MODULE 1: WELCOME

TIME: 30 Minutes

PURPOSE:

Module 1 provides participants with an overview of the workshop and gives them an opportunity to begin to develop a rapport with the trainers and with each other. This module also sets the tone for the entire workshop by identifying the goal of the workshop as well as reviewing the training materials, handouts, and logistical concerns.

LEARNING OBJECTIVES:

Upon completion of this module, participants will be able to:

- Review logistic and housekeeping information;
- Identify trainers and participants;
- Understand the purpose, objectives, agenda, ground rules, and underlying principles of the workshop, including: the paradigm shift that involves recognizing the new flexibility of service delivery options that can address individual and family's needs and preferences; and
- Incorporate into their practice achieving outcomes for children and adults.

MODULE AGENDA:

A.	Welcome	1 Minute
B.	Logistical and Housekeeping Information	2 Minutes
C.	Facilitator and Participant Identification	12 Minutes
D.	Discussion of Goals of Training	5 Minutes
E.	Identifying Needs Pre-test	10 Minutes

TRANSPARENCIES:

T-1.1: Training Agenda
T-1.2: Ground Rules
T-1.3: Training Goal

HANDOUTS:

H-1.1: Ground Rules
H-1.2: The Underlying Principles of This Training
H-1.3: Pre-Test

PREPARED NEWSPRINT:

- Welcome Sheet with Facilitators' Names;
- Training Agenda; and
- Parking Lot

ADDITIONAL SUPPLIES:

- Five to seven post-it or similar adhesive strip pads for the "Parking Lot" exercise;
- Blank tent cards;
- Sign-in sheet; and
- Flip chart/markers.

1 Minute

A. WELCOME

The Facilitator should welcome the participants to the training and acknowledge the time they are taking from their jobs to participate in the workshop. The Facilitator should note that this Workshop is an interagency technical assistance project that has been developed through collaboration between:

- The Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT); and
- The Arizona Department of Health Services (DHS), Division of Behavioral Health Services (DBHS).

Augmenting a series of trainings that ADHS/DBHS conducted for stakeholders in Fall of 2001, this training was developed for Arizona substance abuse treatment, mental health, co-occurring, and children service providers on how to access the State's Covered Behavioral Health Services.

2 Minutes

B. LOGISTICAL AND HOUSEKEEPING INFORMATION

The Facilitator should inform participants where to locate:

- Public telephones;
- Water fountains;
- Emergency exits;
- Telephone messages (at registration table);
- Assistance in adjusting the room temperature;
- Lunch or eating facilities; and
- Please turn your cell phones off.

12 Minutes

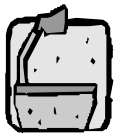
C. FACILITATOR AND PARTICIPANT INTRODUCTIONS

Welcome Sheet and Agenda

The Facilitator should turn to the prepared newsprint *Welcome Sheet with Facilitators' Names*. The Facilitator(s) should introduce themselves and then give each person a few seconds to share the following information:

- Name;
- Agency or organization; and
- Number of years working in the field.

Following participant introductions, the Facilitator should point out the vast amount of experience the participants bring to the workshop and tell them to feel free to share their experiences and expertise as the training progresses.



T-1.1

The Facilitator should refer to T-1.1: *Training Agenda* and discuss prepared newsprint *Training Agenda* that highlights the workshop agenda. After reviewing the agenda, post the newsprint in a location easily seen by all

participants. Also, the Facilitator should note that the training covers the following modules and topics:

- Module 1: Welcome
- Module 2: Assessing Individual Strengths and Needs
- Module 3: Practicing Assessment- Case Study &Video
- Module 4: Introduction to Covered Services
- Module 5: Matching Strengths and Needs to Services
- Module 6: Regional Service Availability

T-1.2

The Facilitator should show T-1.2: *Ground Rules* and handout H-1.1: *Ground Rules,* and make note of the following before the training begins:

- There are no right or wrong answers to any of the exercises. The matters discussed involve clinical judgments and not absolutes.
- The professional expertise for the day's exercises exists within the participants. In other words, the participants are the experts, not the Facilitator. The Facilitator's role is to structure the day and keep the exercises focused.
- All participants are expected to actually engage in the exercises in order to maximize learning.
- Ensure that participants have access to a pad of post-it type notes. Then, direct participants to the prepared newsprint and note that often during discussions, points and/or questions may come to mind that they would like to have addressed. So they will not forget their issue, please write a brief reminder on the post-it note pad provided. At any time during the course of the training, they may list issues or concerns in the "Parking Lot."

H-1.1

Parking Lot

During the breaks, the Facilitator should move the specified items to the "Parking Lot" newsprint and encourage participants to add information and resources to the list. The Facilitator may also add resources and information to the prepared newsprint *Parking Lot* and should remember to glance at this sheet throughout the day. Make sure you have responded to all issues by the close of the day.

5 Minutes

D. DISCUSSION OF GOALS OF TRAINING

T-1.3

Then, the Facilitator should refer participants to T-1.3: *Training Goal,* and state that the goal of the training is to provide frontline behavioral health services providers* with the understanding of how to identify the strengths and needs of an individual and family and then match covered services and natural supports to their strengths and needs.

*Providers include paraprofessionals, behavioral health technicians, and behavioral health professionals.

The Facilitator should note that after completing this training participants will be able to:

- Identify strengths and needs of individuals and families;
- Use covered services to match individual and families' needs and strengths; and
- Be knowledgeable on how to access and create covered services locally.

This training will assist frontline providers in matching individual needs and strengths of individuals and families with available covered behavioral health services and other community supports. *This is NOT a training about how to write a treatment plan and determine billing codes. At the end of this training, you will have new skills involving individuals and families in their service planning.*

H-1.2

At this time facilitator should handout H-1.2: *The Underlying Principles of This Training*. These are the principles on which service provision should be based. The Facilitator will ask each table to spend 10 minutes reviewing the handouts and identifying and discussing which principles resonate most closely with their values.

10 Minutes

E. IDENTIFYING NEEDS TEST

H-1.3

The Facilitator will handout H-1.3: *Pre-Test*, and ask each participant to spend 5 minutes independently identifying needs and strengths. When the exercise is complete, participants should place the paper in the back of their folder and it will be discussed late in the training.

T-1.1: TRAINING AGENDA

This training covers the following modules and topics:

- Module 1: Welcome
- Module 2: Assessing Individual Strengths and Needs
- Module 3: Practicing Assessment- Case Study &Video
- Module 4: Introduction to Covered Services
- Module 5: Matching Strengths and Needs to Services
- Module 6: Regional Service Availability

T-1.2: GROUND RULES

During the training, participants should be aware of the following ground rules:

- There are no right or wrong answers to any of the exercises. The matters discussed involve clinical judgments and not absolutes.
- The professional expertise for the day's exercises exists within the participants. In other words, the participants are the experts, not the Facilitator. The Facilitator's role is to structure the day and keep the exercises focused.
- All participants are expected to actually engage in the exercises in order to maximize learning.
- Cell phones should be turned off except during breaks.
- For purposes of this training, covered services, ancillary services and wrap around services may be used interchangeably.

T-1.3: TRAINING GOAL

The goal of the training is to provide frontline behavioral health services providers* with the understanding of how to identify the strengths and needs of an individual and family and then match covered services and natural supports to their strengths and needs.

* Providers include paraprofessionals, behavioral health technicians, and behavioral health professionals.

H-1.1: GROUND RULES

During the training, participants should be aware of the following ground rules:

- There are no right or wrong answers to any of the exercises. The matters discussed involve clinical judgments and not absolutes.

- The professional expertise for the day's exercises exists within the participants. In other words, the participants are the experts, not the Facilitator. The Facilitator's role is to structure the day and keep the exercises focused.

- All participants are expected to actually engage in the exercises in order to maximize learning.

- Cell phones should be turned off except during breaks.

- For purposes of this training, covered services, ancillary services and wrap around services may be used interchangeably.

H-1.2: THE UNDERLYING PRINCIPLES OF THE TRAINING

The 12 principles are the essence of the federally recognized system of Care Core Values. They were adopted 6/26/01.

The "Arizona Vision," for children is built on twelve principles to which ADHS and AHCCCS are both obligated and committed. The Arizona Vision states:

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults.

Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

1. Collaboration with the child and family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.

4. Accessible services: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. Best practices: Competent individuals who are adequately trained and supervised

provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home- like setting that is appropriate to the child's needs.

7. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

8. Services tailored to the child and family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self- management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the

planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. Connection to natural supports: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

The Arizona Department of Health Services developed these principles in collaboration with the Court Monitor's Office, the plaintiffs, ValueOptions. The principles were reviewed by/and feedback provided by both consumers and family members. The principles were introduced at the SMI Coordinators Meeting.

1. Behavioral health assessments and service plans are developed with the understanding that the system has an unconditional commitment to its consumers.

2. Behavioral health assessments and service plans begin with empathetic relationships and that foster ongoing partnerships, expect equality and respect throughout the service delivery.

3. Behavioral health assessments and service plans are developed collaboratively to engage and empower consumers, include other individuals involved in the consumer’s life, include meaningful choice, and is accepted by the consumer.

4. Behavioral health assessments and service plans are individualized strength-based and are clinically sound.

5. Behavioral health assessments and service plans are developed with the expectation that the individual is capable of positive change, growth and leading a life of value.

The National Institute on Drug Abuse published a monograph titled “Principles of Drug Addiction Treatment: A Research-Based Guide” which outlines the following 13 principles of effective treatment:

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs (see pages 11-49). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. (*Approaches to Drug Addiction Treatment section discusses details of different treatment components to accomplish these goals*.)

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (*see Drug Addiction Treatment Section*).

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-

term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

H-1.3: PRE-TEST

Please spend 5 minutes reading the scenario below. Once you have read the scenario, please make a list of the needs and strengths you have identified. After you have completed the exercise, please put the results in the back of your folder.

Bobby is a nine-year-old boy who was picked up by the police for driving a stolen car. He was initially taken to detention but his behavior became so violent and out of control that he was placed in an acute care facility. Until this time, Bobby has been living with his mother, her boyfriend (of three years) and two sibs, Ben 10 and sister, Brittany, 6. Bobby reports he headed to the store to buy groceries when the police stopped him. He took the money left on the table at home and ran. Mom was asleep and "daddy" was out at the time. Mom reports that Bobby has been somewhat wild lately. He comes and goes as he pleases and rarely attends school. Once when mom and dad were high on drugs and fighting with each other, Bobby even went after "daddy" with a knife. "He's a good boy though and really looks after his brother and sister." Since his real dad was murdered almost two years ago, there has been a big change in him and his behavior.

In the hospital, Bobby continues to tantrum and refuses to follow any rules. He has been assaultive to staff and is on constant AWOL watch. The plan, pending further investigation of the family situation, is to return him home – on probation - as soon as his behavior is under better control.