7. Interventions I: Guiding Principles and Integrated Framework

NOTE: There are three Interventions modules. They are designed to be used together and are not intended to be used separately or as stand alone modules

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Overview

This is the first of three modules on intervention services. The three modules are designed to be used together; they cannot stand alone as the content of any one is not sufficient to understand or provide Psychosocial Rehabilitation (PSR) interventions.

In Interventions I, the guiding principles that underlie the provision of all PSR services are discussed along with an integrative framework model that can be used to coordinate PSR services. The guiding principles are essential for the successful implementation of the interventions discussed in Interventions II and Interventions III. In Interventions II, interventions that have been proven through empirical research to achieve specific outcomes are presented; these are known as evidence based practices (EBPs). In Interventions III, interventions that have shown promise of achieving specified outcomes are presented; these are known as promising or emerging practices. Interventions III also presents supporting services that are widely acknowledged to be essential services for helping people recover from the effects of serious mental illness.

Learning Objectives

At the end of this module you will be able to:

- Identify at least three of the guiding principles for PSR interventions
- Describe four positive outcomes research has identified that result from involving consumers in a shared decision making process
- Describe at least four of the components of the process presented by the integrative framework for provision of PSR interventions
- List the two foci upon which PSR interventions are based

Resources

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources

Required Readings


**Activities**

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

As described in previous modules, studies over the past several decades have shown that many adults with serious mental illnesses can and do recover when they are provided with supports and services that assist them to gain the skills needed to live a satisfying and productive life. In fact, despite long held beliefs that serious mental illnesses are chronic deteriorating illnesses, several meta analyses and summaries of recently conducted studies have appeared and all continue to document that individuals with serious mental illnesses can, and do recover from the effects of their illness (Warner, 2010), and indeed that most have the potential to achieve long-term remission and functional recovery (Zipursky, Reilly, & Murray, 2012).

Users of mental health services have consistently said that they want the same things for themselves that every citizen wants: a family, a safe place to live, meaningful activities, adequate income, job satisfaction, and an enjoyable social life. For people with serious mental illness, attainment of life goals often requires substantial assistance in the form of specially designed psychosocial rehabilitation (PSR) services. While some people with serious mental illness may recover without assistance, many are unable to recover sufficiently to achieve the quality of life that they desire without these specialized services (Silverstein, 2000).

This module of the curriculum does not provide information about specific PSR services. Information about PSR services is provided in the Interventions II module and in the Interventions III module. Rather, this module will discuss the underlying values and characteristics that underlie the provision of PSR services and that must be present to achieve a recovery oriented system of services.

The knowledge base about the range of interventions shown to be effective and the importance of the underlying values and principles have developed considerably over the past twenty five to thirty years. Despite the considerable advances in our knowledge of what can be helpful to people with serious mental illness, there is much that remains unknown. For example, while we have a range of interventions based on empirical research, i.e., evidence based practices (EBPs), that have been shown to be effective in helping people with serious mental illness achieve certain specified outcomes, we know very little about the multitude of factors that can, and often do, impact on the successful provision of these services. The following are but a few examples of these unknown variables:

- The settings in which the interventions are most efficacious
How to implement the practices successfully especially in light of resource constraints

Whether or not all of the components of the EBPs are necessary for success

The contribution of underlying constructs and values such as provider characteristics, relationship with the person(s) being served

The required minimal training levels of providers

Possible interactions between stage of illness, current symptomatology, and residual capabilities such as executive functioning

Cultural background of the persons receiving any given intervention

Intrapersonal characteristics of the individual such as self efficacy, sense of empowerment, etc.

These are but a few of the variables whose impact on the outcome of provision of PSR interventions is unknown. As recently as 2005, authors reinforced the need for better evidence of the impact of interventions on recovery outcomes:

Recovery is an emerging movement in mental health. Evidence for recovery-based approaches is not well developed and approaches to implement recovery-oriented services are not well articulated (Oades, Deane, Crowe, Lambert, et al. 2005).

Despite this, mental health practitioners agree that the underlying values accepted as essential for effective clinical practice should be incorporated into interventions designed to assist people in their recovery from serious mental illness. For example, provision of services within the context of an empathic, genuine, trusting relationship where the person with serious mental illness is involved in a partnership to agree on and design the components of services he or she will receive, is generally considered to be important for the success of recovery oriented interventions (Anthony, Rogers & Farkas, 2003; Mueser, 2012). The importance of these for provision of effective mental health services was articulated several decades ago (Carkhuff, 1969; 1980; Rogers, 1957; Truax & Carkhuff, 1967) and remains relevant today (Miller & Rose, 2009).

**Guiding Principles of PSR Interventions**

Provision of PSR services rests on a platform of principles that are seen as essential for successful outcomes. In addition to the values mentioned above (empathy, trust, genuineness and involvement of people in decisions about their health care), we know that services must be guided by the following:

- Recognition that recovery and return to a satisfying and productive life are possible;
- Provision of interventions that are grounded in research and achieve results;
• Acceptance that, to the greatest extent possible, those with serious mental illnesses and their families are full partners with the service delivery system and determine the services they will receive.

Several principles have been identified as important for provision of effective recovery oriented services. These were originally specified by participants in the National Consensus Conference on Mental Health Recovery and Transformation (U.S. Department of Health and Human Services, 2006) and recently updated to reflect the importance of culture, trauma, and inclusion in family and social networks. These are:

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including trauma experiences – that affect and determine their pathway(s) to recovery.

Recovery pathways are highly personalized: They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches.

Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks.

Recovery is holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations - including values, traditions, and beliefs - are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.
Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

The evidence supporting the importance of these principles for recovery is quite consistent and comes from first person accounts of people who have received services. Whenever consumers are asked about the elements of service provision that made a difference to them, the principles outlined above are often referenced (Deegan, 1988; Jacobson, 2001; Mead & Copeland, 2000; Ridgeway, 2001; Wisdom, Bruce, Saedi, Weis, et al., 2008). To be effective, PSR interventions must be designed with these as the basis for service provision.

**Consumer Involvement in Planning & Evaluating Services/Shared Decision Making**

While consumer involvement and shared decision making are not interventions, they deserve special mention because they are seen as an integral component of the method for delivering PSR services.

A central premise of recovery oriented practice is that the individual is a full partner in making decisions related to which interventions are desired and deemed to be most useful (Deegan & Drake, 2006). Interventions for people with serious mental illness are provided within a person centered approach with full involvement of the individual receiving services. Professionals may resist full involvement of people with serious mental illness in the decision making process, but research has shown that most individuals prefer shared decision making (Adams, Drake & Wolford, 2007); without such involvement services cannot be considered to be recovery oriented.

Research on involvement in general health care has shown that consumers who believe they have been actively involved in decisions about the services they received generally have better outcomes (Greenfield, Kaplan, Ware, Yano, et al., 1988; Stewart & Brown, 2001). Conversely, those who felt they had little input or control over their services were less likely to be involved with their services, rated their health as poorer, and evidenced greater illness burden (Seeman & Seeman, 1983).

Similarly, active participation by consumers of mental health services has also been shown to have several benefits, including increased satisfaction with services and decreased symptom burden (Adams & Drake, 2006; Swanson, Bastani, Rubenstien, Meredith, et al.)
Research data have also suggested that rehabilitation outcomes are better for people who are partners in the planning and delivery of their services (Majumder, Walls, & Fulmer, 1998). Additional benefits have been identified including the person’s increased level of knowledge about their condition, increased self efficacy, greater planning for coping with difficult situations, and increased knowledge of alternatives (Patel, Bakken, & Ruland, 2008). Consumer involvement in designing and delivering mental health services (e.g., program planning, implementation, and evaluation) is increasingly seen as a critical component of a quality management system for any mental health service (Blackwell, Eilers & Robinson, 2000).

Because there may be times when people with serious mental illness cannot make sound decisions due to symptom flare ups, preparation of an advance directive that provides guidance about the person’s preferences in different situations has been recommended (Deegan & Drake, 2006). Most authors also note that research on the complexities and benefits of shared decision making is relatively recent and additional research is recommended (Adams & Drake, 2006; Patel, Bakken & Ruland, 2008).

**Importance of Gender Specific and Culturally Relevant Services**

Most mental health services, like general health care services, were designed with men from the majority culture in mind. While many assume that a “one size fits all” approach is acceptable, gender and cultural considerations are essential if the service system is to be helpful to those who need services.

**Services for Women with Serious Mental Illness**

Women are a sizeable proportion of those with serious mental illnesses and are the most vulnerable adults served within the mental health system. The service needs of women clients can be very different than those of men (Bently, 2005). Homeless women are more vulnerable than homeless men, are poorer, and often have additional stressors due to child care responsibilities (Harris & Bachrach, 1990). Women are more likely to have been abused physically, sexually, or both. Due to their increased vulnerability and poverty, women are more likely to be unable to control sexual situations and may be more often exposed to HIV/AIDS and other sexually transmitted diseases (Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995). Women who have experienced violence, abuse and trauma often have co-occurring mental health and substance abuse problems (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Elklit & Shevlin, 2011). In addition, women that have been abused by men will likely be unable to work through those issues in a mixed group and a mixed trauma group can actually exacerbate their trauma. Services offered in women only groups are essential for women who have been abused both to help them recover and to avoid exacerbating their trauma.
Culturally Relevant Services

Mental health and addictions services must also be culturally informed. Mental health problems among non-white, minority cultural groups can be great, and the actual prevalence may be higher than reported due to a reluctance to access services or to report problems. For example, suicide rates among people from Aboriginal backgrounds are three times higher than among the general population, yet the problems often go unreported or untreated (Kirmayer, Hayton, Malus, DuFour, et al., 1993). Cultural discontinuity and oppression have also been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most dramatic impact on youth (Kirmayer, Macdonald & Brass, 2000). Lack of culturally and linguistically appropriate services has been reported as a reason for the failure to access services by non-majority groups (Elliott, 2003). Additionally, many culturally distinct groups are not used to speaking frankly about problems and may speak in metaphors or use less descriptive words to describe their life situation or problem (Vasiliadis, Lesage, Adair, et al., 2005). People who are immigrants and/or refugees often face even more serious problems that make accessing services very difficult. A more comprehensive discussion of the problems faced by those who are immigrants and refugees can be found in the Engaging People as Partners module and in the Person Centered Planning module. The problems and issues cited are often not recognized by traditional service providers; this speaks to the importance of outreach to ensure access so that appropriate services are available for all who need them.

An Integrative Framework Model for Provision of PSR Interventions

An overall framework for serving individuals with serious mental illness is a useful way to organize services (Anthony, Cohen, Farkas & Gagne, 2002; Anthony, Howell & Danley, 1984; Farkas & Anthony, 1989). The model presented below is an approach to working with people with serious mental illness and is titled the Choose, Get, Keep method for providing PSR services.

The authors recently offered this conceptualization:

Psychiatric rehabilitation interventions are currently a mixture of evidence-based practices, promising practices and emerging methods that can be effectively tied together using the psychiatric rehabilitation process framework of helping individuals with serious mental illnesses choose, get and keep valued roles, and together with complementary treatment orientated psychosocial interventions, provide a broad strategy for facilitating recovery.

A review of PR interventions must therefore take into account the aim of psychiatric rehabilitation (i.e. improving role performance in a chosen environment) within the overall mission of enhancing recovery (Farkas & Anthony, 2010.)
### Process framework for psychiatric rehabilitation, person level process

<table>
<thead>
<tr>
<th>Provider Process</th>
<th>Choosing a valued role</th>
<th>Getting a valued role</th>
<th>Keeping a valued role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging</td>
<td>Linking with existing worker/worker/student/residential/social role opportunities</td>
<td>Assessing critical skill and/or support strengths and deficits</td>
<td></td>
</tr>
<tr>
<td>Assessing and developing readiness</td>
<td>Creating worker/worker/student/residential/social role opportunities</td>
<td>Person-centered planning</td>
<td></td>
</tr>
<tr>
<td>Setting an overall goal</td>
<td>Developing skills to succeed in the preferred role</td>
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**Source:** Farkas & Anthony, 2010

The process is designed to help people decide on the goals they wish to achieve, help them identify what skills they have and what skills they need to learn, and identify the resources or supports they already have and those they need to develop in order to achieve their goals. The next steps are to help them develop the skills and resources they need (Anthony & Farkas, 2009). This process is one that has been incorporated into many aspects of service delivery. For example, people receiving medical and mental health pharmacotherapy often are taught medication use; individuals who receive case management services are given support to access the services they need and people who receive supported employment learn skills to succeed vocationally.

The model is built on the premise that recovery and rehabilitation efforts have two foci: facilitating success and satisfaction in the performance of personally preferred and valued roles, and creating or promoting an increase in opportunities for participation in society. This is accomplished by assisting individuals to achieve their full functional capacity. For some individuals with serious mental illness, this means reduced inpatient stays, while for others it may mean a return to educational training, employment or a more satisfying personal life. Helping people with serious mental illness achieve their goals is accomplished by ensuring that the person has the skills and supports necessary for success and satisfaction and is a basic principle of PSR (Anthony, Cohen, Farkas & Gagne, 2002; Farkas, Jansen, & Penk, 2007).

Recently, Bennett Cattaneo and Chapman (2010) highlighted the importance of learning skills and the link to increased self efficacy and action to practice the skill. Success in taking such action can further refine skills and promote increased self-efficacy, leading to further refinement of skills, and even greater self-efficacy (Kieffer, 1984). Identification of skills available and needed for success is a critical component of the PSR process.
The model focuses on facilitating a specific practitioner and consumer process to guide the consumer to choose, get, and keep preferred societal role(s) or a rehabilitation goal(s). Practitioners develop a personal connection with consumers in order to facilitate, support or teach consumers how to:

- Assess their own readiness for change
- Set their own goal(s) in terms of the role they prefer (student, worker, tenant etc)
- Identify their own skill and resource strengths and deficits in relation to this goal
- Develop a plan
- Teach new skills, or
- Organize strategies to help the person overcome the barriers to using skills they have
- Link to existing resources, or
- Create new resources.

The components of the process are what practitioners do to facilitate rehabilitation (Farkas, Cohen & Nemec, 1988). Choosing, getting and keeping are what individuals do to achieve success and satisfaction in their preferred societal roles. Critical to the approach is an emphasis on developing practitioner competencies in engaging, supporting, and teaching people how to drive and master their own rehabilitation process, regardless of their level of functioning. Pre-experimental studies, quasi-experimental research, and two randomized controlled trials have been conducted on the approach in the domains of employment, housing, and education (Hutchinson, Anthony, Massaro & Rogers, 2007; Shern, Tsemberis, Anthony, Lovell, et al., 2000; Rogers, Anthony, Toole & Brown, 1991). Positive outcomes in the area of quality of life, housing status, work status, other role functioning, and a decrease in service utilization have been identified, among others (Hutchinson, Anthony, Massaro, & Rogers, 2007; Rogers, Anthony & Farkas, 2006).

The approach can be used with the evidence based, promising practices and supporting services discussed in the other two Interventions modules, Interventions II and Interventions III.

**Challenges**

Virtually all mental health practitioners, including psychologists, want to do the best they can to assist the people they work with achieve the best outcomes possible. However, far too few mental health practitioners have been trained to provide services from a recovery oriented perspective and consequently, most do not know how to translate the guiding principles of recovery into practice. Further, too few mental health service delivery systems provide integrated and coordinated services; this is needed to avoid omission of needed services, duplication of service provision, and confusion for service recipients.
Summary

We know that recovery from serious mental illness frequently occurs. Many people with serious mental illness are able to gain or re-gain the functional capabilities needed to have a satisfying, productive, and meaningful life.

In order for the services provided to help people recover, service providers need to demonstrate several critical values and subscribe to the underlying principles that people with serious mental illness consistently describe as critical. These have been enumerated and described during two national processes that gathered input from people who themselves have experienced serious mental illness and have recovered. These guiding principles form the platform upon which PSR interventions are designed and implemented.

In order to implement PSR interventions properly, services need to be coordinated and integrated. One model that can be used to help with this is known as the Choose, Get, Keep model, which is designed to assist practitioners as they work to help consumers engage in the process, set goals for themselves, identify the skills and resources they need to achieve their desired goals, and acquire the needed skills and resources.
Sample Learning Activity

There are two parts to this exercise. For the first part of the exercise, depending on the size of the group, participants should be divided into groups of 8 to 10 members. Do not give out the instructions for subsequent portions of the exercise until the start of that portion.

Part I - Do not tell participants that something on the list will be crossed off. On a blank sheet of paper, each person is to write down the three most important things in his or her life – the things that give meaning, keep him or her happy, the individual reasons each person gets up in the morning, etc. Only the three very most important things in each person’s life are to be written down.

When each person has written the three things on his or her paper, the following instruction is to be given: Group members are to exchange the lists with the person next to each one – there should be no discussion about the lists. The person who receives the list is to cross one thing off the list without consulting with the original writer and return it.

With a consumer participant as the leader of the group, the following questions should be discussed/processed:

General – for the full (small) group:

• What kinds of things got crossed off the lists?

For each participant:

• How does it feel to imagine your life without the item that was crossed off?

• How does it make you feel that the person crossed one of the most important things in your life (e.g., your daughter/gardening/faith in God/etc.) off the list without asking for your input?

Part II: For the second part of the exercise, the large group should reconvene if participants were divided into smaller groups.

As a large group, participants should discuss each of the following:

• In traditional treatment settings, other people have the power to decide the focus of a consumer’s life over the next several months or years – what makes it on the list and what doesn’t?

• Some consumers are excluded completely from these decisions, others are told it is “not in their best interest,” or the “timing is not right” to… go back to school/work… move out of the group home… regain custody, etc.

• Over 90% of treatment plans continue to identify the goals of clinical stability/med-compliance/and abstinence as the only priorities -- to the exclusion of other life domains that are critical elements of anyone’s sense of well being.
• Whenever clinicians work with people, it is helpful to remember this exercise and how it feels to have something important to you crossed off your list because someone said it was not a priority or said you needed to wait until you were ready, etc.

• Now imagine what your attitude and response to this kind of treatment would be if this were not just an exercise. What if this happened to you?
### Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The following are some of the guiding principles identified as important for recovery:</td>
<td>g) is the correct answer</td>
</tr>
<tr>
<td>a) Sense of hope</td>
<td></td>
</tr>
<tr>
<td>b) Empowerment and self direction</td>
<td></td>
</tr>
<tr>
<td>c) Assistance from support networks</td>
<td></td>
</tr>
<tr>
<td>d) Avoidance of stress, especially discussions of past trauma</td>
<td></td>
</tr>
<tr>
<td>e) all of the above</td>
<td></td>
</tr>
<tr>
<td>f) a and c only</td>
<td></td>
</tr>
<tr>
<td>g) a, b, and c</td>
<td></td>
</tr>
<tr>
<td>2. Which of the following are part of the process of delivering psychosocial rehabilitation?</td>
<td>e) is the correct answer</td>
</tr>
<tr>
<td>a) Assisting people to set goals for themselves</td>
<td></td>
</tr>
<tr>
<td>b) Identifying skills that the person possesses and those that are needed to achieve the desired goal(s)</td>
<td></td>
</tr>
<tr>
<td>c) Providing services that the person served agrees are best suited to helping him or her achieve the desired goal(s)</td>
<td></td>
</tr>
<tr>
<td>d) b and c</td>
<td></td>
</tr>
<tr>
<td>e) all of the above</td>
<td></td>
</tr>
<tr>
<td>3) When a person’s symptoms flare up and he or she is having difficulty making decisions, an advance directive should be prepared by the family to ensure that the person receives the most appropriate treatment</td>
<td>X</td>
</tr>
<tr>
<td>4. Recovery from serious mental illness will be facilitated by professionals who are familiar with the literature and make decisions based on the research about interventions each person should receive</td>
<td>X</td>
</tr>
<tr>
<td>5. Research has shown that prior to beginning the PSR process, people with serious mental illness should be psychiatrically stable, i.e., they should not be experiencing any symptoms so they can participate fully</td>
<td>X</td>
</tr>
</tbody>
</table>
Lecture Notes Citations


**Additional Resources**


Citing the Curriculum

Citation for this Module:


Citation for the full Curriculum:


For additional information, contact:

Recovery to Practice initiative at the American Psychological Association, www.apa.org/pi/rtp

or

Mary A. Jansen, Ph.D., at Bayview Behavioral Consulting, Inc., mjansen@bayviewbehavioral.org or jansenm@shaw.ca