but we went our separate ways" "People at church were sometimes supportive (some were not)"

Health		
<ul style="list-style-type: none"> - Good overall physical health - Anti-depressants are helpful, but Remeron doesn't seem to be helping as much as it did at first - Taking walks helps with stress 	<p>“I would like to quit smoking at some point (I only smoke outside on the patio right now)”</p>	<p>I used to get more exercise (mostly walking and swimming)</p>
Leisure / Recreational		
<ul style="list-style-type: none"> - Watching sitcoms on TV - Reading science fiction novels - Reading books to my kids 	<p>“I would like to do more things with the kids outside of the house”</p>	<ul style="list-style-type: none"> - Used to enjoy riding bikes - Always enjoyed reading - Used to enjoy writing poetry and other things (helped to get what I was feeling out)
Spirituality		
<p>Praying helps out at times</p>	<p>“I have hope the future is going to be better”</p> <p>“My kids are my hope”</p>	<ul style="list-style-type: none"> - Used to go to church with mom a lot - Used to be involved with church youth activities

What are my priorities?

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Being able to raise my kids 2. Overcoming the depression | <ol style="list-style-type: none"> 3. Having more friends 4. Having a better life for me and my kids |
|--|--|

Consumer's Comments:	Case Manager's Comments:
<p>_____</p> <p>Consumer's Signature Date</p>	<p>_____</p> <p>Case Manager's Signature Date</p>

APPENDIX G

Progress Notes – Example

Progress Note

Date of Service: 10/03/05

Start Time: 9:00am End Time: 10:00am

Goal: Be able to spend quality time with my kids without all the symptoms

Objective: Increase alternatives for keeping self well

Intervention:

Today Mary and I talked about doing a WRAP plan. She states it has been difficult to get up in the morning because of the depression and this affects her ability to care for her two children. We started by making a list of things that are helpful to her when she is not feeling well. From her strengths assessment, we identified: 1) taking a walk with her children; 2) reading science fiction novels; 3) reading books to her children; 4) having her mom take the kids for while and 5) talking with her best friend Susan on the phone.

Mary also reported that she does not think her medications are helping anymore with her depression. She states that she has slept more than usually during the past week. We called to make an appointment with her psychiatrist for 10/10/05 at 2:00pm.

Plan:

I will pick up Mary next week for her appointment with the psychiatrist. Following the appointment, we will continue to work on the WRAP plan. Mary will continue to think of other things are helpful to her when she is not feeling well. Mary will keep a log of the number of hours she is sleeping and report this to her psychiatrist. I will also call to check in with Mary later in the week.

Progress Note

Date of Service: 10/07/05

Start Time: 3:45pm End Time: 4:00pm

Goal: Be able to spend quality time with my kids without all the symptoms of depression

Objective: Increase alternatives for keeping self well

Intervention:

I called to check in on Mary. She made arrangements with her mom to keep the kids overnight because she didn't feel she had the energy to take care of them. Her mom will bring them back over in the morning. I asked Mary about her plans for the weekend. Mary plans on taking the kids to the park on Saturday with her friend Susan. She did not report any suicidal ideation. Mary stated her mom will help out with the kids if needed.

Plan:

Mary will call on her mom and her friend Susan for support if needed over the weekend. I gave Mary the number to Crisis Services in case she needs additional support over the weekend. I will pick Mary up for psychiatrist appointment on Monday 10/10/05.

Progress Note

Date of Service: 10/10/05

Start Time: 9:00am

End Time: 10:00am

Goal: Be able to spend quality time with my kids without all the symptoms

Objective: 1) Increase alternatives for keeping self well
2) Find a medication that helps with the depression

Intervention:

I met with Mary following her psychiatry appointment. She stated her doctor increased her Remeron to 60mg. Mary did not feel like working on the WRAP plan afterwards, instead we went to refill her prescription. Mary and I did make a plan for some activities she could do with her kids this week and also discussed what she could do if she felt overwhelmed by symptoms of depression including having mom come over to get the kids, calling Susan, or calling crisis services.

Plan:

Mary and I will meet on 10/17/05 to continue working on WRAP plan.

Progress Note

Date of Service: 10/17/05

Start Time: 10:00am End Time: 11:00am

Goal: Be able to spend quality time with my kids without all the symptoms of depression

Objective: 1) Increase alternatives for keeping self well

Intervention:

Mary and I completed the first two sections (Wellness Toolbox and Identifying Triggers) of the WRAP plan (See WRAP plan in chart for more information). Mary found this helpful to write things out. Mary will put her Wellness Toolbox sheet on her refrigerator and use it when she experiences any of the triggers she has listed. I also helped Mary start a daily journal, so she can track how things are going using her WRAP plan.

Plan:

Mary and I will meet next on 10/24/05 to review progress on using her WRAP plan and review her daily journal.

Progress Note

Date of Service: 10/24/05

Start Time: 10:00am End Time: 11:00am

Goal: Be able to spend quality time with my kids without all the symptoms of depression

Objective: 1) Increase alternatives for keeping self well

Intervention:

Mary and I reviewed her daily journal and her use of the WRAP plan. Mary reports taking a walk with her kids after dinner each evening was helpful. She has also been able to read with the kids each night before going to bed. Mary wanted to go get some new books for herself, since this helps with her depression, so we went to the used book store to purchase some books for her and the kids.

Mary reports that she is feeling more energy with her increase in medications and that the WRAP plan is helpful. Though she has not felt like journaling every day, she says she would like to continue doing this.

Plan:

Mary and I will meet next on 10/31/05 to review her journal and WRAP plan. Mary will look at the next two sections of the WRAP plan and try to complete what she can.

APPENDIX H

Strengths Assessment – Bad Example

Strengths Assessment

Consumer's Name _____

Case Manager's Name _____

Current Status: What's going on today? What's available now?	Individual's Desires, Aspirations: What do I want?	Resources, Personal Social: What have I used in the past?
Daily Living Situation		
- Has own apartment -	"I like my apartment and want to keep it" "Would like to get my license back and get a car"	"I do best when I'm living on my own (no roommates, especially ones that drink)" Lived in Montana. Used to have a car Used to have a motorcycle (Harley)
Financial/Insurance		
- Receives SSDI and SSI - Medicaid pays for medications and services	"I need more money to live on"	Used to make good money when I worked. A few months ago I made some extra money doing day labor (unloading trucks)
Vocational/Educational		
Made it through 11 th grade Christy is supported employment worker	"I want a job so I can build my own house someday" "I've thought about getting my GED, but not sure what I'd do with it"	Has held many jobs in the past
Social Supports		
- Go to AA - Brother (Dan) - mom - Becky (therapist) - Jay (case manager)	"I need people in my life who believe in me"	- Used to be married (2 years) - My dog buddy (went everywhere with me)

Health		
“My back, arms and legs work”	“I need to eat better” “I don’t want my liver to quit like my dad’s did”	
Leisure / Recreational		
“I like to go down by the river – clears my head” - Listen to music occasionally (county)	“I need more things to occupy my time” “I would like to get a fishing pole”	- Fishing - Camping - Biking across the county - Used to build model cars - Drawing
Spirituality		
“I believe in a higher power” “I have a bible I read occasionally. Reminds me there is more to life than this one”		-Raised Baptist

What are my priorities?

- | | |
|----------------------|------------------------|
| 1. Stay sober | 3. Stay out of trouble |
| 2. Keep my apartment | 4. |

Consumer’s Comments:	Case Manager’s Comments:
<hr style="width: 80%; margin-left: 0;"/> Consumer’s Signature Date	<hr style="width: 80%; margin-left: 0;"/> Case Manager’s Signature Date

APPENDIX I
Progress Notes – Bad Example

Progress Note

Date of Service: 7/6/05

Start Time: 9:00am

End Time: 10:00am

Goal: Maintain sobriety

Objective: 1) Increase supports to help with support for sobriety

Intervention:

Mike has been sober now for almost two months. We talked about how this has been going. Mike says that going to AA, seeing his sponsor and seeing his therapist are being helping to keep him sober. Mike appeared in good spirits and was not overly symptomatic. Mike says he has been taking his medications. Once Mike reaches his two months of sobriety, we will look into making an appointment with supported employment.

Plan:

I will meet with Mike next week at 9:00am.

Note for Record

Date of Service: 7/13/05

Start Time:

End Time:

Goal: Maintain sobriety so I can keep my apartment

Objective: 1) Increase supports to help with support for sobriety

Intervention:

Mike was not home when I showed up at his apartment for his appointment. I called Mike on my cell phone and left a message that I was there and for him to call me back.

Plan:

I will call Mike later this week to reschedule.

Progress Note

Date of Service: 7/18/05

Start Time: 9:45am

End Time: 10:00am

Goal: Maintain sobriety so I can keep my apartment

Objective: 1) Increase supports to help with support for sobriety

Intervention:

I called Mike at his home to see how he was doing. Mike stated he is still maintaining his sobriety, but had a rough weekend after getting into an argument with his brother over money. He was able to go out with his sponsor on Sunday which he found helpful

Plan:

Mike and I will meet on 7/20/05.

Progress Note

Date of Service: 7/20/05

Start Time:

End Time:

Goal: Maintain sobriety so I can keep my apartment

Objective: 1) Increase supports to help with support for sobriety

Intervention:

I went to Mike's house today to see how he was doing. He did not look well, but insists he has not relapsed. It appeared to me that he had been drinking, though I couldn't detect the smell of alcohol. I asked Mike if he was going to his AA meeting today and he said that he was.

Plan:

Meet with Mike next week

Note for Record

Date of Service: 7/27/05

Start Time:

End Time:

Goal: Maintain sobriety so I can keep my apartment

Objective: 1) Increase supports to help with support for sobriety

Intervention:

I went to Mike's house today, but he was not there. I left a message for Mike letting him know I stopped by and asked him to call me.

Plan:

Let Mike's therapist know I was not able to meet with him again today and express concerns about a possible relapse for Mike. I will call Mike again later today.

Progress Note

Date of Service: 7/27/05

Start Time: 1:30pm

End Time: 2:00pm

Goal: Maintain sobriety so I can keep my apartment

Objective: 1) Increase supports to help with support for sobriety

Intervention:

I was able to contact Mike today and he confirmed that he had relapsed. He stated that he went over to neighbor's house where they started drinking together. Mike wants to get back into inpatient treatment. I will contact Mike's therapist and see what we need to do to get him back in.

Plan:

Contact Mike's therapist.

APPENDIX J

Field Mentoring Scenario #1

Field Mentoring Scenario #1
Skill Focus: Motivational Interviewing

Client

You have been thinking about going back to work for a few months now, but have never told anyone before today. Today, you decide to tell your case manager that you are thinking about going to work. You still aren't sure that you really want to go back to work, but you want to see what your case manager thinks. Throughout the conversation bring up a lot of uncertainties you have about working. For example: 1) you are worried about losing your benefits and being able to pay for medications; 2) you are worried about transportation; 3) you are worried that your family will not be supportive of you working since you went into the hospital after your last job attempt three years ago; and 4) you are worried about co-workers knowing about your disability if you do return to work.

The case manager may not acknowledge all your concerns, but just keep going along with the case manager's recommendation. In the end, allow the case manager to go ahead and set up an appointment for you to see the supported employment worker.

Field Mentoring Scenario #1
Skill Focus: Motivational Interviewing

Case Manager

The client is going to tell you that they are thinking about going back to work. Act excited about hearing this news. Immediately start to set up an appointment with supported employment. The client will be telling you some uncertainties they have about going to work, but just discount them. Keep telling them that the supported employment worker will help them sort all those things out. Keep coming back to the fact that first we need to get you in to see a supported employment specialist. Be friendly, keep assuring the client that it's going to be okay and be persistent on getting the appointment with the supported employment worker set up before the appointment is over.

APPENDIX K

Field Mentoring Scenario #2

Field Mentoring Scenario #2
Skill Focus: Processing Decisional Uncertainty

Client

You have been struggling with taking your current medications and are thinking about going off them. Your case manager will ask you how you are doing, so tell them about your concerns about the medications: 1) you don't think they are working (they only seem to be making you feel sleepy; and 2) you don't seem to have the energy anymore to get out of the house and do anything like visit friends and you are having difficulty reading, which is important to you.

The case manager will want to get you back in to see the doctor. Tell him/her that the doctor doesn't seem to listen. In the end, agree to continue with the medications for now and meet with the case manager again next week.

Field Mentoring Scenario #2
Skill Focus: Processing Decisional Uncertainty

Case Manager

The client is going to tell you that they are thinking about going off medications. Act surprised and a little nervous about this decision. They will be giving you reasons why they want to stop medications, but keep telling them about the importance of taking medications. Emphasize that they have been doing better than they have in a long time. Tell them that if they go off their medications there is the possibility they will get worse and go back into the hospital. Ask them if they would like to talk to the doctor about the medications. No matter what they say, continue to stress the importance of continuing their medications.

If the client doesn't want to set an appoint to talk to the doctor about meds, at least get them to agree to continue with the medications for now and the two of you can talk more about this next week.

APPENDIX L

Field Mentoring Scenario #3

Field Mentoring Scenario #3
Skill Focus: Goal Setting

Client

Your case manager has been taking you to the grocery store every week for the past six months. They are going to ask you about other goals you want to work on besides just going to the grocery store. You can't think of anything else. Keep telling them how important it is that you get to the grocery store and how you don't feel comfortable going there alone. You have no one else in your life to take you. Your case manager is the only person that seems to care about you.

Your case manager will try to help you think of other goals. Go along with them, but every so often say "I don't know why you just can't take me to the grocery store". Whatever plan the case manager helps you develop, go along with it.

Field Mentoring Scenario #3
Skill Focus: Goal Setting

Case Manager

You have been taking this particular client to the grocery store every week for the past six months and you are beginning to feel a little frustrated that this is all you seem to be doing together. Let the client know that you will not be able to do this with them forever. Try to set some goals with the client around helping them to do grocery shopping on their own. For example, explore with them some options of either someone else taking them to the grocery store or getting their own transportation. If there is no one else to take them, consider setting a goal of meeting new people who could be supports.

One of the reasons the client wants you to take them to the grocery store is because they don't feel comfortable being there alone. Consider setting a goal to gradually increase shopping by themselves. Offer some strategies for how you might do this.

APPENDIX M

Field Mentoring Scenario #4

Field Mentoring Scenario #4
Skill Focus: Strengths Assessment

Client

You want to move out of your parent's house, but have never lived on your own before. Your parents are okay with you moving out, but would rather you live in the one of center's congregate living facility. Your case manager is willing to look into both options, but keep stressing that you really want to live on your own.

Your case manager will do a strengths assessment with you. You do not have a lot of resources, but give the case manager some information on the strengths you do have (e.g. know how to cook, has a best friend who you see once a week, knows the bus system, like dogs, etc.).

Field Mentoring Scenario #4
Skill Focus: Strengths Assessment

Case Manager

The client wants to move out on his/her own, but they have never lived on their own before. The client's parents want them to move into your center's congregate living facility, so the client can have the support he/she needs and can eventually learn the skills needed to live independently. Tell them about the benefits of the facility, but also be willing to explore living independently. Do a strengths assessment with the client and see if living on their own is possible at this time.

APPENDIX N

Title Page Abstract – Barriers to EBP Implementation

Barriers to Evidence-Based Practice Implementation:

Results of a Qualitative Study

November 30, 2006

Abstract

This study reports on a qualitative study of barriers to EBP implementation in one state that sought to implement supported employment and integrated dual diagnosis treatment. The study found that the most significant obstacles emanated from the behavior of supervisors, front-line staff and other professionals in the agency. A lack of synergy profoundly impeded implementation.

Key Words

Evidence-Based Practice Implementation, Integrated Dual Diagnosis Treatment, and Supported Employment.

Barriers to Evidence-Based Practice Implementation:

Results of a Qualitative Study

November 30, 2006

Charles A. Rapp, PH.D.
Diane Etzel-Wise, M.A.
Doug Marty, M.S.W.
Melinda Coffman, B.S.
Linda Carlson, M.S.W.
Dianne Asher, M.S.W.
Jennifer Callaghan, M.S.W.

The University of Kansas
School of Social Welfare
Twente Hall
Lawrence, Kansas 66044
785-864-8946
Fax: 785-864-5277
e-mail: charlier@ku.edu

The authors would like to thank Professor Edward Canda from The University of Kansas School of Social Welfare, and Rob Whitley and Greg McHugo from the Dartmouth College Psychiatric Research Center for their assistance with this paper.

Developed by The University of Kansas School of Social Welfare Office of Mental Health Research and Training through a contract with the Kansas Department of Social and Rehabilitation Services.

APPENDIX O

Barriers to EBP Implementation: *Results of a Qualitative Study*

Barriers to Evidence-Based Practice Implementation: Results of Qualitative Study

During the last decade, multiple sources have documented that people with psychiatric disabilities have difficulty accessing mental health treatment (Wang, Demler & Kessler, 2002; Kessler et al, 1996) and once they do, they infrequently receive services with effectiveness demonstrated through research (U.S. Dept. of Health and Human Services, 1999; New Freedom Commission Mental Health, 2003). The Schizophrenia Patient Outcome Research Team (PORT) revealed that people with schizophrenia were unlikely to receive effective services (Lehman, Steinwachs, et al, 1998). They found, for example, that only 22% of consumers in outpatient programs received any vocational services and Tashjian, et al (1989) found that only 5% of people with psychiatric disabilities received supported employment service. The situation is parallel with other evidence-based practices: medication service, family psychoeducation, integrated dual diagnosis treatment, etc.

A lack of knowledge about implementation processes acts as one barrier to faithful dissemination (Torrey & Gorman, 2005). The National Evidence-Based Practice (EBP) Implementation Project was mounted to explore whether EBP's can be implemented in routine mental health service settings and to discover the facilitating conditions, barriers, and strategies that affected implementation. The project involved 49 sites in eight states. All but one state sought to implement two of the five targeted practices: supported employment, integrated dual diagnosis treatment, family psychoeducation, illness self-management, and assertive community treatment. The project's active stage intervention lasted two years with the first year being devoted to implementation and the second year on sustaining the practice.

This article reports on a qualitative study of barriers to EBP implementation in one Midwestern state that sought to implement supported employment (SE) and integrated dual

diagnosis treatment (IDDT). Each practice was implemented at 3 community mental health centers as part of their Community Support Services. Although all six sites in the state reached a high level of fidelity, it was not an easy task. This paper describes the major challenges experienced by the agencies involved. Subsequent reports will explore facilitating conditions and strategies that benefited implementation.

Methods

The evaluation of the Kansas EBP Implementation Project was carried out in Fall 2005 through Spring 2006. In contrast to the evaluation of the National EBP Implementation Project, this evaluation focused solely on the six sites in one state implementing IDDT or SE EBP's. The research was based on the naturalistic paradigm of Lincoln and Guba (1985).

Sample

After making a commitment to participate in the national project, the Kansas' Department of Social and Rehabilitation Services (SRS- umbrella agency for the state mental health authority) issued a request for and gathered applications from community mental health centers (CMHC) who were interested in either implementing Integrated Dual Diagnosis Treatment or Supported Employment. The SRS Commissioner of Mental Health selected five mental health centers from those applying to participate based on the guidelines presented by the National Project oversight committee (one site offered both EBPs). Guidelines for selection included a mix of rural and urban sites and commitment of agency leadership. Each CMHC designated a team to implement each EBP. The teams consisted of a program leader (in some case, two supervisors shared the role) and 3-6 direct service staff. Each site created a Leadership Team comprised of the CMHC executive director, Community Support Services director, program leader, consumers, families, and a state representative. These meetings were initially facilitated by the Consultant and Trainer (CAT) assigned to the site. The CAT was the principle

support for implementation. The Leadership Team had overall oversight of the project at each site and was the central decision-maker.

Data Collection

Implementation data were collected over two years by implementation monitors and trainers during site visits, trainings, leadership meetings, team meetings, shadowing workers, and through interviews with consumers, direct service workers, supervisors and administrators. Notes reflecting implementation efforts came from monthly Leadership Team meeting minutes, semi-monthly trainer contact notes during the implementation phase (bi-monthly during the sustaining phase), and implementation monitor site visit summaries which occurred monthly through the implementation phase. Implementation monitors and trainers met regularly to share observations, notes and impressions to help ensure consistency with data recording and accuracy. Formal fidelity reviews were conducted every six months by the implementation monitor and CAT during the implementation and sustaining phase of the project. These reviews assessed the agencies' degree of adherence to the particular practice's standards (Bond, Evans, Salyers, Williams & Kim, 2000). Ratings were established in partnership between the implementation monitor and trainer.

Data Analysis

The first step was to organize the raw narrative data for each of the six sites into three categories: Facilitating conditions, strategies, and barriers. Facilitators identified evidence of factors that helped EBP implementation but were not intentionally developed as a result of implementation. Strategies identified evidence of intentional actions seeking to help EBP implementation. Barriers identified evidence of actions seeking to hinder or the intentional failure to act in support of EBP implementation. The second step was to identify the major

themes within this data that helped or hindered implementation. A theme was considered to be a thread of activity or condition that was “salient, prominent, conspicuous, or non-ignorable”. Key stakeholders involved with the theme were also identified. Additional sources of data available for this study included the six final individual site reports. Discussion with the implementation monitor and trainers and, in some cases, agency program leaders were used to clarify “meaning” of some of the data.

In order to enhance trustworthiness (Lincoln & Guba, 1985) (inter-rater reliability), all implementation monitors for the national project participated in monthly conference calls throughout the project and attended annual meetings to learn, discuss and clarify any process or technical issue that arose. This technical assistance was overseen by the project’s coordinating body, Psychiatric Research Center at Dartmouth College (PRC). To enhance reliability, the PRC requested that all participants take turns in submitting examples of collected data monthly. These would then be distributed to the rest of the implementation monitors, coded independently and then reviewed by PRC for reliability. Upon completion of the project and when coding was complete, the Atlas program (Atlasti, 2002) was used to compile the necessary data into structured formats to be used in a final report for each site.

Locality Specific Re-coding

These themes were re-analyzed inductively for this project by a primary team of three. At this stage of analysis, investigators who were not involved in the prior deductive analysis examined the data in the six site reports without preconceived notions of what they would find. This was accomplished by removing the contextual label identified for the theme. They allowed themes to emerge from the data which advanced new concepts not previously theorized. The goal was to develop a set of categories that adequately organized and accounted for the data in the local context of it. The process

was iterative where deeper analysis uncovered flaws and inadequacies in a category scheme demanding reformulations of the categories. In this way, the data continued to drive the analysis.

As a new coding guide was being developed, open coding followed by axial coding (Strauss & Corbin, 1990) led to the emergence of categories establishing a conceptual set of codes for continued analysis. Once a tentative coding guide was determined, two analysts independently coded the data contained from one site. In conjunction with the primary investigator, the results were compared. Through explanation and collaboration, the codes were modified and a final coding guide was established. The final coding guide was then applied to the data of all six sites. Part of the process involved going back to the raw data or the trainers to clarify, inform, and elaborate on specific data contained in the display that appeared ambiguous or lacking of context.

The final categories of barriers were:

Behavior of Front-Line Supervisors

Behavior of Front-Line Practitioners

Behavior of Intra-Agency Member

External Stakeholder Involvement

Funding

All investigating entities participating in the National Evidence-Based Practice Project applied and received approval from their local IRB prior to involvement. For Kansas, application to participate was sought and approval granted from the University of Kansas – Human Subjects Committee Lawrence (HSCL) on January 28, 2002.

Findings

While five categories of barriers were identified, three emerged as most powerfully influencing implementation of the EBP across at least five sites. This was determined based on frequency of mention across sites, the difficulty in overcoming the barrier, and the severity of consequences caused by the barrier. The judgments were made by the four person research team in consultation with the two trainers. Although funding interfered, all six sites easily found ways to overcome it. Similarly, the National EBP project placed primacy on consumer and family involvement as external stakeholders. Despite concerted efforts at all six Kansas sites, this was not achieved but did not seem to influence implementation. The data on barriers that profoundly influence implementation coalesced around the roles, responsibilities, and behaviors of three clusters of personnel: Front-line supervisors, practitioners, and other professional staff within the agency. It is important to note that these barriers endured for 6-9 months of the project depending on the sites. Each of the sites were able to overcome these barriers and achieve high fidelity with the particular practice. The strategies used to overcome these barriers will be presented in a second paper.

Front-Line Supervisors

At each site, the front-line supervisors of pilot teams were designated the program leaders. In every instance, these supervisors and their practice were found seriously lacking and probably was the single greatest barrier to implementation. While supervisory practice deficits were numerous, there were several that were common across sites.

First, at most sites supervisors did not set expectations (EBP-related or otherwise). Practitioners developed their own sense of how to do their jobs. Although clearly understanding the administrative requirements for billable hours and documentation, consultation with supervisors around service delivery only occurred when confronted with difficulties. There were

few prescriptions or structure to their practice. One supervisor saw himself as more of a “buddy” than a “boss”. They seemed to go out of their way to avoid conflict with their staff. At one SE site, practitioner rebellion was answered by placing the project and training on hold for three months because “the team is upset”. (At which time a new program leader/supervisor was hired and some practitioners were transferred or resigned).

There were few examples in the data of workers receiving meaningful feedback on their practice. In fact, few supervisors had but the most superficial knowledge of how their workers practiced. This “laissez faire” form of leadership has been found ineffective in producing high rates of client outcomes (Corrigan, Lickey, Champion & Rashid, 2000). The introduction of the EBP’s with their specific practice guidelines required a new set of behaviors by supervisors who had great difficulty making the transformation. Each attempt to set and enforce EBP expectations was based largely on coaxing, persuasion, and the fervent hope that training and time would eventually produce conforming behavior by direct service workers. There were rarely any consequences for poor performance.

In the EBP project, team meetings were to be dominated by application of the practices to the myriad of ideosyncratic consumer situations. It was to be a primary mechanism for improving the practice of team members. A specific model for doing this, group supervision, was introduced to each agency (Rapp & Goscha, 2006). At the onset, team meetings were not well run and in most cases, the initial set of supervisors never mastered the skills of group supervision. In over half the sites, team meetings were devoted to reviewing administrative matters or brief discussions of consumer crises. The CAT’s notes described this incident:

An employment specialist asked to speak about a consumer issue and the supervisor said “No, not now, I’m on a roll”. The supervisor had been reading administrative announcements from a handout that all employment specialists had received.

In other cases, the meetings were unfocused discussions often dominated by one person that never arrived at a conclusion or next step. In some meetings, direct care staff would do their

paperwork or have side conversations while a case was being discussed, and in others attendance was uneven. At one site, the supervisor never mastered the skill of following a disciplined format for case reviews despite training, consultation and modeling.

Second, according to interviews and site observations two supervisors sabotaged the project in several ways. These supervisors would not follow-through on decisions/instructions emanating from the leadership team or the CAT even when they seemed to agree and endorse the decision. For example, they would follow the guidelines for team meetings when the CAT was present, but otherwise would ignore them. In another case, a supervisor refused to set EBP expectations nor did he set up opportunities for learning or practice and created a team environment of low enthusiasm for the EBP. He did not require practitioners to discuss stage specific interventions and would shorten supervision time because “nothing is going on”. At this site, supervision scores as measured by the General Organizational Index (Drake, Rapp, & Bond, 2002) were on or below 2 (on a 5 point scale) until the 18 month review period when a new program leader was hired and trained in IDDT.

The reasons for these situations were varied. In many cases, supervisors did not know the EBP skills and felt inadequate to supervise the practice. This was true in all IDDT sites. In the SE sites, job development was new to all supervisors. In some cases, supervisors were afraid of exercising their authority and had been imbedded in agencies that did not demand it. In most cases, these supervisors were not involved in the decision to be undertake the EBP project or only superficially so. In three sites, the supervisor also had significant responsibilities unrelated to the particular team’s efforts to implement the EBP. In one case, the supervisor also oversaw therapists and the day treatment program; in another, the supervisor was also the Community Support Service Director; in the third, the supervisor also oversaw the COMPEER and day treatment program. In these situations, their attention was diffused and was susceptible to distractions to EBP implementation.

It should be noted that five out of six project sites enjoyed the support or active championing of the EBP by upper management. In the one exception, the executive director agreed to do the project, delegated overall responsibility for its operation to the clinical director and was never seen again. The clinical director's contribution seemed monopolized with protecting the agency's budget. A sample of statements that occurred in leadership meetings included:

I'm quite concerned about the cost of this plan

Consumers should receive assistance from staff with getting to groups. This will increase billable hours.

I want to avoid having the staff to come to one site for meetings because it eats up too much time in travel.

A new policy on treatment plans was defended: "The advantage of this plan include reduced travel expenses and reduced overhead expenses".

The clinical director did not agree with all the practices imbedded in the IDDT model, had very little commitment to implementation and routinely refused to alter policies (reducing billable hours requirements to facilitate training) or to procure needed resources (attendant care position to help with medications).

Front-Line Practitioners

Data in this barrier category were defined as "Behavior observed of any agency members that have direct responsibility for the implementation of the EBP, indicating doubt or resistance toward consumer recovery or the EBP practice". Practitioner's resistance to the new practices was present in all six sites and formidable at five of the sites. The nature of the resistance varied from profound indifference to open hostility. Others were passive-aggressive, seeming to cooperate when the CAT was present then sabotaging implementation at other times. Often

power struggles ensued between practitioner and program leaders. As one practitioner expressed:

“You are saying that we can’t work with anyone unless they want to work and then we have to get them a job in one month. We are doing bad work. Nothing we are doing is right. When we finish the project, can we go back to doing things the way we are now?”

This resistance occurred in the fertile ground provided by the “laissez faire” management style of the supervisors in five of the six sites. It should be noted that this resistance was not universal. In most of these sites, there were practitioners who were enthused about the EBP and a few even acted as champions of it. The oppositional practitioners, however, created a hostile work environment that made it difficult for other practitioners to express excitement about the EBP or to actively engage.

In virtually all cases, the initial resistance was viewed by agency leaders and the CATS as emanating from the practitioners’ assumptions and lack of knowledge about the work that was contrary to EBP practice. For example, many SE practitioners believed that pre-vocational activities and volunteer work contributed to consumers becoming employed; that in areas of high unemployment employers were not likely to hire consumers; that symptoms needed to be controlled, substance abuse avoided, and hygiene attended to before a consumer could get a job.

“I’ve been doing this for so many years – I disagree with not doing groups and [placing people in] volunteer [positions]. [This change] is not going to last. It’s a big change of who we are... “Volunteering is the root of who we are. I created contract work for people not ready to work. They cleaned group homes, parks, movie theaters...For clients not ready for competitive employment they need to volunteer and to participate in groups to get ready.”

The overwhelming agency belief was with more information, training, and time these myths and the resultant resistance by staff would wane. Much time, often six months or more, was committed to this strategy before it was deemed a failure. In only two situations did practitioners who opposed the practice change their perceptions through training, etc. In the majority of cases, resistant practitioners either left their position or the agency reassigned them.

Intra-Agency Synergy

For a given EBP to reach high fidelity and produce the desired level of consumer outcomes requires agency personnel, beyond the staff targeted for EBP implementation (e.g. supported employment specialist), to practice in certain ways. In both EBP projects reported here, psychiatrists and other medical personnel, were important. Case managers and their supervisors in the supported employment sites were particularly important and substance abuse counselors were necessary for IDDT sites.

Psychiatrists and other medical personnel were important to the implementation of both evidence-based practices yet in four of the six sites, their practice interfered with successful implementation. At one site, the psychiatrist's prescribing practices were contraindicated by IDDT practice and research evidence. He routinely prescribed benzodiazines for DD clients despite the dangers of abuse and further addiction, and told at least one consumer that drinking in "small amounts now and then" was OK. He was also unavailable for team meetings or individual consultations with staff. Of greater concern was that when presented with information concerning these issues, he remained steadfast to refusing to change.

In all the SE sites, psychiatrists, nurses and clinicians rarely discussed work with consumers nor referred consumers to SE services. In general, the SE program was operating in a sea of indifference or hostility to work among other agency personnel. In fact, they often discouraged consumer interest in work because of beliefs such as: 1) work will increase stress and exacerbate symptoms; 2) the clients need their energy focused on "more fundamental issues". One psychiatrist would not grant permission to work when medication regimens were changed until the client was "stabilized" on the regimen (90 days) despite the consumer's desire to work.

Case managers were to be the principle source of referrals to the SE program at all three sites. Case managers, however, informally screened out consumers based on their beliefs about the consumer's ability to succeed or their belief that symptoms would increase due to stress caused by employment. They had little or no knowledge of the role of employment in recovery. They did not understand how work could improve hygiene or decrease substance abuse. Rather, they assumed adequate performance in these areas must pre-date employment. Furthermore, some case managers (and other agency personnel) could not accept alternative perspectives even when presented with considerable evidence.

The integration of SE services into case management teams was difficult. While each site moved quickly to assign one SE specialist to each team, actual integration took longer. CM team leaders, case managers and even SE specialists were not sure how they were to act during these meetings or what role they were to play. At first, they just attended. The team meetings did not allow for participation of SE specialists, and work was rarely mentioned as teams reviewed particular case situations.

The integration of substance abuse counselors was critical to IDDT implementation. In two of the three IDDT sites, there were significant problems. At one site there were no SA counselors within the agency. This was a barrier throughout the implementation. The CSS program created an IDDT Liaison position, but this position served all of CSS (650 consumers). This made it impossible for the IDDT Liaison to become integrated into the IDDT team (couldn't attend very many team meetings). There was also limited availability for individual SA counseling for IDDT clients.

At another site, the IDDT practitioners did not have contact with the agency's substance abuse counselors who were housed in a different building across town. These counselors were not providing services to dually diagnosed consumers. One team member did assume the role of "unofficial substance abuse specialist" by virtue of facilitating a dual diagnosis group based on

the “12 steps”. Other practitioners looked to him for dual diagnosis expertise. The introduction of the IDDT-EBP threatened his role of “expert” and led him to frequently question and object to key elements of the practice. His attitude and behavior contributed to “doubts” about the practice by other practitioners.

Discussion

Great care was devoted to ensuring the internal validity of the findings. As in much qualitative research, external validity is severely limited by the boundaries of the study. The study involved only six sites within one state implementing two specific EBP’s. It is likely that other states confronted a different configuration of obstacles. It is also possible that different EBP practices conjure different obstacles. However, it also seems likely that barriers emanating from supervisors, direct service staff and other agency professionals would be common occurrences (Torrey, Drake, Dixon, et al, 2001).

Funding and top-level administrative support are the most frequently cited elements in making program improvements and implementing new interventions (Drake, Goldman, Leff et al, 2001). The findings of this study suggest that these are probably necessary but insufficient conditions for successful implementation. In this study, top-level administrative support was present in five of the six sites and the few funding barriers were quickly resolved yet the EBP implementation still progressed slowly at first.

The findings suggest that implementation of EBP is a complex undertaking requiring varied groups of people to behave in ways that are different from current practice. To successfully implement EBP, there needs to be a synergy operating that involves upper level administration, program leaders/supervisors, direct service workers, and related professionals within the agency. In some cases, external stakeholders need to also be part of the synergy. This

synergy is both powerful and fragile. When in place, the EBP is implemented well; yet if one party is out of synchronicity, performance can lag.

Synergy emerges when all the key players are fulfilling their necessary role and meeting expectations. The barriers to implementation were often traced back to the lack of expectations or their enforcement by one or more groups. At the team/service delivery level, the culture of low or no expectations was present in 5 of the 6 sites at the beginning of the project. Direct service workers and supervisors went about their jobs as they saw fit. There was little discipline to their practice. In fact, supervisors were shockingly unaware of the “actual” practice of their teams (e.g. how they engaged with consumers, how they interacted with employers, what methods and strategies they employed to help consumer reach their goals). While most people worked hard, there seemed to be few demands placed on workers beyond that (except insuring paperwork and billable hours standards were met). The vacuum caused by the lack of expectations led to highly ideosyncratic and reactive practice.

The difficulty of implementing EBP in an environment that has few expectations was manifest when practitioners resisted implementation. The preferred solution to the resistance was providing more information, training, and at times, individual conversations. There was a universal and profound avoidance by the supervisors to setting expectations and demanding efforts towards compliance. At times, this was due to ambivalence by the supervisor to all of the EBP elements or fear of not being “liked”. What became clear was that the project was asking supervisors (e.g. set and enforce expectations) and direct service workers to perform behaviors that they had rarely done before within an organizational culture that never demanded it. Direct service workers were given de facto authority to reject the EBP.

While the successful implementation of EBP’s requires the constructive involvement of a host of players, the front-line supervisors (project leaders) were in many ways the most critical. Structural changes were the province of upper management, but making those structural changes

actually work for clients and the implementation of practice skills fell most directly on the front-line supervisors. For example, upper management created interdisciplinary teams for IDDT and assigned an employment specialist to each case management team for SE. But it was the front-line supervisors that had to ensure that these contributed to the practice. Resistance by front-line practitioners to these changes should be addressed by the supervisor. The initial set of supervisors in Kansas was passive custodians of their teams rather than leaders. Two SE sites were “getting nowhere” until the supervisor was replaced by a more committed and skilled person.

The National Project astutely identified that EBP implementation would require the constructive involvement of a variety of key actors/stakeholders. Attention was paid to and materials developed for agency administrators, families, consumers and state mental health authorities. In Kansas, therapists, medical staff and case managers emerged as critical actors. For SE, therapists, medical staff, and case managers often discouraged or “prohibited” people from pursuing work. These people were the source from which the SE programs should receive most of their referrals. For IDDT, medical staff and their prescribing practices, and substance abuse staff were particularly important.

The findings of this study suggest a framework for investigating and understanding barriers to EBP implementation. The approach would identify the key participants and specify the behavior necessary for implementation. Fidelity guides already specify the behavior of front-line staff and structural elements which are usually the responsibility of administration to make. Largely missing is the expectations of supervisors and the necessary role of other agency professionals. Once these guides are developed, implementation research could more completely understand the process.

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APPENDIX P
Case Management Tasks

Case Management Tasks: A Functional Job Description

“The primary goal of our work is to help people with psychiatric disabilities recover their lives. Every action, word, policy, procedure and service must contribute to that end. If it does not, then it is not worth doing” – Rick Goscha, Program Director, Center City Homeless Program

Engagement

Establish contact with a client within 72 hours of being assigned to work with an individual to begin the working relationship. If contact is not able to be made, document steps taken to contact the person.

Discuss with each person where initial meetings are to take place. Ensure that the working environment is in a setting that is most comfortable to the person.

Discuss with each person the role of case management and the recovery process. Come to a mutual understanding of what the working relationship might entail in terms of helping the person in their recovery journey.

Create an environment of hope by using reflexive listening skills, being genuine in wanting to get to know the person better, sincerely acknowledging things that are important to the person, and expressing a sincere belief that recovery is possible.

Assessment

Start an initial Strengths Assessment within the first month after working with a new person to establish what current strengths they are using that contributes to their well-being, what strengths/resources they have used in the past, and what are their current desires and aspirations.

Discuss the purpose of the strengths assessment in terms of the working relationship and the context of recovery. Explain how the strengths assessment is used to help the person set their own recovery goals and use their strengths to reach these goals.

Try to get information in each of the six life domains: independent living, vocational/educational, financial/insurance, social supports, health, and leisure/recreational. Strive for information that is thorough, detailed, and specific. Use client’s own words. Put direct quotes in quotations. It is important to remember though to work at the client’s pace. While the initial strengths assessment should be started within the first month, it may take several meetings to get detailed information in each of these domains.

Use the Strengths Assessment to set some initial long-term goals. The long-term goal(s) will come from the middle column of the strengths assessment (desires/aspirations) and should be something the person is passionate about. If a passionate goal can not be identified, choose a goal that meets an immediate need. It is possible that the two of you may be working on a goal that holds passion (e.g. “I want a job working with animals) and one that meets an immediate need (e.g. “I need to have some dental work done”).

Acknowledge client strengths that you observe, even if these are not stated by the person. For example, “You do a great job getting the kids ready for school in the morning. That takes some strong organizational skills”. Note these observed strengths on the strengths assessment.

Update the Strengths Assessment at least quarterly. It should be updated more frequently when the person is still trying to identify a goal or would like help with strategies to reach a goal. At minimum, a quarterly review of the strengths assessment keeps you focused on continuously looking for new strengths the person possesses. It also allows for new recovery goals to surface.

Goal Planning

Write goals that you have identified from doing the Strengths Assessment on the Treatment Plan. Goals for the treatment plan should be ones that require involvement from the case manager in the helping relationship. People may have life goals that they do not wish involvement from the case manager. Treatment plan goals should use the client’s words as much as possible. If the goal cannot be written on the treatment plan using the client’s exact words, then put the client’s words in quotations next to the treatment plan goal, so it is clear what the person means by this goal. Example: Goal #1: I want more supports in my life to help me stay out of the hospital “I would like to have a girlfriend”.

Write objectives for each goal. While the treatment plan goal can be broad, the objectives should be measurable and specific. The objectives should convey what you will be doing over the next three months to make movement towards this goal. It is expected that objectives will change each quarter as you make progress towards the goal. Objectives should reflect strategies obtain from information on the Strengths Assessment.

Use the personal plan with the following types of goals:

- 1) The overarching passion statement. This is the goal that holds the most passion for the person you are working with and is sometimes defined by the person as synonymous with recovery. Examples: “I want to get my kids back”, “I want to be a librarian”, “I want a house with a backyard and a dog”, etc. Using the personal plan acknowledges the importance of this goal to the person and helps the two of you stay focused on this throughout the helping relationship
- 2) Goals that may take over one year to achieve. Goals that require an extended amount of time to achieve can sometimes get displaced. Keeping this goal active

- on the personal plan helps to monitor progress over time and retain focus even in the midst of other activities going on.
- 3) Goals that need to be broken down in greater detail in order to make progress. Some goals require multiple small steps to achieve. Each step may be a major accomplishment that is worthy of recognition and celebration.
 - 4) Goals where it is unclear on how to proceed. Sometimes a person has a goal, but does not know where to start. The personal plan can be used to explore this goal in further detail. Each step to gather more information on the goal should be documented on the personal plan.
 - 5) Goal that have failed in the past. Sometimes people lose confidence in a goal if they have had a previous failed experience. The personal plan can be used to explore alternative steps to achieving that goal or looking for ways to build additional support for each step towards reaching the goal.

Use the personal plan during almost every meeting with the person once a goal has been identified. It is good to start each meeting with the person by reviewing the personal plan to see the progress you have made so far in goal attainment and discuss the steps you will take during the current meeting. At the end of the meeting, it is important to take time to review next steps and negotiate when these will be accomplished. It is important to have at least one step that you can accomplish during your next meeting. Use of the personal plan in this way helps to define the helping relationship and put it in the context of the person's recovery.

Designate who will be responsible for working on each step that is written on the personal plan.

Set timelines for when each step is to be accomplished. Try to set steps that can be accomplished either prior to or during your next visit.

Resources

When identifying a goal to work on, first review the Strengths Assessment to see what naturally occurring resources might be available to assist the person in achieving this goal. This might be a good time to further develop the Strengths Assessment to see what additional strengths might be identified.

Only explore the use of formal mental health services, when there is no naturally occurring resource available or accessible to achieve a particular step towards the goal. When a formal resource is used (except for psychiatric services or therapy), begin exploration with the person how this could be replaced with a naturally occurring resource. This goal should be added to the Treatment Plan.

Only use transportation as a case management function when it is related to a specific goal being worked on and an identified rationale for using the case manager in this context has been established. For example, the person has a goal of getting their own place. The case manager may take them around to look at different housing options. If

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- 2) Goals that may take over one year to achieve. Goals that require an extended amount of time to achieve can sometimes get displaced. Keeping this goal active

Supervision

Attend group supervision one day per week at day and time established by the program supervision. This is a required meeting and staff are expected to show up on time. Missing any portion of group supervision must be approved in advance by your supervisor.

Present at least one client per month at group supervision. Your supervisor may ask you to present additional clients, so that all clients on your caseload can be presented at least once over the course of a year.

Bring a current strengths assessment for each client that is presented at group supervision. If it has been more than three months since the last update, update it prior to the presentation.

Write down all suggestions that are offered during a group supervision presentation.

Develop a plan for follow-up after group supervision to use some of the suggestions offered at group supervision

Meet with your supervisor individually if you need any assistance carrying out any of the suggestions offered. Make use of supervisor assistance in the field if needed.

Be prepared to update the team during the next group supervision on what happened with the suggestions you tried.

Participate in asking questions and providing suggestions to help other case managers during group supervision presentations.

Other meetings

Attend all program staff meetings

Contribute to program staff meetings by offering ideas on:

- 1) how to improve client outcomes
- 2) making program changes to better serve clients
- 3) improve communication among team members to more effectively deliver services
- 4) accessing community resources

Contribute to program staff meetings by sending in any client success stories or nominate another staff member who contributed to a client success story.

Professional Development

Work with your supervisor to develop a yearly plan for on-going professional development. Identify areas where you would like to achieve excellence.

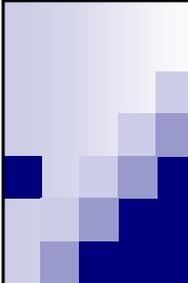
Meet with your supervisor at least quarterly to discuss progress towards your professional development.

Attend Basic Case Management training within first six months of employment and at least one Advanced Case Management training each year thereafter. Work with your supervisor to find a training that fits your professional development plan.

Attend all required in-house professional development workshops.

Meet with your supervisor after each training attended to develop a plan for applying skills and tools learned to practice.

NEXT: STRENGTHS-BASED SUPERVISION POWERPOINT HANDOUT

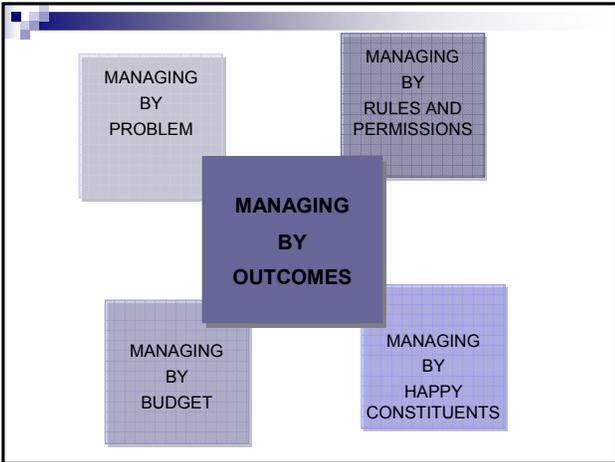


Strengths-based Supervision

- ### Strengths-Based Practice
- Philosophy of Practice
 - Way of viewing the people we serve
 - Way of being in relationship to people
 - Set of Tools
 - Strengths Assessment
 - Personal Plan
 - Group Supervision

Pawnee Strengths Model Project

Outcome Area	Baseline	6-months	12-months	18-months
Fidelity Score	25	38	45	46
Employment	8%	15%	18%	26%
Hospitalizations	24%	10%	8%	8%
Education	1%	1%	1%	6%
Independent Living	95%	96%	96%	95%



- ### Four Assumptions of Client-centered Management
1. Clients are the focus of all of our activities
 2. Ultimate criterion of organizational performance is improving client outcomes.
 3. Managerial performance is identical to organizational performance.
 4. Primary role of supervisor is to help staff do their job more effectively and efficiently.

- ### Principles of Client-Centered Management
1. Venerating the People We Call Clients
 2. Learning for a Living
 3. Healthy Disrespect for the Impossible
 4. Creating and Maintaining a Focus on Client Outcomes



Performance Planning

- ## Managing Information
- Select the information that is important for increasing client outcomes.
 - Give the information/data to staff.
 - Teach staff how to use the information.
 - Give the data relevance - find ways to help give the data meaning to others.
 - Make sure concrete action steps follow review of data.

- ## Performance Planning
- Choose an outcome area where you would like to see improvement
 - Write a goal for the outcome area chosen
- Example
- ✓ Increase the number of people competitively employed by 10% (10 people) by December 2007

Strengths Assessment

Types Of Strengths

1. Qualities/Personal Characteristics
2. Talents
3. Environmental Strengths
4. Interests/ Aspirations



5 Critical Components of the Strengths Assessment

- Thorough, detailed, and specific
- On-going process/updated on regular basis
- Conducted in conversational manner
- Consumer paced
- Consumer language used



Group Supervision:
Process Description

Step 1: Hand out Strengths Assessment

Step 2: What do I need?

Step 3: Thumbnail sketch

Step 4: Questions only

Step 5: Brainstorming

Step 6: Clarification of Ideas

Step 7: Next Steps

■ Ensures case review remains a focused, task-oriented process that produces specific plan or menu of options appropriate for EBP model. Supervisor prepares staff for presenting good case presentations.



- Supervisor documents discussions and provides follow-up on ideas and suggestions from previous meetings and ensures implementation occurred where feasible.



- Requires completion and distribution of EBP relevant material (i.e., strengths, contextual analysis, vocational profile, etc.) prior to staffing.



- Ensures that all team members display behavior, language and the focus of the interventions and brainstorming is consistent with EBP philosophy elements:

- Respect for client choice
- Attention to strengths
- Hopeful, recovery-oriented



- Supervisor minimizes extraneous information and distractions and creates an environment where all participants are encouraged to give and receive feedback from peers in a positive manner as evidenced by group participation and attention.



- Supervision is held weekly and follows an organized structure that includes case reviews, celebrations, and brainstorming.



- The supervisor assists team in generalizing specific client situations reviewed in team meeting, ideas generated, and lessons learned from those specific situations to staff's caseload.



- The supervisor knows and enforces rules for good brainstorming to create a climate within team meeting where good brainstorming can occur.



Integrating The Strengths Assessment

The 8 Hour Supervisor

- 2 Hours a Week in Group Supervision
- 2 Hours a Week Doing Quality Review of Documentation (Specifically looking for integration of skills and tools in practice.)
- 2 Hours per Week Providing Field Mentoring
- 2 Hours a Week Giving Staff Feedback (For every 4 people supervised.)

Use of Strengths Assessment

- Engagement
- Helping people to set goals
- Viewing larger context of recovery
- Magnifying people's strengths
- Identifying ways to achieve goals
- Focusing on naturally-occurring resources
- Enhancing group supervision

Reviewing Documentation

- We recommend spending at least two hours per week reviewing staff documentation (e.g., goal plans, strengths assessments, progress notes, etc.)
- Reviewing documentation is enhanced when the supervisor is familiar with the client, the client's goals, and the services provided to the client
- There are two core components of reviewing documentation: quality and integration

Reviewing Quality

- Supervisor must be skilled at knowing how to complete quality documentation
- Supervisor must understand the importance of specific documentation
- Provide staff with examples of how you want documentation completed
- Give staff the opportunity to practice writing good documentation
- Give staff regular feedback on the quality of their documentation

Reviewing Integration (1 of 5)

- Sit down with an entire chart for a particular consumer
- Review treatment plan
 - Are these the client's goals?
 - Do goals meet both Strengths and Medicaid criteria?
 - Do objectives reflect what staff are actually doing?
 - Are objectives written in such a way as to generate movement or progress?

Reviewing Integration (2 of 5)

- Review all documentation tools that are completed by the staff you supervise (i.e., strengths assessment, recovery goal worksheets, vocational profile, contextual analysis, etc.)
 - Is the information collected with these tools able to generate movement toward the goal(s)?
 - Is there missing information or areas that could be further explored?
 - Are the client's strengths emphasized and made specific?

Reviewing Integration (3 of 5)

- Review Progress Notes
 - Go back three months or to the time of last chart review.
 - Progress notes should clearly reflect the work being done and demonstrate progress towards goals and objectives
 - Does the work reflect the goals and objectives on the treatment plan?
 - Goal displacement
 - Mismatch of stage of change
 - Ineffective/unnecessary interventions
 - Client goals ignored or put on hold

Reviewing Integration (4 of 5)

■ Review Progress Notes (continued)

- Are there any warning signs that indicate a need for intervention?
 - Risk of suicide
 - Risk of potential hospitalization
 - Risk of drug/alcohol relapse
 - Decisional conflict not being addressed
 - Mismatch between case manager/client
 - Oppressive/abusive behaviors
 - No progress
 - Client no longer needing case management

Reviewing Integration (5 of 5)

■ Review Progress Notes (continued)

- Is information from the strengths assessment being reflected in practice?
 - Used to develop goals
 - Naturally occurring resources identified and used
 - Client skills identified and used
 - Use of client's personal medicine
- Do the notes reflect a continuous search for or development of client strengths?
- Does the work reflect purposeful movement toward goals and objectives?
 - Does the case manager appear stuck, frustrated, or reactive in their work?

Field Mentoring

Purposes Of Field Mentoring

- Observe Skills of Staff
- Provide Feedback on Skills
 - e.g. Assessing strengths, formulating goals, building relationships
- Modeling Skills
- Prompting of Skills



Benefits Of Field Mentoring

- Reinforce Strengths of Staff
- Enhance Transfer of Training
- Build Skills
- Build Confidence
- Better Assist Staff in Areas They Identify That They Struggle With



Low Direction / High Support

WHEN STAFF HAS:

- Variable Commitment & Confidence & Moderate to High Competence

SUPERVISOR ROLE IS:

- Encouraging & Supporting

High Direction / Low Support

WHEN STAFF

HAS:

- High Commitment, Confidence & Low Competence

SUPERVISOR ROLE

IS:

- Directing

Low Direction / Low Support

WHEN STAFF

HAS:

- High Commitment and Competence

SUPERVISOR ROLE

IS:

- Delegating

High Direction / High Support

WHEN STAFF

HAS:

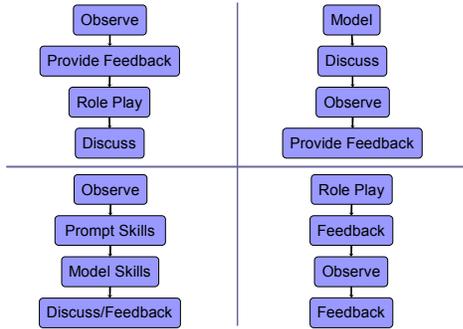
- Low Commitment, Confidence & Low Competence

SUPERVISOR ROLE

IS:

- Coaching & Teaching

Field Mentoring Interventions



Format For Field Mentoring

1. Restate the purpose of the particular field mentoring session.
2. Point out specific strengths of the case manager observed during field mentoring.
3. Point out specific words, behaviors or actions that might have been obstacles to the case manager/employment specialist reaching his or her desired outcomes.
4. Make a plan for follow-up.

Client-Centered Feedback



Minimum Conditions For Successful Feedback

1. Making standard for work clear
2. Create a learning environment
3. Believe people can learn, grow, and change
4. Everyone has strengths
5. Seeing feedback as helpful rather than punitive
6. Be specific

Assessing The Situation

1. What is happening that presents a problem?
2. What do you want? What are your expectations?
3. What are the person's strengths?
4. What can you do to help?

The Process Of Giving Feedback

- ✓ Identify strengths
- ✓ State situation in a matter of fact manner
- ✓ Set tone of discovery process
- ✓ Brainstorm alternatives and strategies

Rewards-Based Environment



The Power of Positive Reinforcement

1. Reinforce Specific Behavior
2. Use Immediate Reinforcement
3. Reward Small, Incremental Achievements
4. Use Intermittent Reinforcement



Types of Rewards

- Verbal Praise
- Written Praise
- Symbolic Rewards



Factors in Implementing a Reward-based Environment



- Diversity in Rewards
- Amount of Rewards
- Specificity
- Sources
- Individualize

Strengths-based Supervision Wrap-up...

- Performance Planning
- Strengths Assessment
- Group Supervision Fidelity
- Integrating The Strengths Assessment
- Field Monitoring
- Client-Centered Feedback
- Rewards-Based Environment

The End...