Mental Health in APS Practice

Instructor Led Training (Virtual or In-Person)

TRAINER MANUAL

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

This training was developed by the Academy for Professional Excellence in 2017 and revised in 2022 with funding from the California Department of Social Services, Adult Programs Division.

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INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to **Mental Health in APS Practice: Skill-Building Instructor-Led Training, Trainer Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

In partnership with state and national organizations, APSWI is developing a national APS Supervisor Core Competency Training Curriculum. This curriculum is developed, reviewed and approved by experts in the elder and dependent adult abuse fields.

APSWI's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)

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California Department of Social Services, Adult Programs Division
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TRAINER GUIDELINES

It is recommended that someone with education in behavioral health or experiencing working in the behavioral health field facilitate this workshop.

Suggestions for virtual training when possible:

- Have a moderator or co-host who can primarily focus on the virtual aspects of this training (e.g., monitoring chat box, launching polls, assigning breakout groups, monitoring participant reactions, etc.).
- Test out the use of the breakout room feature prior to conducting this training.
- Log in at least 30 minutes prior to the training to ensure the virtual classroom is fully functioning and that you are comfortable navigating it.
- Your equipment and platform may dictate how you do some activities or discussion. There are times you may not be able to see everyone's faces, names or reactions (thumbs up, mute/unmute, etc.). There is a need for both verbal discussion and chat discussion. At such times, the moderator will fill a critical role monitoring those features you cannot. Practice during a run through how you will use the various functions for each section.
- The optimal size for this virtual training is 20-25 participants.

This curriculum was revised with intentional use of person-centered, trauma-informed and recovery orientated language. Visit (APA Inclusive Language Guidelines and Utah Division of Multicultural Affairs) to learn more how you as a Trainer can incorporate similar efforts. In an effort to reduce the stigma of mental health disorders, it will be important to challenge and support participants in using similar language when discussing cases and life experiences.

Teaching Strategies	The following instructional strategies are used: o Lecture segments o Interactive exercises (e.g., breakout rooms or table groups, chat box discussion, polling activities) o Question/answer periods o PowerPoint Slides
Materials and Equipment	**The following materials are provided and/or recommended:** o Trainer Manual o Participant Manual (fillable PDF) o PowerPoint Slides o Headset with microphone o Computer

VIRTUAL TRAINING TIPS

Training and facilitation have always been an art. Virtual training is no exception. Below are some helpful tips to remember and implement when training in a virtual environment.

Assume nothing.
- Do not assume everyone has the same knowledge/comfort level with technology or has access to equipment like printers, video camera, headsets or even reliable Wi-Fi.

Distractions are everywhere.
- Participants have greater access to distractions (email, phone, others at home) which can take their focus away from the training. Therefore, explain everything and summarize before asking participants to complete an activity and check for clarification.

Over explain when possible.
- The virtual room doesn't allow for participants to see everything you're doing as they can in-person. Share as you navigate the virtual environment. If you are silent while looking for something or finding a screen, they may think something is frozen.

Mute with purpose.
- "Mute all" function can help ensure we don't hear conversations we're not supposed to. However, it can also send a message to the participants that they are a passive participant and may not make them feel comfortable taking themselves off mute when you want them to speak.

Two screens can be a lifesaver.
- This allows you to move your chat box or participant gallery view away from your presentation so you can see more of what's going on.

Rely on practice, not luck.
- Winging it during an in-person training or facilitation may work from time to time, but doesn't work in the virtual environment. In addition to covering the content, you have to manage all of the technology issues, learning styles in a virtual room, and it will show if you're not prepared.

Bring the energy.
- As trainers, we are no strangers to being "on," standing and moving around. However, some of the body language, subtle nonverbal skills we relied on the in-person training room do not translate well in the virtual environment. While this may make you more tired, it's important to up your enthusiasm, voice, and presence in order to engage with attendees.

Be mindful of your space.
- Training virtually brings an entirely new component of what we're willing to share with others. Learners can get distracted with what's in your background, whether what is physically there or if you set your video to use a virtual background.
- It's important to reflect on questions of privilege, diversity and equity when thinking of your training space.
- Are there objects in your background that can symbolize status, privilege and/or power? If so, consider removing them to dismantle any added power dynamics that already exist with you as the Trainer.
- Unknowingly, objects can come across as offensive or can activate unpleasant or traumatic memories, and can instantly discredit your rapport building. Think of neutral backgrounds that are not distracting and allow you to be the focus of what learners see.

EXECUTIVE SUMMARY

Mental Health in APS

This training is Module 6 of the NAPSA Core Competency Curriculum and designed for Instructor-Led facilitation for either in-person or virtually.

During this highly engaging and captivating skill building session, participants will continue the learning from the foundational eLearning and review characteristics of common mental health disorders to better understand challenges and problem solve solutions when working with clients with mental health conditions. While exploring the stereotypes and stigmas surrounding mental health conditions, participants will develop empathy which will help the APS professional enhance rapport building skills and understanding to ensure a thorough service plan is created. Participants will work through a powerful thought disorder simulation, allowing them to engage in an experiential activity of someone who is living with an untreated mental health condition. This skill-based session provides participants a safe place to explore working through a suicide risk assessment in order to confidently assess for suicide risk when working in the field.

The following instructional strategies are used: Experiential exercises (e.g. small group discussion, case studies); PowerPoint slides and video clips; participant guide (encourages self-questioning and interaction with the content and process); and transfer of learning tool to access knowledge and skill acquisition and how these translate into practice in the field.

Training Goal: Better equip APS professionals to understand and communicate with clients and tailor referrals. Familiarizing oneself with mental health conditions will help the staff develop appropriate intervention skills, such as a suicide risk assessment, and be able to effectively communicate with mental health partners.

Learning Objectives: Upon completion of this training session, participants will be better able to:

- Describe the common symptoms and behaviors of the five broad categories of mental health disorders and how they may impact APS casework.
- Identify personal and cultural experiences which influence working with clients with mental health conditions.
- Explain ways to adapt the interview and case planning process to better accommodate a client experiencing symptoms of mental health conditions.

Continued

- Identify and practice elements of a suicide risk assessment.

Course Requirements: This instructor-led skill-building session was developed as a blended model, designed to be used to practice and reinforce the skills and information presented in the Mental Health in APS Practice eLearning. Participants should complete the eLearning prior to this Instructor-Led Training. eLearning registration can be found at https://theacademy.sdsu.edu/programs/apswi/core-competency-areas/mental-health-in-aps-practice-elearning/

Target Audience: This course is designed for new APS professionals as well as Aging & Adult Service partners (e.g. IHSS, Long-Term Care Ombudsman). This course is also appropriate for experienced staff that could benefit from knowledge and/or skills review.

COURSE OUTLINE

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, & COURSE OVERVIEW		30 minutes
Welcome and Housekeeping		
Learning Objectives and Guidelines		
Introductions and Icebreaker		*15-20 min*
MENTAL HEALTH DISORDERS		90 minutes
Activity #1: Mental Health Disorders Review and Presentations (Small Groups)	Paper, Flip Charts, Markers, Extra PPT slides	*30-35 min*
Activity #2: Depression Video and Discussion	Video clip	*15 min*
Schizophrenia Discussion		
Activity #3: Experiential Thought Disorder (Small Groups)	Handouts #1 , paper towel roll or rolled paper, cell phone, ear bud, YouTube link	*15 min*
STIGMA AND STEREOTYPES OF INDVIDUALS WITH MENTAL HEALTH CONDITIONS		15-20 minutes
Stigmas and Stereotypes Discussion		
Personal Experiences with Mental Health Conditions		
CAROLINE CARSON CASE		45-50 minutes
Activity #6, Part 1: Intake Review (Large Group)	Handout #3	*7-8 min*
Activity #6, Part 2: At the Door (Large and Small Group)		*15 min*
Activity #6, Part 3: Interviewing the Client (Large and Small Group)		*20 min*
SUICIDE RISK ASSESSMENT		65 minutes
SAFE-T From	Handout #5	
Activity #7- Assessing Caroline for Suicide Risk (Individual)	Handout #6	*5 min*
Activity #8: Suicide Risk Assessment Demonstration Scenario 1 (Large Group)	Case Scenario #1	*15 min*

Continued

Activity #9: Suicide Risk Assessment Demonstration Scenario 2 (Large Group)	Case Scenario #2, Handout #7	*15 min*
WRAP-UP AND EVALUATIONS		10 minutes
Training Takeaways	List of Resources	
Questions and Evaluations		
TOTAL TIME (WITHOUT BREAKS)		**4.5 hours**

WELCOME, INTRODUCTION, AND COURSE OVERVIEW

TIME ALLOTTED: 30 MINUTES

Slide #1: Mental Health in APS Practice (Title Slide)

Welcome participants and **allow** folks to settle in.

Slide #2: About the Academy and APSWI

Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations and communities.

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide #3: Welcome and Housekeeping (5 minutes)

Welcome participants to class. **Introduce** yourself by name, job title, organization, and qualifications as the trainer for this topic.

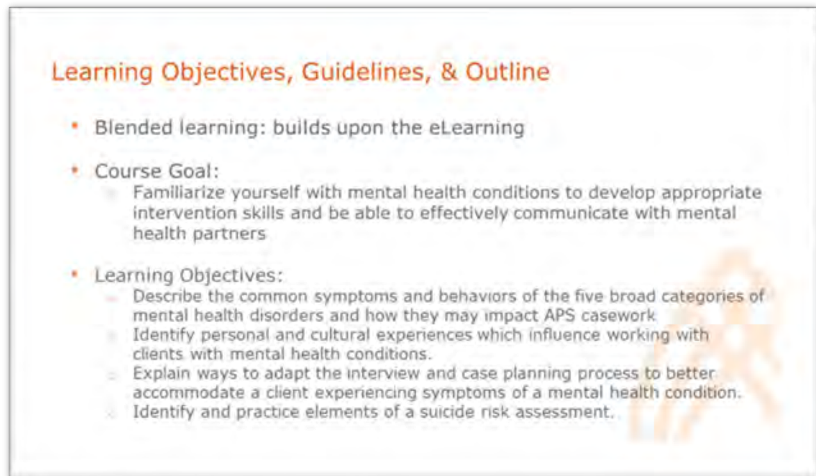
Review the following housekeeping items:

- Respect everyone opinions, each other's time, and speakers
- Raise your hand to ask questions
- Timeliness- be on time back from breaks.
- Confidentiality- at any point when we discuss real cases, do not share names or identifying information. Let us know if at any point we are talking about family who you know on a personal level and if we need to choose a different case.

Virtual Modifications:

- Always keep your audio on mute, unless instructed otherwise.
- Use the raise hand option to ask questions.
- Post any questions in the chat box that need additional clarification or information.
- Use of camera
    - Hide self-view is an option on Zoom
- Reaction tabs

Slide#4: Learning Objectives, Guidelines, and Outline for the Day (5 minutes)



Explain: This training builds on information presented in the Mental Health Issues in APS Practice eLearning.

Ask: By show of hands, how many people have taken the eLearning?

- *Note: If any participant has not yet taken the eLearning course, be sure to provide information on the APSWI website and how to access the eLearning. Advise them to take the eLearning as soon as possible after this skill building training.*

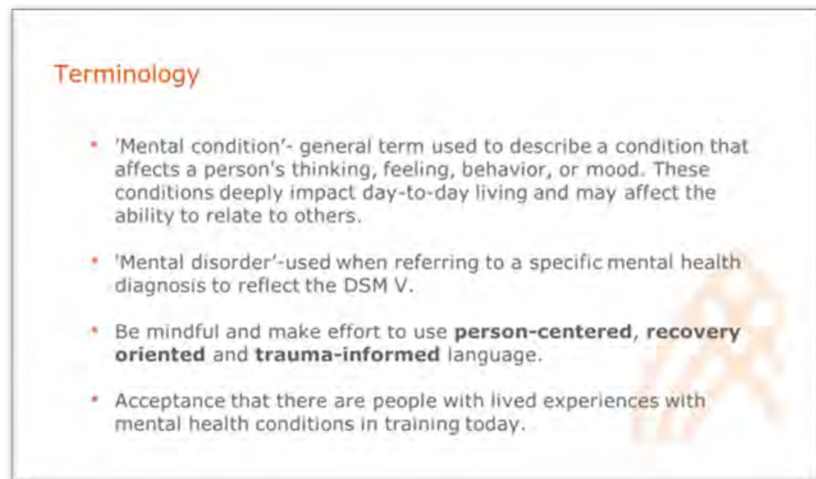
Explain: The goal of the course is to better equip you with information on mental health so you can understand and communicate with clients with mental health conditions and effectively tailor referrals. Familiarizing yourself with mental health conditions will help you develop appropriate intervention skills, such as a suicide risk assessment, and be able to effectively communicate with mental health partners.

Review the Learning Objectives.

Upon completion of this training session, participants will be able to:

1. Describe the common symptoms and behaviors of the five broad categories of mental health disorders and how they may impact APS casework.
2. Identify personal and cultural experiences which influence working with clients with mental health conditions.
3. Explain ways to adapt the interview and case planning process to better accommodate a client experiencing symptoms of a mental health condition.
4. Identify and practice elements of a suicide risk assessment.

Slide#5: Terminology (2 minutes)

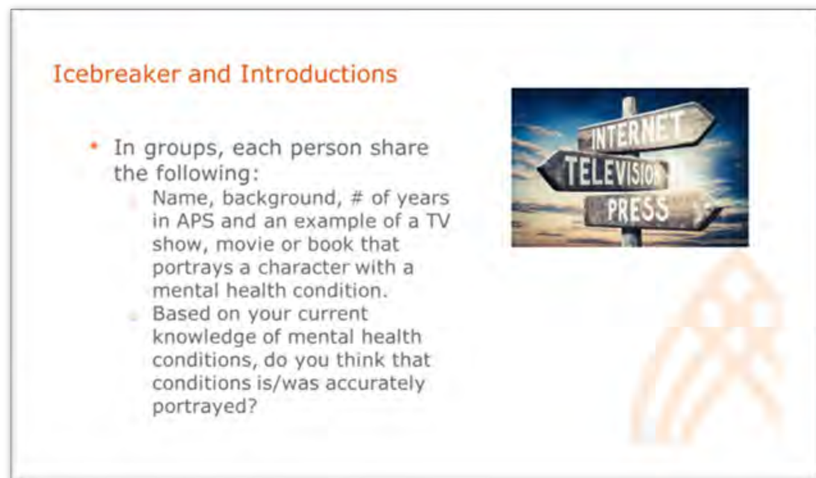


Explain for many organizations, mental health conditions, mental illness, and mental disorders are often used interchangeably. For this training, we will use the following terms:

- 'Mental condition' is a general term used to describe a condition that affects a person's thinking, feeling, behavior, or mood. These conditions deeply impact day-to-day living and may affect the ability to relate to others.
- 'Mental disorder' is used when referring to a specific mental health diagnosis to reflect the terminology used in the Diagnostic and Statistical Manual of Mental Disorders (DSM V).
- We will refrain from using mental illness due to its stigmatization and stereotypes associated with that term. Instead we'll be using the above terms and welcome you to do so when participating in today's training. When needing to discuss someone living with mental illness, it's suggested to use "someone living with or experiencing mental illness" as opposed to "mentally ill".

Share that this curriculum has been revised to intentionally and mindfully use person-centered, recovery oriented and trauma-informed language. People in the room (virtually or in-person) may have personal lived experiences with various aspects of mental health and participants are asked to be mindful and respectful of the language they are using. We can all learn from each other and we may make mistakes. That's okay; it's being mindful and willing to hear others which make this work.

Slide #6: Icebreaker and Introductions (15-20 minutes)



Explain that the participants will be divided into groups for introductions. **Inform** the class that these will be their groups for the training session.

Share that once in their breakout groups, they have 10 minutes total for everyone to discuss the following:

- Their name, background, number of years with APS, and a response to the icebreaker question.
  - Provide an example of a TV show, movie, or book that portrays a character with a mental health condition. Based on your current knowledge of mental health conditions, do you think the mental health condition was accurately portrayed?

Each team must select one person to present for the group. Presenter will have 2 minutes to provide a few examples from their discussion.

Note: It may be helpful to reference these examples later during the Stigma and Stereotype discussion.

Divide participants into groups of 4 and set the timer for 10 minutes.

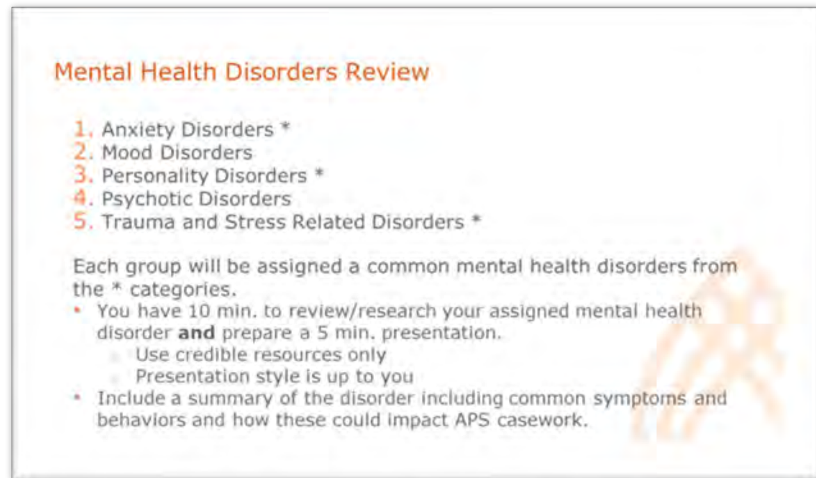
- In-person: **Use** current table groups, **have** participants count off into groups, or **split** into groups by areas of interest (allow participants to choose which topic from the course outline they want to work on or learn more about).
- Virtual: **Ensure** enough breakout rooms for each group (no more than 4 in group) are created.

After 10 minutes, **gather** everyone back on **call** on each group's lead to provide some highlights in less than 2 minutes.

MENTAL HEALTH DISORDERS

Time allotted: 90 Minutes

Slide #7: Mental Health Disorders Review (35-40 minutes)



Remind participants that five categories of mental health disorders were outlined in the Mental Health eLearning:

1. Anxiety Disorders
2. Mood Disorders
3. Personality Disorders
4. Psychotic Disorders
5. Trauma and Stress Related Disorders

Activity #1: Mental Health Disorders Review and Presentations (30-35 minutes)

Small Groups

Share that everyone will be back in their groups and will be assigned one of the most common mental health disorders from most of these categories. **Share** that in their groups, they will have 10 minutes to review and research their mental health disorder and prepare a presentation on their topic. The group will have five minutes to present on their assigned mental health disorder. The mental health disorders are:

1. Generalized Anxiety Disorder
2. Bipolar Disorder
3. Obsessive Compulsive Personality Disorder
4. Post-Traumatic Stress Disorder (PTSD)
5. Phobias
6. Obsessive Compulsive Disorder (Anxiety disorder)

Continued

Note: Depression (from the mood disorder category) and schizophrenia (from the psychotic disorder category) will be explored in more detail later as a class with additional activities.

Divide the class into the same groups from the icebreaker.

Activity Instructions: The groups will prepare a brief presentation on their assigned mental health disorder. Participants may recall or research information on their given mental health disorder using credible online resources for additional information (using smartphones, tablets, or laptops, as available). They have 10 minutes for this part and the style of presentation is up to them (e.g. flip chart, PPT slides-share screen if virtual, whiteboard, verbal report out, etc.)

Each group is responsible for presenting the following information:

- A summary of the mental health disorder including some common symptoms and behaviors.
- Explanation on how these symptoms and behaviors could impact APS casework.

Each team must select one person to present for the group. Presenter will summarize the information gathered on the assigned mental health diagnosis. <u>Presentations should not last longer than 5 minutes</u>.

Provide participants with a few examples of credible mental health resources (provided on the PowerPoint slide and also in the participant guide). **Explain** that credible websites are those which provide information based on accepted standards of research and reliability established by a particular profession. Generally, these are government, professional, and education websites. **Caution** participants against any website that tries to sell them something, has odd pop-ups, or contains advertising.

Gather groups back and **welcome** the first group presentation. During the presentations, **invite** participants to share any personal or professional experiences with these mental health conditions, as they feel comfortable.

Slide #8: Depression Discussion (20 minutes)

Explain: Depression is one of the most encountered mental health conditions in the world. Per National Institute of Mental Health (NIMH), approximately 8.4% of adults in the US has experienced at least one major depressive episode (2019). However, these numbers have increased significantly due to the onset of the COVID-19 pandemic. While specific numbers of diagnoses are still being determined, according to a report from the CDC, the number of individuals experiencing depression appear to be about double the rates that would have been expected before the pandemic hit (Czeisler et. al. 2020).

Activity #2: Depression Video and Discussion (15 minutes)
Large Group

Share that we'll be watching a four-minute video from the World Health Organization's website, and is a testament that major depressive disorder is a worldwide phenomenon.

Show the 'I had a black dog, his name was depression' video found at https://www.youtube.com/watch?v=XiCrniLQGYc or https://www.who.int/health-topics/depression#.

Virtual Note: Depending on virtual platform used, some systems or internet bandwidth may not be able to project the video for the participants. You may need to email the link and provide sufficient time for the participants to view on their own systems individually.

Engage participants in class discussion and debrief the video with the discussion points below.

Continued

Ask: What signs and symptoms did you see in the video?
Possible answers include:

Lack of pleasure in enjoyable activities, lack of appetite, difficulties with attention and memory, fatigue, irritability, disruptions in sleep, self-medicating, social isolation, etc.

Ask: How is major depression different from grief/sadness or feeling blue?
Possible answers include:

Major depression episodes last for extended periods of time. Persistent inability to experience and anticipate pleasure or happiness. Symptoms include excessive feelings of guilt, worthlessness, and hopelessness. Grief is usually associated with feelings of emptiness and loss, but may be accompanied by positive emotions and humor, which are characteristically absent in a major depressive episode (2013, DSM V, pg. 161).

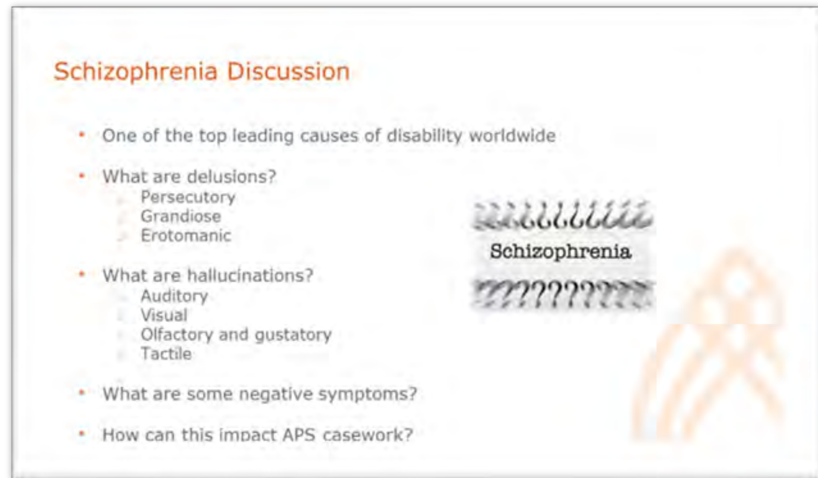
- **Explain:** Symptoms of depression can often mimic certain Neurocognitive Disorders (previously known as dementia). Memory loss, confusion, and personality changes are some of the shared characteristics of both diagnoses. It is one reason why we should refer our clients for medical work-ups when they present with these symptoms.

Ask: How can the symptoms of major depression interfere with APS casework? Does anyone have an example of working with someone with major depression they would like to share?
Allow class to discuss. **Offer** the following suggestions:

Low energy and lack of motivation may impact follow-through with service planning. May observe noncompliance with medications or appointments and other self-neglecting behaviors such as poor hygiene, lack of upkeep on the house, etc. May observe substance use behaviors as a means of self-medicating.

- **Explain:** Individuals with symptoms of depression are sometimes labeled as 'lazy, resistant, and non-compliant.' Consider that it is possible that a client's depression may have been so bad this week, it took every ounce of energy they had to just answer the door to see you. They could not find the energy to make that phone call they agreed to make. While we want to empower our clients to be active in their case planning, you must also be sensitive to the effects their mental health diagnosis may have on their situations.

Slide #9: Schizophrenia Discussion (5 minutes)



Explain: According to the National Institute of Mental Health (NIMH), schizophrenia is a psychotic disorder which affects less than 1% (0.25-0.64% specifically) of the adult population in the US or roughly 1.5 million people. Despite its low prevalence, schizophrenia is one of the top leading causes of disability worldwide. The course of schizophrenia can be severely disabling when left untreated. Common symptoms include delusions, hallucinations, disorganized thinking, abnormal motor behavior, and negative symptoms.

Engage participants in class discussion with the following discussion points:

Ask: What are delusions?
Answer: Delusions are fixed beliefs which do not have a basis in reality. Some themes for delusions in schizophrenia include:

- Persecutory delusions - Someone is coming after them or trying to kill them.
- Grandiose delusions - They believe they have exceptional abilities or fame.
- Erotomanic delusions - They falsely believe that another person (such as a celebrity) is in love with them.

Delusions occur with most individuals with schizophrenia.

Ask: What are hallucinations?
Answer: Hallucinations are sensory perceptions that no one else is experiencing. The types of hallucinations in schizophrenia include:

- Auditory - Hearing voices.

Continued

- Visual – Seeing lights, objects, people, or patterns.
- Olfactory and gustatory – Experiencing good or bad smells and tastes.
- Tactile – Feeling of things moving on your body.

Delusions and hallucinations are examples of positive symptoms of schizophrenia.

Ask: What are some negative symptoms of schizophrenia?
Answer: Avolition (a lack of interest in engagement or goal-directed behavior), apathy or diminished emotional expression (flattened affect, seems unemotional or detached or responds to social situations in unusual ways), anhedonia (lack of pleasure).

Ask: How can this impact APS casework? Does anyone have an example of working with someone with schizophrenia they would like to share?
Allow class to discuss.

Offer the following suggestions: A person with schizophrenia may have difficulty distinguishing reality from their symptoms. Symptoms of schizophrenia can impair the ability to carry out day-to-day activities and can impair relationships. This can result in a limited support system. Major symptoms of schizophrenia require a great level of care and if left untreated, could place the individual in a dangerous situation. For an APS professional, it may be challenging to complete an interview and gather the necessary information you need from a person actively experiencing symptoms of schizophrenia.

Slide #10: Schizophrenia Simulation Exercise (15-20 minutes)

Trainer Note: There are 2 options to conduct this exercise in-person and groups should have the choice of which option. Familiarize yourself with the options prior to training.

CONTENT WARNING:
Explain that you are sharing a content warning for this activity, as participants will either hear or verbalize thoughts of someone experiencing an untreated thought disorder. The language is powerful and can activate strong emotion. **Allow** for participants to sit this one out if needed and **encourage** everyone to do what they need during the activity to promote their own psychological safety.

Activity #3: Experiential Thought Disorder (15 minutes)
Small groups

Reviewing the characteristics, we know that auditory hallucinations are the most common symptom in schizophrenia. We are going to do an exercise that mimics what it is like to experience auditory hallucinations.
Option 1: *This option is available for classroom sessions. Participants will decide on which method they would prefer to use for the activity.*

Activity Instructions: Divide the class back into their small groups of 4. One person will act as the client. Another person will voice the auditory hallucinations. The third person will act as the social worker. The fourth person will act as the observer.

The person acting as a social worker will read the questions from **Handout #2-Benefits Application** while the person voicing the auditory hallucination will be given a tube and a **Handout #1-Script** from which to read. When the time begins, the 'voice' will use the tube to whisper into the client's ear using the prepared script on Handout #1. The person acting as the client will attempt to answer the questions from the social worker. The

Continued

observer will watch the interaction and document any interesting observations made during the interaction.

After 3 minutes, **tell** the groups to stop and switch roles. Each person will be given the opportunity to experience each role.

Option 2/Virtual Adaptation: *While this option was created for the virtual option, it will also work as an alternative to the first option which requires closer contact between participants. This second option allows for social distancing and space between individuals in the classroom.*

For this option, the participants will need to have a smartphone with the ability to listen to an audio clip (youtube) or use the phone to talk to their group member.

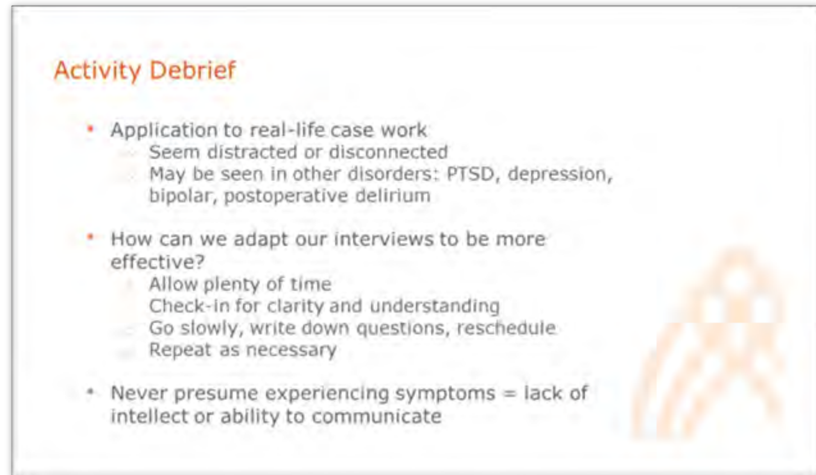
Activity Instructions: Divide the class back into their small groups of 4. One person will act as the client. Another person will voice the auditory hallucinations. The third person will act as the social worker. The fourth person will act as the observer.

The person acting as the social worker will read the questions from **Handout #2-Benefit Application**. The person voicing the auditory hallucination will call the person playing the client and read the script from **Handout #1**. Using headphones (with one ear bud left out) or by holding their phone up to one ear, the person acting as the client will attempt to answer the questions from the social worker. The observer will watch the interaction and document any interesting observations made during the interaction.

Note: Another option for groups of 2 – A recording of an auditory hallucination can be used as a substitute for a person reading the auditory hallucination script. The location of a quality auditory hallucination can be found here: https://youtu.be/0vvU-Ajwbokv (Auditory Hallucination - An Audio Representation).

After 3 minutes, **tell** the groups to stop and switch roles. Each person will be given the opportunity to experience each role.

Slide #11: Activity Debrief (5 minutes)



Spend approx. 3-5 minutes **asking** participants to share their experiences with the activity.

Explain: When you are interviewing someone that is actively experiencing auditory hallucinations, they may appear to not be paying attention you. They may seem easily distracted or even disconnected from the interviewing experience altogether. This activity is intended to help you gain perspective with what a person is experiencing when they are experiencing an auditory hallucination.

Explain: Many of these symptoms are not unique to schizophrenia and they may be seen in other diagnoses such as post-traumatic stress disorder, depression, bipolar disorder, drug-induced psychosis, and even during postoperative delirium.

Ask: How can we adapt our interviews to be more effective with someone that may be experiencing mental health symptoms, such as an auditory hallucination?
Allow participants to shout out some responses. Be sure to **cover** the following points:

- Allow plenty of time for the contact.
- Without condescension, check in with the person about their ability to hear and understand your questions.
- If the person appears distracted or frustrated during the interview, offer to go more slowly, write down your questions, or possible reschedule the interview.
- Use simple language without appearing to ‘talk down’ to the person. Repeat questions as necessary.

Continued

Explain: APS works with a variety of individuals from a variety of ages, cultures, personalities, and backgrounds. Never presume that because a person is experiencing a delusion, hallucination, or other serious symptom of a mental disorder that they lack the intellect or ability to communicate with you, including their opinion on their services or care. Each person is unique, and we must be prepared to adapt our communication methods as necessary.

HANDOUT #1-VOICE SCRIPT FOR THOUGHT DISORDER SIMULATION

Instructions:

Using the cardboard tube or a rolled-up stack of paper, ***whisper*** into your client's ear, the following phrases:

- Why are they asking that!? It's not their business. They're trying to trick you.
- Don't answer. Remember the last time they asked questions. They put you away.
- They're not your friends, they want to put you away. They'll put you away and you'll be lost forever. Don't listen to them, you can't trust them. You'll be sorry.
- You're so stupid. Don't look up. Don't say anything. They won't ever leave you alone. Tell them that you'll do whatever they want.
- No!
- They'll just control you and then they'll put you away. Listen! Shh, if you talk, your thoughts will bleed out. That's how they catch you.
- Don't you know what's true? Why are you here? It's worse if you try, then they'll know. They'll know and they'll see.

Repeat the paragraph, if needed.

HANDOUT #2-BENEFIT APPLICATION

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), use page 10 "Additional Writing Space" section and attach additional sheets of paper if needed to provide the information. Please be sure to identify which question you are writing about in the extra space or on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOUR HAVE ONE AND ARE APPLYING FOR BENEFITS)	
HOME ADDRESS OR DIRECTIONS TO YOUR HOME	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

CONTACT AUTHORIZATION

Please give the county the best contact information to reach you. This will help in processing your application. By providing your contact information below, you are authorizing the county to contact you by phone, email or text, or to leave a phone message regarding your application.

HOME PHONE	CELL PHONE	CHECK BOX FOR TEXT ☐
WORK/ALTERNATIVE/MESSAGE PHONE	EMAIL ADDRESS	

Are you homeless? ☐ Yes ☐ No If **yes**, please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_______________________________
What language do you prefer to speak (if not English)?_______________________________

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

	(PLEASE CHECK ONE)
Do you or anyone in your household have a disability (optional question)?	☐ Yes ☐ No
Do you or anyone in your household need an accommodation due to a disability (optional question)?	☐ Yes ☐ No
Has there been a history of domestic violence/abuse (optional question)?	☐ Yes ☐ No
Are you interested in applying for Medi-Cal? If you answer **yes** the County will use your answers to find out if you can get Medi-Cal.	☐ Yes ☐ No
Is your household's monthly gross income less than $150 and cash on hand, or in checking and savings accounts is $100 or less?	☐ Yes ☐ No
Is your household's combined monthly gross income and cash on hand or in checking and savings accounts less than the combined cost of rent/mortgage and utilities?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100 and either your income stopped or you will not get more than $25 in the next 10 days?	☐ Yes ☐ No

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1) for the CalFresh Program.
- I read, or had read to me, the CalFresh Program Rules and Penalties (Program Rules Page 2).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility for CalFresh is fraud. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits.
- I understand that Social Security Numbers or immigration status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

SIGNATURE OF APPLICANT(OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN)	DATE

***If you have an Authorized Representative please complete question 2 on the next page.**

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh benefits for your household? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

NAME		PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

3. RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	Are you Hispanic or Latino? (Please Check One) ☐ Yes ☐ No	If you are of Hispanic or Latino origin, do you consider yourself: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other__________

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed __________

☐ Asian (If checked, please select one or more of the following)

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify) __________

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following)

☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You or another adult member in your household will need to have an interview with the County to discuss your application and to receive CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. In-person interviews will only happen during the County's normal office hours.

☐ Please check this box if you would prefer an in-person interview.

☐ Please check this box if you need other arrangements due to a disability.

Please check the boxes below for your preferred day and time for an interview:

Day: ☐ Today ☐ Next available day ☐ Any day ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Late afternoon ☐ Anytime

5. OTHER PROGRAMS

Have you or anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program [CalFresh], General Assistance (GA)/General Relief (GR), etc.)? (Please Check One) ☐ Yes ☐ No

IF **YES**, WHO?	WHERE (COUNTY/STATE)?
IF **YES**, WHO?	WHERE (COUNTY/STATE)?

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

6a. HOUSEHOLD'S INFORMATION

Complete the following information for all persons in the home that you buy and prepare food with, including you. **If applying for noncitizens, please complete question 6b and 6c. If not, go to question 6d.**

Social Security number is optional for members not applying for benefits. You must answer the questions below for each person applying for benefits.

Applying for benefits (✔ Check Yes or No)	Name (Last, First, Middle Initial)	How is the person related to you?	Date of birth	Gender (M or F)	U.S. Citizen or National (✔ Check Yes or No) If no, complete question 6b below	Social Security Number
☐ Yes ☐ No		SELF			☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	

Please list the names of anyone who lives with you that does not buy and prepare food with you:

NAME	NAME
NAME	NAME

6b. NONCITIZEN INFORMATION - Complete for those listed in question 6a above who are not citizens and are applying for aid.

Name	Date of Entry into U.S. (If known)	Give one of the following (if known): Passport Number, Alien Registration Number, etc.	Sponsored? (✔ Check Yes or No) If yes, complete question 6c below:
		DOCUMENT TYPE:________ DOCUMENT NUMBER:________	☐ Yes ☐ No
		DOCUMENT TYPE:________ DOCUMENT NUMBER:________	☐ Yes ☐ No
		DOCUMENT TYPE:________ DOCUMENT NUMBER:________	☐ Yes ☐ No

(PLEASE CHECK ONE)

Does anyone listed above have at least 10 years (40 quarters) of work history or military service in the USA? ☐ Yes ☐ No
If **yes**, who?____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa, U-Visa or VAWA status? ☐ Yes ☐ No
If **yes**, who?____

6c. SPONSORED NONCITIZEN INFORMATION - Complete for those listed in question 6b above who are sponsored noncitizens and are applying for aid.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question. If the sponsor signed an I-134 then skip this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If **yes**, how much? $___________

Does the sponsor regularly help with any of the following (check all that apply)?
☐ rent ☐ clothes ☐ food ☐ other ______________________________

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

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6d. STUDENTS

Is anyone who is applying for benefits including you attending a college or vocational school? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

Name of person	Name of school/training	Enrolled status (✔ Check one)	Are they working?
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_______
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_______

6e. Is there a foster child living in your home? ☐ Yes ☐ No If **yes**, who?____________________________________

Please answer the following questions about the child(ren):

Was this child(ren) placed in your home under a dependence order of the court? (Please Check One) ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

7. UNEARNED INCOME

Do you or anyone you buy and prepare food with get income that does not come from a job (unearned)?
(Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI
- ☐ Room and board (from your renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits, or Military pension
- ☐ Financial aid (school grants/loans/ scholarships)
- ☐ Gift of money
- ☐ Unemployment Insurance/State Disability Insurance (SDI)
- ☐ Worker's compensation
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Strike benefits
- ☐ Other ___________________ ________________________

Person getting the money?	From where?	How much?	How often received? (Once, weekly, monthly, or other)	Expect to continue? (✔ Check Yes or No)
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No

If this income is not expected to continue, please explain:

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STIGMAS AND STEREOTYPES OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

Time Allotted: 20 Minutes

Slide #12: Stigma and Stereotypes (5-8 minutes)

Explain: Our ability to work with people with mental health conditions may be based on stereotypes and stigma which are commonly reinforced in media. We are also influenced by our own encounters with mental health conditions in our personal lives or with some of our clients. As a society, these beliefs influence not only the treatment of the people with mental health conditions, but also funding for services, which we know are inadequate.

Ask: What are some common stereotypes about mental health you have encountered?
Allow class to share some answers. It may be helpful to **refer** back to the icebreaker activity and recall some examples from TV shows, movies, and books.

Be sure to **cover** the following stereotypes and discussion points:

- Stereotype: People with mental health conditions are more violent.
  - Answer: Violence in the context of mental health is sensationalized in Hollywood and the media and contributes to the stigma that those with mental health conditions are dangerous.
  - In reality, most individuals with mental health conditions are no more violent than anyone else. Less than 7% of violent acts are committed by a person with symptoms of a mental health condition.
  - In fact, people with severe mental health conditions are 10 times more likely to be victims of a violent crime than the general population (Vashney et.al. 2015).

Continued

- Stereotype: People with mental health conditions just aren't trying hard enough to 'get better.'
    - Answer: Many people with a mental health diagnosis have been blamed for their condition at some point in their lives. They may have been told they can control their symptoms if they were trying hard enough.
    - Stigma causes people to feel ashamed for something that is out of their control. This stigma may prevent people from getting the help they need as it may be seen as a sign of weakness.
    - Reinforce with your clients that seeking appropriate help is considered a strength, not a weakness.

Slide #13: Personal Experiences with Mental Health (6-8 minutes)

Share that the following questions may make people feel vulnerable and/or evoke feelings. Through this discussion, we'll want to come from a place of "I" or in "my experience" and not that one's experience speaks for an entire culture or community.

Emphasize that participants are to share only at the level with which they are comfortable. This is not meant as a support group or therapy exercise. It is intended to raise conscious awareness of how our experiences, family, and cultural background have shaped our personal beliefs.

Share that all cultures have mental health conditions, so we have all encountered mental health at some point of time in our lives.

Ask: What, if anything were you told about mental health conditions by your family, culture, and/or community?
Allow for class discussion.

Ask: How have your views about mental health conditions changed over time?
Allow for class discussion.

- Follow-up questions may include how working for APS has affected those views towards mental health conditions?

Remind the class that this discussion is not strictly limited to the conditions discussed in class. This could include other conditions such as hoarding disorder, eating disorders, and substance use disorders among many others.

Explain: Some additional examples of historical/cultural responses to mental health conditions include:

- These conditions are shameful or a reflection of poor parenting.

Continued

- They are a punishment to the individual or for the family for some transgression.
- They are a spiritual malady which can be cured through prayer or exorcism.
- They are an imbalance of various elements, which can be cured through diet and exercise.

While all cultures have persons with mental health conditions, it is the level of acceptance/stigma which determines how these individuals are treated and integrated into their community.

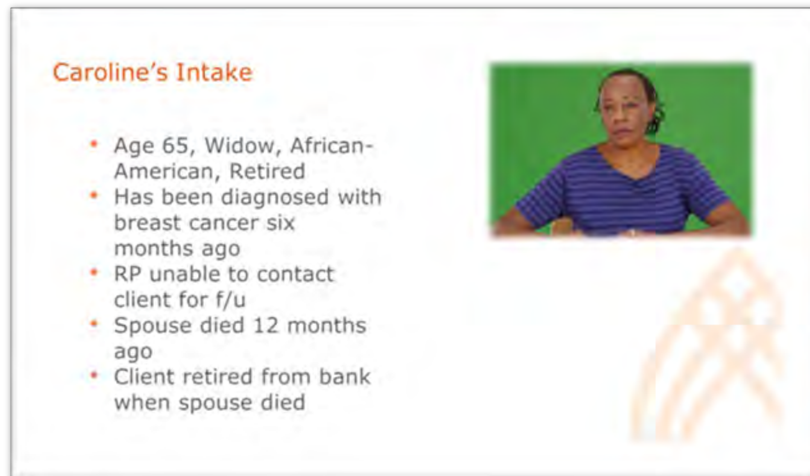
Ask: What can we do to help minimize stereotypes or stigma against those with mental health conditions?

- Answer: Awareness of our own biases, stereotypes, and fears will help us to suspect judgment of those with mental health conditions and treat them with respect and support. Use person-first language and do not use mental health conditions as adjectives (such as joking about a person being "OCD" because they like to organize things). In other words, we treat them as a person, not a diagnosis.

CAROLINE CARSON CASE

Time Allotted: 45 minutes

Slide #14: Caroline's Intake (8-10 minutes)



Activity 6, Part 1: Intake Review (7-8 minutes)
Large Group Discussion

Refer participants to or **distribute Handout #3-Caroline Carson Initial Report Document**. **Allow** five minutes for participants to read over the report. **Engage** in class discussion to discuss the key elements from the intake report.

- Key elements of the intake report:
  - Age 65, Widow, African-American, Retired
  - Has been diagnosed with breast cancer six months ago
  - RP unable to contact client for f/u
  - Spouse died 12 months ago
  - Client retired from bank when spouse died

HANDOUT #3 CAROLINE CARSON INITIAL REPORT

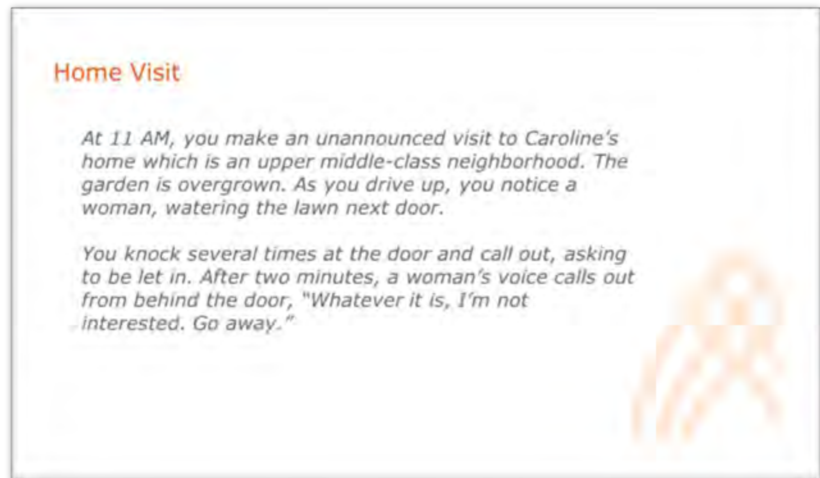
Client Name: Caroline Carson
Age: 65
Ethnicity/Race: African-American
Language: English
Employment: Retired bank teller
Marital Status: Widowed
Living Situation: Unknown, owns her home
Reporting Party: Ellen Williams, Office Manager for Dr. Patel, client's physician

Allegation:
Client was diagnosed with breast cancer six months ago and was to have returned for a surgical consult two weeks ago. Client missed that appointment. Reporting Party (RP) has left voicemail messages on Caroline's phone and sent emails to Caroline, to reschedule appointment. Yesterday, client did pick up the phone and told RP to "Leave me in peace," and hung up the phone. RP is concerned as Ms. Carson has always been very talkative and followed up in the past-she has been a patient for 10 years.

RP states that client's spouse died from a heart condition about a year ago. Client then retired. Client has two adult children who live out of state. Her emergency contact is a neighbor, named Delores DeLa Cruz.

RP does not have any other information about the client.

Slide #15: Home Visit (1 minute)



Activity 6, Part 2: At the Door (15-17 minutes)
Large Group and Small Groups

Ask a volunteer to read the following, found on the PPT slide:

At 11 AM, you make an unannounced visit to Caroline's home which is an upper middle-class neighborhood. The garden is overgrown. As you drive up, you notice a woman, watering the lawn next door.

You knock several times at the door and call out, asking to be let in. After two minutes, a woman's voice calls out from behind the door, "Whatever it is, I'm not interested. Go away."

Trainer Note: This activity continues on next slide.

Slide #16: At the Door Activity (13-15 minutes)

Trainer Note: This slide is animated to first share instructions and then the debrief question.

At the Door Activity

- In groups, decide what is the best next step and why:
  1. Leave immediately, leaving your card in the door, plan on coming back the next day.
  2. Call the mental health crisis assessment team in your area.
  3. Call the police to assist getting in the door.
  4. Knock on the door and try again.
  5. Go over to the neighbor and enlist her help in getting in to see Mrs. Carson.

  What did your group decide?

Explain that participants will go back to their small groups and decided what they should do next as the APS professional in this case.

Share that they have 10 minutes to discuss and come to an agreement on best option and why! They should choose a member who will report out to the larger group.

Refer participants to their participant manual where they have the options they need to choose from, which they will be discussing as a group.

1. Leave immediately, leaving your card in the door, plan on coming back the next day.
2. Call the mental health crisis assessment team in your area.
3. Call the police to assist getting in the door.
4. Knock on the door and try again.
5. Go over to the neighbor and enlist her help in getting in to see Mrs. Carson.

Activity Instruction: Allow table groups 10 minutes to discuss and come to an agreement on the best option. They must be prepared to explain their rationale.

Virtual Adaptation: Participants will be sorted back into their previous breakout rooms.

After 10 minutes, **allow** one representative from each team member to write down (or type in the chat box feature) the number that corresponds to their answer and ask teams to simultaneously hold up their answers. **Allow** each group to briefly provide justification for their responses.

Continued

Note: Refer to the following "Rationale for Responses for Part 2" for this activity to help facilitate group discussion and guide group consensus to the preferred option.

Rationale for Responses for Part 2: At the Door

1. Leave immediately, leaving your card in the door, plan on coming back the next day.

   Why this is **not** the best response: You do not know who it was that denied you access. Was it the client or someone else?

2. Call the mental health crisis assessment team in your area.

   Why this is **not** the best response: You do not have enough information to make a request for a mental health evaluation, in particular a crisis assessment team.

3. Call the police to assist getting in the door.

   Why this is **not** the best response: The police can only enter a residence under exigent circumstances, when they believe there is either imminent risks to persons, or when they believe a crime is actively in progress. Again, you don't have enough information for this request. There are some racial considerations to have in mind as well when it comes to police interactions with Black or African-American people.

4. **Knock on the door and try again.**

   Why this is the BEST response: Even though APS services are voluntary, the woman who declined your entry may or may not be the client. The principle of informed consent applies. You haven't had the opportunity to give the client information to make an informed choice. The second principle is that of 'due diligence' or 'due care.' Due diligence is defined as "the care that a reasonable person exercises to avoid harm to other persons or their property" (Merriam-Webster). This principle implies a dedicated effort to carry out your responsibilities as an APS worker to promote the welfare of your client.

5. Go over to the neighbor and enlist her help in getting in to see Mrs. Carson.

   Why this is **not** the best response: This may violate confidentiality, as you do not yet have client's consent to speak with her neighbor.

Slide #17: The Interview (18-20 minutes)

The Interview

Handout #4

- In groups, decide what is best next move and why:
  1. Tell her you know about the breast cancer diagnosis and explore her treatment options with her.
  2. Get consent to speak with Mrs. DeLa Cruz, conclude the interview and then interview Mrs. DeLa Cruz for additional information.
  3. Assess the client for depression and possible suicide risk.
  4. Refer the client to community resources for bereavement counseling and conclude the interview.
  5. Recommend the client go see her doctor to find out why she has no energy and conclude the interview.

Activity 6, Part 3: Interviewing the Client (15-18 minutes)
Large group and breakout groups

Refer participants to or **distribute Handout #4-Caroline Carson Interview**. **Allow** 5 minutes for participants to read over the report. **Engage** in class discussion to discuss the key elements from the interview.

- Key elements of the interview:
  - Alert, engages in conversation
  - One-word answers
  - States "I'm fine"
  - Has telephone calls from children weekly
  - Attends church weekly, otherwise doesn't leave the house
  - Sleeps most of the time
  - Doesn't feel like eating when she's up

Explain that participants will go back to their small groups and decided what they should do next as the APS professional in this case.

Share that they have 10 minutes to discuss and come to an agreement on best option and why! They should choose a member who will report out to the larger group.

Refer participants to their participant manual where they have the options to choose from, which they will be discussing as a group. PowerPoint slide reveals the following options:

1. Tell her you know about the breast cancer diagnosis and explore her treatment options with her.

Continued

2. Get consent to speak with Mrs. DeLa Cruz, conclude the interview and then interview Mrs. DeLa Cruz for additional information.
3. Assess the client for depression and possible suicide risk.
4. Refer the client to community resources for bereavement counseling and conclude the interview.
5. Recommend the client go see her doctor to find out why she has no energy and conclude the interview.

Activity Discussion: Allow table groups 10 minutes to discuss and come to an agreement on the best option. They must be prepared to explain their rationale.

Virtual Adaptation: Participants will be sorted back into their previous breakout rooms.

After 10 minutes, **allow** one representative from each team member to write down (or type in the chat box feature) the number that corresponds to their answer and ask teams to simultaneously hold up their answers. **Allow** each group to briefly provide justification for their responses.

Note: Refer to the following "Rationale for Responses for Part 3" for this activity to help facilitate group discussion and guide group consensus to the preferred option.

Rationale for Responses for Part 3: Interviewing the Client

1. Tell her you know about her breast cancer diagnosis and explore her treatment options with her.

   Why this is **not** the best response: By disclosing that you have knowledge of her breast cancer diagnosis, you are essentially revealing the reporting party. Also consider that you are not a doctor and reviewing treatment options are not within your scope of practice. Lastly, the more imminent risk here is depression and suicide.

2. Get consent to speak with Mrs. Dela Cruz, conclude the interview, and then interview Mrs. Dela Crus for more additional information.

   Why this is **not** the best response: Client is demonstrating signs and symptoms of a major depressive disorder and you are knowledgeable of the factors which contribute to this possibility. You need to address the depression and possible suicidal ideations before you can conclude the interview.

3. **Assess the client for possible suicide risk.**

Continued

Why this is the best response: Client has experienced some major life stressors in the past 12 months, including the death of her spouse, retirement, and a breast cancer diagnosis. She has symptoms of major depression including: hypersomnia (sleeping a lot) and a loss of appetite. The risk of suicide is the most imminent risk to the client and the one which should take priority in your interview.

4. Refer the client to community resources for bereavement counseling and conclude the interview.

   Why this is **not** the best response: The client is likely grieving the loss of her spouse and you may want to refer these resources after you address the immediate risk of depression and suicide.

5. Recommend the client go see her doctor to find out why she has no energy and conclude the interview.

   Why this is **not** the best response: You would want to do this after you assess the client's suicide risk which is the imminent risk. (It is always best practice to refer the client for a medical work-up when there has been a significant change in one's functional abilities. Even though we strongly suspect there is major depression, there could also be organic reasons causing/contributing to the symptoms you are seeing.)

HANDOUT #4 CAROLINE CARSON INTERVIEW

Using your best rapport building skills, you convince the woman, who turns out to be Ms. Carson, to let you in. You interview her in her living room, which is nicely furnished, but dusty. On the tables and chairs are piles of what appears to be unopened mail. On the walls are photos depicting what you assume are family members.

Ms. Carson is dressed in a clean nightgown and a bathrobe, she states she had been sleeping when you knocked. She is thin and her hair is unkempt. Her responses are brief and to the point.

You explain that your office received a call asking your office to make sure she was OK. She states "I'm fine" in a tired voice. You ask about her health, she states "I'm fine," with no mention of breast cancer diagnosis.

You ask about the photos on the wall, she reveals her spouse died last year and that she has weekly phone calls from both of her children, who live out of state. She tells you she still goes to church every week with her neighbor, Mrs. DeLa Cruz, but otherwise, spends most of her days in bed. She tells you she has lost weight, because she doesn't feel like eating when she is up.

SUICIDE RISK ASSESSMENT

Time Allotted: 45 minutes

Slide #18: SAFE-T Form (5 minutes)

Provide the following Content Warning:

> This next section addresses elements of suicide including a role play where an assessment for suicide risk will be completed. Participants are encouraged to do what they need to do in this section to protect their own psychological safety. It's important that we practice this "real-time" self-care and psychological safety in training, so that it can carry over when we might become activated in the field in front of people we are working with.

Refer participants to **Handout #5- SAFE-T form**.

Explain this form was created by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist professionals in evaluating suicide risk.

Review the key components of the SAFE-T form: Risk Factors, Protective Factors, and Suicidality (thoughts, intention, plan, and means). Based on these components, one assesses the client's level of risk.

HANDOUT #5 SAFE-T FORM

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

ACKNOWLEDGEMENTS

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National Suicide Prevention Lifeline

1.800.273.TALK (8255)

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www.sprc.org

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE

1.800.273.TALK (8255)

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Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior**: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders**: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
  Co-morbidity and *recent onset of illness increase risk*
- **Key symptoms**: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history**: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal**: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment**: discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal**: ability to cope with stress, religious beliefs, frustration tolerance
- **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation**: frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan**: timing, location, lethality, availability, preparatory acts
- **Behaviors**: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent**: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

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Slide #19: Caroline's Level of Risk (7-8 minutes)

Caroline's Level of Risk

- What are some of Caroline's protective factors?
- What are some risk factors which may lead you to believe she could be suicidal?

Assessing Caroline for Suicide Risk:
1. Individually, write down some questions that would help assess Caroline's suicide risk. These will be used in a role-play/demonstration.
   Address additional risk or protective factors, intent, plan and/or means to carry out plan

Ask: What are some of Ms. Carson's Protective Factors?
Allow group to shout out some responses. Possible answers may include spiritual/religious orientation, frequently telephone contact with her kids, weekly visits with Ms. Dela Cruz.

Ask: What are some risk factors which may lead you to believe she could be suicidal?
Allow group to shout out some responses. Possible answers may include death of her spouse, loss of job, breast cancer diagnosis (all which occurred in a short period of time).

Activity 7: Assessing Caroline for Suicide Risk (5 minutes)
Individual activity

Activity Instruction: Allow participants 5 minutes to write down some questions that would help assess Ms. Carson's suicide risk. Each question should address additional risk or protective factors or should address intent, plan, and/or the means to carry out the plan.

Explain that these questions will be used for the next role play activity.

Advise participants that they have been provided with **Handout #6- Geriatric Depression Scale**. This may be a useful tool for screening for possible depression for clients that are older adults. Note that this scale will not be used for this class session but that the participants should check with their supervisors to determine if it is appropriate for their agency to use for casework.

HANDOUT #6-GERIATRIC DEPRESSION SCALE (SHORT FORM)

Geriatric Depression Scale (Short Form)

Patient's Name: ______________________ Date: ____________

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	***YES*** / NO	
5.	Are you in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	YES / ***NO***	
12.	Do you feel pretty worthless the way you are now?	***YES*** / NO	
13.	Do you feel full of energy?	YES / ***NO***	
14.	Do you feel that your situation is hopeless?	***YES*** / NO	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

- Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol.* 1986 June;5(1/2):165-173.
- Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull.* 1988;24(4):709-711.
- Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res.* 1982-83;17(1):37-49.

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Slide #20: Demonstration Scenario 1 (15-20 minutes)

Trainer Note: Familiarize yourself with the Caroline Carson Roleplay Card: Case Scenario 1 in order to answer participant's assessment questions during activity.

Activity 8: Suicide Risk Assessment Demonstration Scenario 1 (15 minutes)

Large Group

Activity Instructions: For this role-play activity, the trainer will play the role of Caroline Carson (Roleplay Card: Case Scenario 1). The participants will play the role of the APS professional collectively, taking turns for approx. 10 minutes, asking the questions they have written down. Each participant must ask at least one question each, provided it's safe for everyone to do so.

Once all questions have been asked, participants will be given 2 minutes to use the SAFE-T tool to determine Ms. Carson's level of risk.

CAROLINE CARSON ROLEPLAY CARD: CASE SCENARIO 1 (FOR TRAINER)

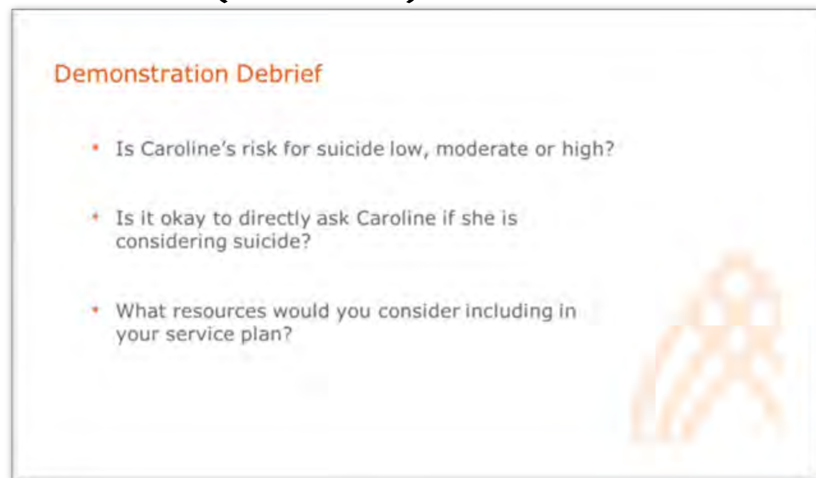
- You miss your spouse, who was very loving and supportive. You find yourself crying frequently and are unable to remember things.

- You know you are depressed, because you've experienced this before. You've been hospitalized for depression in the 1970's (following the birth of your second child). At that time, you received electroshock therapy and you never want to experience that again.

- Because of your religion, you will not kill yourself, although you have passive thoughts of dying (going to sleep and not waking up); you pray daily that God will take you soon so you can be with your spouse again.

- You haven't spoken with anyone about these feelings.

Slide #21: Demonstration Debrief (5 minutes)



Allow class to debrief the scenario by asking the following questions:

1. What is Ms. Carson's risk for suicide? Low, moderate, or high?

Answer: In this scenario, Ms. Carson is considered at moderate risk. She has passive thoughts of death and wants to join her spouse. She may be seen as passively committing death by suicide by not seeking treatment for her breast cancer.

2. Is it okay to directly ask Ms. Carson if she is considering suicide?

Answer: Yes, the best way to know if someone is considering suicide is by asking them. You can lead up to direct questions first by asking about her feelings and outlook on her situation. When you ask whether she is considering suicide, it is important to be sensitive *and* direct. Do not ask if Ms. Carson is thinking of 'hurting herself,' as this is something completely different from suicide. Instead, asking "Do you have plans to kill yourself or take your life" leaves no question on what you are asking.

3. What resources would you consider including in your service plan?

Answer: In this scenario, a referral back to her physician for treatment options for her breast cancer and an assessment/treatment for possible depression including medication and/or bereavement counseling/psychotherapy. Additional resources may include financial planning assistance resources and socialization resources.

Slide #22: Demonstration Scenario 2 (15-20 minutes)

Trainer Note: Familiarize yourself with the Caroline Carson Roleplay Card: Case Scenario 2 in order to answer participant's assessment questions during activity.

Demonstration Scenario 2

- Everyone will ask their questions.
- Listen to the answers from Caroline.
- Once activity is complete, use SAFE-T Form to assess Caroline's level of risk

Activity 9: Suicide Risk Assessment Demonstration Scenario 2 (15 minutes)

Large Group

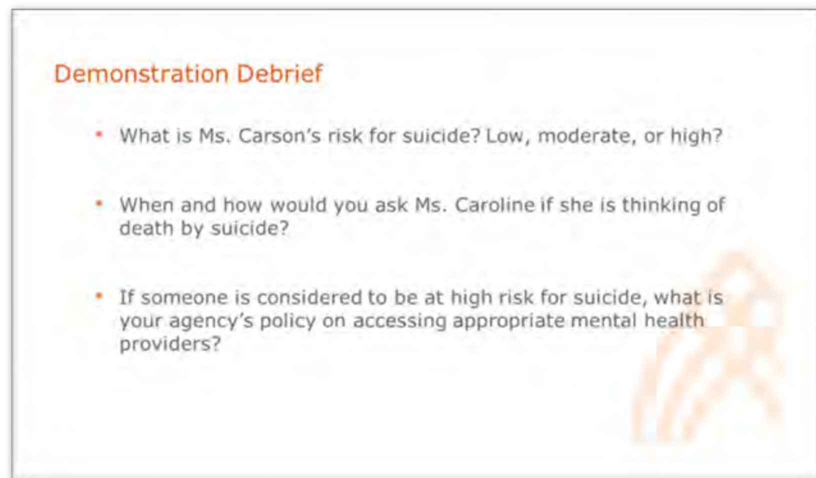
Activity Instructions: For this role-play activity, the trainer will resume the role of Caroline Carson, but will use the information from Scenario 2. The participants will resume the role of the APS professional collectively and again, take turns for approx. 10 minutes, asking questions to assess Ms. Carson's risk. Each participant must ask at least one question each.

Once all questions have been asked, participants will be given 2 minutes to use the SAFE-T tool to determine Ms. Carson's level of risk.

CAROLINE CARSON ROLEPLAY CARD: CASE SCENARIO 2 (FOR TRAINER)

- You feel very guilty about the death of your spouse, who was killed in a car accident while running an errand for you.
- Immediately after they died, you quit your job, because you weren't able to concentrate at work and couldn't do your job.
- You have chronic back pain for which you take muscle relaxants and Oxycodone. The pain has gotten worse over the past few weeks.
- You believe that the breast cancer diagnosis is God's way of punishing you and you have chosen not to seek treatment because you want to die anyway.
- You intend to overdose on your pain medications and drink a lot of alcohol if the pain gets too bad.
- You have purchased a burial plan and have written instructions to your children about how to dispose of your estate after you are gone.

Slide #23: Demonstration Debrief (10 minutes)



Allow class to debrief the scenario by asking the following questions:

1. What is Ms. Carson's risk for suicide? Low, moderate, or high?

Answer: In this scenario, Ms. Carson's suicide risk would be considered high. She has intent, a plan, and the means to execute that plan. Compounding the other losses and stressors she has experienced; she is feeling guilty that she was the cause of her spouse's death.

2. When and how would you ask Ms. Caroline if she is thinking of death by suicide?

Answer: As discussed in the previous scenario, the best way to know if someone is considering suicide is by asking them. You can lead up to direct questions first by asking about her feelings and outlook on her situation. When you ask whether she is considering suicide, it is important to be sensitive *and* direct. Do not ask if Ms. Carson is thinking of 'hurting herself,' as this is something completely different from suicide. Instead, asking "Do you have plans to kill yourself or take your life" leaves no question on what you are asking. Avoid leading questions like, "You're not really thinking of killing yourself are you?"

3. If someone is considered to be at high risk for suicide, what is your agency's policy on accessing appropriate mental health providers?

Answer: Some policies may include reaching out to law enforcement, a psychiatric emergency response team, or another entity. If you do not know the answer to this, it is highly encouraged you speak to your supervisor before a situation like this comes up, so you can be prepared if/when a situation like this presents itself.

Continued

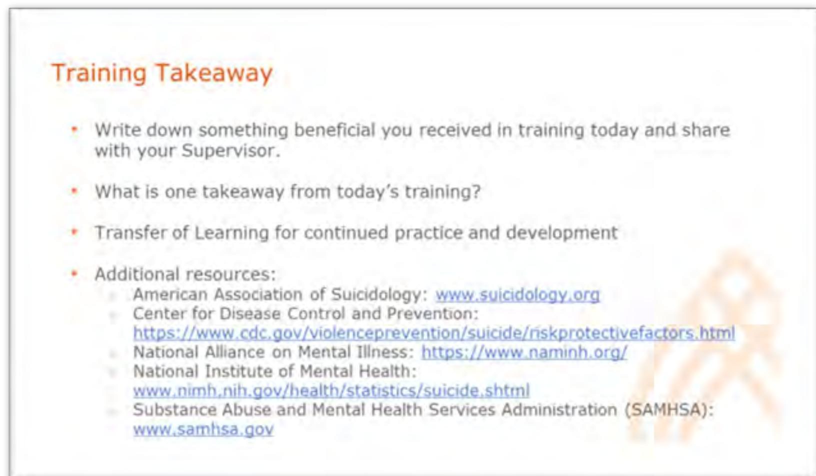
Explain: Talking about suicide with clients can be uncomfortable and scary. And like CPR, we don't have regular opportunities to practice this in a supportive setting. We encourage you to discuss with your supervisor and other experienced social workers how they have handled such situations. It is important to know what your policy is in advance on how to access emergency mental health services. We also encourage you to continue to learn more about available behavioral health resources in your community. The last couple of slides in this presentation list resources you can use for future reference.

Trainer Note: If participants would like more support around working with people experiencing various risk levels of suicidality, there are more opportunities in the Transfer of Learning packet which is mentioned on next slide.

WRAP-UP AND EVALUATIONS

Time Allotted: 10 minutes

Slide #24: Training Takeaway (5 minutes)



Explain: In your work with APS, you will encounter individuals with mental health conditions. It is your job to stay informed, be empathetic, and be sensitive to the effects a mental health condition may have on a person's situation and their service plan.

Ask participants to write down on thing that they received in this training and commit to sharing this information with their supervisor.

Ask for volunteers to provide one key takeaway they have from today's training.

Share that **Handout #7-Transfer of Learning,** found in the Appendix, will help provide additional opportunities to reflect on and practice the content and concepts from today's training. **Encourage** everyone to choose at least one activity they will commit to doing in the next 2 weeks.

Provide participants with some additional resources on the topics covered today:

American Association of Suicidology: www.suicidology.org

Center for Disease Control and Prevention:
https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

National Alliance on Mental Illness: https://www.naminh.org/

National Institute of Mental Health:
www.nimh.nih.gov/health/statistics/suicide.shtml

Substance Abuse and Mental Health Services Administration (SAMHSA):
www.samhsa.gov

Slide #25: Questions and Evaluations (5 minutes)

Ask if there are any questions or comments about their experience today.

Allow time to complete class evaluations. **Emphasize** that their feedback is vital to meet the needs of the APS programs, we encourage honesty and suggestions.

Thank the class for participating in today's training and investing in their professional development.

APPENDIX:
HANDOUT #7- TRANSFER OF LEARNING PACKET

Mental Health Issues in APS Transfer of Learning (TOL) Activities

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Academy for Professional Excellence

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Mental Health Issues in APS Practice
Transfer of Learning

How to Use:
This Transfer of Learning (TOL) Packet is designed as a companion to NAPSA Core Competency Module 6: Mental Health Issues in APS, both eLearning and ILT modalities.

This TOL packet can be used in a variety of settings to include:
- Instructor-Led Training (virtual or in-person) with support from a facilitator
- During supervision when coaching staff around the skills of identifying mental health issues with people APS interacts with and appropriate interventions and referrals
- Unit Meeting as a group activity with guidance from a Supervisor or Lead Staff
- Individually with follow-up from a supervisor or trusted peer

There are **four** activities available, independent of each other that continue the conversation around:

- Appropriate resources and referrals
- Support around suicidality and depression with clients
- Mental Health Disorders:
    - Anxiety Disorders, Mood Disorders, Personality Disorders, Psychotic Disorders and Trauma and Stress-Related Disorders
- APS staff challenges when working with people experiencing mental illness

Content Warning:

APS professionals may have lived experience with a spectrum of mental illness. Completing any of the activities may bring personal and professional challenges for the learner. **Content Warning** text will be displayed on any scenario involving suicide. Learners, Facilitator and Supervisors are all encouraged to utilize self-care while completing activities.

Activity #1: Identifying Resources

Purpose:

Mental Health resources are continuously changing and programs come and go based on eligibility and funding. APS is often having to think outside the box when it comes to resources they provide. This activity allows learners to review in-depth resources that are local or on-line in order to provide more informative and personalized referrals.

Instructions:

1. Choose 1-3 resources you are likely to provide people you work with and complete the following prompts and questions. *Choose between resources you've used before, resources you've heard about from colleagues or that you have previous experience with and resources you are unfamiliar with.*
    - Suggested resources to choose from:
        - Substance Use Support Center,
        - Local Mental Health Counseling,
        - Veteran's Affairs (VA),
        - National Association for Alcoholism and Drug Abuse Counselors (NAADAC),
        - National Association Social Workers (NASW),
        - National Alliance on Mental Illness (NAMI),
        - Substance Abuse and Mental Health Services Administration (SAMHSA),
        - Crisis Intervention Team (CIT)

2. Thoroughly review the resources website, brochure, or when possible, call and speak with staff and/or schedule a visit in-person.

3. Answer (and discuss if applicable) the questions below

Questions:

- Why is this a resource you would provide to someone?
- What is the fee?
- Are there workshops available for individuals living with mental health disorders? What are they?
- Are there workshops available for people's whose loved ones are living with mental health disorders? What are they?
- What is the eligibility requirement?

Activity #2: Depression and Suicidality Scenarios

Instructions:

Read the scenarios below and answer the questions with as much detail as possible.

Scenario #1: George

*Content Warning

You have received a report of self-neglect that indicates George, a 72-year-old male is not caring for himself or taking his medication. You have completed your initial steps of the investigation by talking with the reporter and George. You conducted your 1st interview with George in his home. You learn that George is a veteran of the Navy and was married for 40 years before his wife died a year ago. While in the home you notice several food containers in and around the trash can, George's hair appears uncombed, clothing appears dirty, in disrepair and you smell what you believe to be is extensive body order. While talking with George he reveals that he was diagnosed with PTSD and depression about 10 years ago, but he thinks it's just a bunch of new age stuff and ways to medicate people. He also shared that he had a heart attack 2 years ago. When you ask about medication, Georges states they are on the counter in the kitchen but is unable to tell you what he takes or the last time he took any medication. The reporter indicated that George has not been taking his medication as prescribed, is isolating himself and not participating in his usual activities like his daily walks around the lake or weekly meetups at the coffee shop with his best friend. When you addressed these concerns with George, he scoffs at you and tells you it does not matter what he does. As you continue to talk with George you hear a load noise that sounds like something fell outside and suddenly Georges yells at you to get the hell out of his house and to mind your own business.

4

Questions:

1. What are your concerns, if any, for current symptoms of depression or suicide?
   a. Document George's behavior, your observations and reason for concerns.

2. What steps would you take and why?
   a. Find out what is your APS program doing with people who may be experiencing depression or having suicidal thoughts? What tools are available to you?
      i. What is expected from you as an APS professional?
      ii. What tools/screening instruments does your APS program use?

3. Are there groups, programs available for individuals living with mental health disorders?
   a. What are they?
   b. What is the eligibility requirement?

4. Are there groups or programs available for people's whose loved ones are living with mental health disorders? What are they?
   a. What are they?
   b. What is the eligibility requirement?

Scenario #2: Mariela

You receive a report of financial exploitation of a Mariela, age 65. The reporting party is Mariela's adult child who reported that Mariela's neighbor is using her debit card without her permission. The reporting party also states they believe Mariela has early stages of Alzheimer's disease. When you meet with Mariela to discuss the reporting party's concern of possible financial exploitation, you notice her hands look extremely dirty and that she may have rheumatoid arthritis in her hands and ask about it. She informs you that she sleeps well, but has very low energy and that showering takes too much out of her lately and that she keeps forgetting to take her medication and confuses which medication is for her arthritis and which is for her heart condition.

She shares that she feels lonely and sad but does not want to bother anyone for help. She shares that her kids try to help out, but she has a particular way she likes things done and it's just better if she does it herself, even if it exacerbates her arthritis pain.

Questions:

1. What are your concerns, if any, for current symptoms of depression or suicide?
    a. Document Mariela's behavior, your observations and reason for concerns.
    b. What questions would you ask Mariela about your concerns? (be specific)

2. What steps would you take and why?
    a. Find out what is your APS program doing with people who may be experiencing depression or having suicidal thoughts? What tools are available to you?
        i. What is expected from you as an APS professional?
        ii. What tools/screening instruments does your APS program use?

3. Are there groups, programs available for individuals living with mental health disorders?
    a. What are they?
    b. What is the eligibility requirement?

4. Are there groups or programs available for people's whose loved ones are living with mental health disorders? What are they?
    a. What are they?
    b. What is the eligibility requirement?
    c. What is the eligibility requirement?

Scenario #3: Keon
*Content Warning

You received a report of physical abuse of a 90-year-old male, Keon, from a RN. The RN reported that he is on dialysis, and at his last visit he was, "sad, crying, and resentful of others around him". When you talk with Keon at his home, he tells you he is just tired, and the dialysis hurts and takes all his energy for the day. When sitting with Keon you talk to him about the process of dialysis. Keon informs you that he has kidney failure, has arthritis in his hands back and legs for the last 25 years. As you look around the home, the kitchen and living area appears clean and well kept. You can see what appears to be bruises on Keon's arms and red mark on his neck going from left to right and across the back of the neck. As you are sitting there you detect an aroma that is sweet – when you ask Keon what that aroma is, Keon states that is his stuff his daughter Jill does. Keon states she does what she wants when she wants and lives downstairs. Keon states Jill takes care of the home and takes him to dialysis. Keon explains that his daughter makes her living selling aroma things from home yet does not pay a dime for living in the home. When you ask who owns the home Keon states he does, but he can't live in the home without her help, so he lets her stay at the house for free. As you talk to Keon about his health, Keon looks to the ground and does not respond, states, "none of my kids care about me, all they do is take from me, and expect me to pay for everything". Keon states it is hopeless to think anything will change and thinks he should just stop the dialysis and die.

Questions:

1. What are your concerns, if any, for current symptoms of depression or suicide?
    a. Document Keon's behavior, your observations and reason for concerns.
    b. What questions would you ask Keon about your concerns? (be specific)

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2. What steps would you take and why?
    a. Find out what is your APS program doing with people who may be experiencing depression or having suicidal thoughts? What tools are available to you?
        i. What is expected from you as an APS professional?
        ii. What tools/screening instruments does your APS program use?

3. Are there groups, programs available for individuals living with mental health disorders?
    a. What are they?
    b. What is the eligibility requirement?

4. Are there groups or programs available for people's whose loved ones are living with mental health disorders? What are they?
    a. What are they?
    b. What is the eligibility requirement?
    c. What is the eligibility requirement?

Activity #3: Mental Health Disorders Symptoms

Purpose:
Many times, APS professionals struggle with boundaries and their own frustrations when working with people living with mental health disorders. This can result in the APS professionally informally/quietly "diagnosing" people as a way to explain why the person isn't allowing for engagement or following through with a service plan. They may even identify a person by their diagnosis (e.g. "My borderline client"). This activity is designed to:

a. Allow APS professionals to identify symptoms of various mental health disorders
b. Remind APS professionals that just as there are symptoms of other illness (e.g. runny nose from a cold) there are symptoms of mental health disorders (e.g. lack of motivation from someone experiencing depression)
c. Critically think through next steps to move toward safety and well-being and document appropriately

Instructions:
Imagine you are on the phone or in-person with the people in the scenarios. Complete the questions with as much detail as possible.

Scenario #1: Joanne

Joanne is a 76-year-old Army veteran who was a Nurse when she served. Joanne's cousin has made a report to APS on behalf of the family It has been reported that Joanne appears confused and disoriented. The family reports they are not sure what to do and think Joanne needs to go to an assisted living or memory care unit. After confirming the initial report with the reporter, you go to Joanne's home to speak with her. Joanne tells you about her duty as a nurse in the Army and at times she has thoughts that take her back to the days of combat and taking care of soldiers

who were sick and wounded. Sometimes it is very distressing for her, but she will avoid the thoughts or feelings by doing something different like going out for club activities like gardening club. Joanne tells you some days she has difficulty concentrating on current events which causes her stress and difficulty falling asleep. Joanne tells you that she has no issues, and the family is overreacting. As you are talking with Joanne, she appears to understand where she is, the day, date and year and tells you about her current activity of attending clubs and other organized events.

Questions:

1. What are you hearing or seeing that is raising concerns for Joanne's mental health?
   a. Document this accordingly.
2. Based on this information you have, which of the five broad categories of mental disorders (Anxiety Disorders, Mood Disorders, Personality Disorders, Psychotic Disorders, Trauma and Stress Related Disorders) would you think Joanne falls under and why?
3. What steps would you take and why?
4. Is there a screening tool your agency has for you to use?
   a. If positive screening, what is your next steps?
5. Why would you refer Joanne and where would you refer Joanne to? (be specific)

Scenario #2: Charlie

You receive a report of a 69-year-old individual named Charlie. Charlie is reported as having difficulties with the activities of daily living, unable to get in and out of the shower by himself, having occasional accidents with urine and struggles to fasten the buttons on his shirts or zip his pants. You also learn that Charlie struggles with some instrumental activities of daily living such as keeping track of his finances or paying bills. The report indicates Charlie is not sleeping well, sleep patterns appeared mixed up, and is not eating well.

You arrive at Charlie's house and meet Charlie's husband Robert. As you speak with Robert; you learn that Charlie has been irritable for the last 6 months. Robert states they have been married for 10 years and that he has known Charlie for about 15 years. Prior to getting married, Robert said Charlie had medical issues that included confused thoughts and disorganization. Robert stated that he has learned more about Charlie's medical history over the years. Charlie was under a lot of stress in his younger days around age 25 Charlie ended up in the hospital, had a "nervous breakdown". Robert said it was right after Charlie graduated college, told his parents he was gay. Charlie's parents were not very understanding and refused to let Charlie remain in the home. As far as he knows after a couple years Charlie got better and began to reestablish himself. From what Robert understands Charlie had several different jobs, not sure why, but since they have been together Charlie has been very calm, friendly, and took care of himself. Robert states Charlie lately can be heard talking to himself and when asked about it, becomes defensive. Some days it appears Charlie is arguing with himself. Robert said Charlie is unable to judge depth and distances which is odd for Charlie as he was always very good at judging distance, he could always tell you how close you were or how far something was. Robert reports Charlie was always very meticulous about his appearance, but lately Charlie is not showering, or keeping himself groomed; Charlie is preoccupied with what others are doing outside the home. Charlie is now isolating, avoiding groups or other activities. Robert states over the last year Charlie began to struggle to put words and thoughts together that would make sense, and it is getting worse. Robert explains it is hard to talk with Charlie. Charlie sometimes becomes very agitated, angry, and then appears to check out and stares out the window or right through you.

Questions:

1. What are you hearing or seeing that is raising concerns for Charlie's mental health?
    a. Document this accordingly.

2. Based on this information you have, which of the five broad categories of mental disorders (Anxiety Disorders, Mood Disorders, Personality Disorders, Psychotic Disorders, Trauma and Stress Related Disorders) would you think Charlie falls under and why?
3. What steps would you take and why?
4. Is there a screening tool your agency has for you to use?
    a. If positive screening, what your next steps?
5. Why would you refer Charlie and where would you refer Charlie to (be specific).

Activity #4: Individual Reflection and Support

Purpose:
Mental Health concerns with people APS professionals interact with continues to be an area where support is needed. This activity allows the learner to first reflect on their training and what concerns, fears, or unknowns they still have. It then provides opportunities to collaborate with a Supervisor or trusted colleague around these concerns, fears and unknowns.

Instructions:

1. Think about or review the training you have received, the resources you have reviewed and/or the programs you have spoken to.
2. What questions come to your mind and what possible concerns can you think of for yourself and others when working with individuals experiencing symptoms of mental or behavioral health issues?
3. Write these questions, concerns, or fears down and then set a time to talk with your mentor or supervisor to explore the stigma and your concerns. Ask them for some direction.
4. Pay attention to any cultural understandings or considerations when it comes to living with mental illness.

This Transfer of Learning Packet was developed by Michael Hagenlock, LCSW, LAC, in collaboration with CA's Curriculum Advisory Committee. March 2022. Contact apstraining@sdsu.edu for any questions or feedback.

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