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The Supervision Curriculum for Family and Person Centered Practice - *Supervision 301: The Clinical Track*

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Learning Objectives
The Supervision Curriculum for
Family and Person Centered Practice –
Supervision 301: The Clinical Track

❖ Clinical Thinking in Family and Person Centered Practice

Readers will be able to:
- Define therapeutic effectiveness and state at least five factors that determine it
- Define restrictiveness and state at least five factors that determine it
- State at least five program types and the characteristics that make them therapeutically effective or restrictive

❖ What do People Mean When They Talk About Mental Illness, Emotional Disturbance, Developmental Disability and Behavior Disorders?

Readers will be able to:
- Define mental illness
- Define emotional disorder
- Define developmental disability
- Define behavior disorder
- Identify at least three facts and three common myths about mental illness
- Describe the salient features of each of the following:
  - Schizophrenia
  - Bipolar Disorder
  - Tourette’s Disorder
  - Encopresis
  - Enuresis
  - Separation Anxiety Disorder
  - Reactive Attachment Disorder
  - Anxiety Disorders
  - Obsessive Compulsive Disorder
  - Posttraumatic Stress Disorder
  - Borderline Personality Disorder
  - Attention Deficit/Hyperactivity Disorder
- Conduct Disorder
- Oppositional Defiant Disorder
- Learning Disorders
- Major Depressive Disorder
- Dysthymic Disorder
- Developmental Disability: Mild, Moderate, Severe and Profound
- Pervasive Developmental Disabilities: Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, Pervasive Developmental Disability, Not Otherwise Specified

❖ Supervision and Clinical Analysis
*Readers will be able to:*
- State at least 10 questions to resolve as part of a clinical analysis
- Complete a clinical analysis using one of the scenarios provided
- Complete a clinical analysis with an employee on an actual consumer or family situation
- Draft remedial plans for increased mastery in selected areas

❖ Introduction to Applied Behavior Analysis
*Readers will be able to:*
- Describe Abraham Maslow’s Hierarchy of Basic Needs and what it means
- Accurately define at least 20 key behavioral terms
- Describe the three major ways to change behavior
- State how behavior is changed by modeling
- State how behavior is changed by direct instruction
- State how behavior is changed by motivational strategies
- Describe how rewards and punishments can backfire and state at least three examples
- Describe how perspective and bias influence the way people understand and respond to behavior
- Describe twelve steps to change behavior
  - Describe how to collect and review information about behavior
  - Describe how to assess the need for medical intervention in behavior intervention planning
  - Describe how to do a basic behavior assessment
- Name at least five issues to consider when targeting behavior for intervention
- Define a target behavior accurately and describe the impact of antecedents, setting and consequences
- Define what function means in terms of behavior
- Name at least five questions to ask in a functional analysis
- Describe how at least one behavior is functioning and suggest at least one functional, alternative behavior
- Define task analysis and describe why, when and how it is used
- Complete a task analysis on a specific behavior

❖ Assessment in Family and Person Centered Practice

Readers will be able to:
- Name at least three issues to consider in reference to assessment in Family and Person Centered Practice
- Define at least five key terms used in treatment and service planning in Family and Person Centered Practice
- State at least eight questions that are important to answer in treatment and service planning and why they are important
- Describe the use of positive and negative evidence in protective services and court applications of Family and Person Centered Practice
- Describe the impact of culture on assessment
- Describe the impact of bias on assessment
- State at least five ways to enhance assessment rapport

❖ Research in Family and Person Centered Practice

Readers will be able to:
- Describe the purpose of research in the design of treatment and service plans
- Give at least four examples of specific information learned by researching consumers’ and families’ strengths, interests, etc. and how what is learned could be used in treatment or service planning
- Complete specific research in at least five areas and design at least one strategy that reflects what you learned about each

❖ Treatment and Service Planning: Outcomes, Needs & Strategies
Readers will be able to:
- Define outcomes, needs and strategies and describe how they relate to each other
- Give at least three examples of service plans that are structured around outcomes, needs and strategies.

- Crisis Planning in Family and Person Centered Practice: An In Depth Look for Supervisors
  Readers will be able to:
  - Define reactive and proactive crisis plans
  - State at least six tips for supervisors to use when teaching staff about crisis planning
  - Complete at least two reactive and proactive crisis plans for two of the scenarios provided
  - Evaluate a crisis plan designed by an employee

- Safety Planning in Family and Person Centered Practice: An In Depth Look for Supervisors
  Readers will be able to:
  - List at least 10 things to consider in safety planning and five basic questions used to assess safety
  - List 10 analysis and planning questions to use in safety planning along with at least three reasons the questions are important
  - Complete two safety plans for two of the scenarios provided

- Transition Planning in Family and Person Centered Practice: An In Depth Look for Supervisors
  Readers will be able to:
  - State why transition planning is an important part of Family and Person Centered Practice
  - Name at least eight potentially difficult transitions consumers and families involved in Family and Person Centered Practice may face
  - Complete two transition plans for two of the scenarios provided
Introduction

Welcome to The Supervision Curriculum for Family and Person Centered Practice - Supervision 301: The Clinical Track. In this manual, the emphasis is on clinical practices, insights and interventions in Family and Person Centered Practice.

Supervisors have more influence on clinical practice than anybody else involved. They shape practice through training, modeling and feedback. Employees learn about the policies, the values and the mission of their organizations from supervisors. More importantly, in terms of policies, values and expectations, they learn what they are really expected to do and what they are permitted to ignore.

Supervisors need to master all the fundamental tasks inherent in leading, monitoring, instructing and nurturing staff. Many of these fundamentals were explored in The Supervision Curriculum for Family and Person Centered Practice - Supervision 101: The Fundamentals of Supervision. But there’s more to it than that. Supervisors must also model, teach and inspire performance as it relates to the clinical aspects of Family and Person Centered Practice. This is a more subtle and complex mission.

Family and Person Centered Practice is very different from other practice models. This seemingly minor point is hugely important. There are few practice traditions and modalities that resemble Family and Person Centered Practice. It’s easy to think that this is the same old thing, repackaged. It isn’t. This practice is a radical change in how we support vulnerable families and consumers. The Latin meaning of the word radical is root. In other words, a radical change means a fundamental shift in thinking that begins at the very root of everything we do from how we understand a situation to how we accommodate it and work with it.

A review of the values and principles that define Family and Person Centered Practice is in The Supervision Curriculum for Family and Person Centered Practice - Supervision 101: The Fundamentals of Supervision. Supervisors have to believe that these values and principles are not symbolic, but actual and evident in every aspect of direct practice. They are not optional or relevant exclusively to sympathetic situations in which they are easy to apply. They are guiding principles; basic, definitional hallmarks that make practice Family and Person Centered.

This part of the Supervision Curriculum for Family and Person Centered Practice focuses on the clinical insights and processes that form the very foundation of this practice model. It will hopefully lead supervisors to adjust, inspire and hold staff accountable for transformed practice that gives consumers and families voice and that helps them achieve outcomes that are important to them and their communities.
Clinical Thinking in Family and Person Centered Practice

Therapeutic Effectiveness and Restrictiveness

When implementing Family and Person Centered Practice, supervisors may encounter concern about the therapeutic effectiveness of this practice model, because people often confuse restrictiveness with therapeutic effectiveness. In other words, they assume that restrictive environments deliver more than they may actually deliver. Similarly, they assume that less restrictive, community environments are necessarily less therapeutic and less therapeutically effective. This is not accurate. In fact, the two concepts are very different. Therapeutic effectiveness is not about geography or location. Interventions are as therapeutically effective as they are designed, implemented and funded to be. Supervisors cannot afford to miss this key distinction.

Therapeutic effectiveness is a function of…

- The availability of comprehensive and competent medical services especially as they relate to assessment, evaluation and intervention.
- The degree to which interventions are individualized and based on strengths.
- The amount of time the individual spends in positive, enjoyable activities that reflect cultural and community norms.
- The degree to which interventions contribute to important insights and new ways of interpreting events.
- How much emphasis is placed on meeting unmet needs and on learning new, adaptive skills across all relevant areas of the individual’s or family’s life.
- Whether or not the desired outcomes that are to be achieved by the service or service environment are identified in advance.
- The degree to which the treatment/service plan reflects daily, ongoing activity related to the defined outcomes.
- The consistent implementation of potentially helpful strategies and the ease of revising strategies as needs change and additional strengths are discovered.
• The degree to which the treatment plan reflects efforts to establish permanent, satisfying relationships.

• Whether or not new skills, alternate responses and replacement behaviors are taught effectively by using every sensory tract possible, using short and long term person-centered rationales, actually demonstrating options and providing feedback during rehearsals.

• How much emphasis is placed on communication skills that work in the real world and that further the development of durable relationships.

• The degree to which motivational strategies are individualized and altered to produce results when they fail.

• How easily new behaviors, skills and insights will transfer to other, desired settings and how much support there is to make that happen.

When you’re determining how restrictive a service is, ask instead…

• To what degree does the physical setting resemble norms for people of similar age and development in the community? Is it near other people? Does it look like the places other people and families live?

• Are social and recreational opportunities readily available? Can a friend sleep over? Can a guy call his girlfriend and chat? Can he call his boyfriend? Can the runner, run? The reader, read?

• How are work and education accessed? With support from a professional or family and friends? Is it the same school the children in the neighborhood attend? Is it a real job?

• How would you characterize the interactions and conversations in which the person typically participates? Are they more clinical or more average?

• To what degree do people have age appropriate access to decisions that affect their day to day lives? Can a person make a sandwich anytime? Stay up late? Stay out late?

• How easily can people participate in activities related to their culture, faith and preferences?
• How much access do people have to their families and friends?

• Who’s in charge? Are there compelling, external forces that determine what happens, (e.g., court orders, protective services directives, custody agreements, articles of probation or parole)?
In Family and Person Centered Practice, practitioners maximize therapeutic effectiveness while minimizing restrictiveness.

Consider the two concepts **together**...

The options above the dashed line are most likely to be Family/Person Centered except for Kinship Care (see note).

<table>
<thead>
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<th>HIGH</th>
<th>EFFECTIVENESS</th>
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| ♦ Wraparound | ♦ [Kinship Care]*  
♦ Wraparound Foster Care  
♦ Treatment Foster Care with individualized supports  
♦ Treatment Foster Care |
| ♦ Intensive In-Home  
♦ In-Home Services | ♦ Specialized Foster Care with an emphasis on outcomes and generalization  
♦ Specialized Group Home with emphasis on outcomes and generalization  
♦ Residential Treatment Center & Psychiatric Facility with Community Outreach Services, active follow up, an emphasis on outcomes and individualized supports. |
| ♦ Intensive Out-patient Therapy and Intensive Resource Coordination (see below) | ♦ Foster Care  
♦ Emergency Foster Care  
♦ Day Treatment with defined treatment approaches  
♦ Group Home with defined treatment approaches  
♦ Residential Treatment Center  
♦ Therapeutic Camp  
♦ State Hospitals |
| ♦ Resource Coordination  
♦ Outpatient Therapy (largely limited by the amount of time the service is available, i.e. the 50 min. hour in a 168 hour week) | ♦ Shelter Care  
♦ Temporary School  
♦ [Kinship Care]*  
♦ Group Home without defined treatment approaches  
♦ Day Treatment with out defined treatment approaches  
♦ Correctional Facility, Jail & Detention Center |

LOW | RESTRICTIVENESS | HIGH

* Kinship care is generally less restrictive and more therapeutic than many alternatives, even though its healing power is different from that in other settings designed to be therapeutically intensive.
What Do People Mean When They Talk About Mental Illness, Emotional Disturbance, Developmental Disability and Behavior Disorder?

What Do People Mean When They Talk About Mental Illness?

Mental illness has been difficult to define since the first moments it was observed. People are sad. Is it life or depression? People get nervous. Is it a passing sensation or a generalized anxiety disorder? People worry that others are talking about them; they see things in the world that others don’t. Are they realistic about human nature or paranoid? Are they gifted with vision and creativity or psychotic?

How people react to atypical thoughts and actions also varies. What one point of view or culture benignly ignores or absorbs, another will find disturbing and deviant. Age and intellectual capacity also influence how people interpret, understand and respond to people who do not fit whatever notions of normal are predominant in their communities. Even gender plays a role in what people accept or refuse to accept as normal.

Still, there are certain things that people do and say that most of the people around them regard as problematic. This is when the dysfunction becomes evident and is commonly understood to be dysfunction. Dysfunction means exactly what it looks like it means: an impaired, altered or absent ability to function successfully, take care of oneself, be happy and engaged in the world.

Different does not equal dysfunction. Many people who act and speak in ways that are unusual are gifted, creative, eccentric, even idiosyncratic but not mentally ill. The issue here is whether or not a person can live a safe, satisfying life.

Delusional and psychotic states are a little different. A delusion is the belief that something is true when it isn’t. It is related to a person’s inability to distinguish between what is real and what isn’t, or what only seems to be real.\(^1\) Psychosis is similar. A person who has psychosis has lost or has poor contact with reality\(^2\) as indicated by delusions, hallucinations and disorganized behavior.

People are sometimes satisfied with the illusory worlds their delusions create. They may even feel safe in them. More often, however, psychotic states produce fear, uneasiness, suspicion and outright terror for the people who experience them. For

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these disorders, an important feature for diagnosis is that their worlds are illusions, as determined as objectively as possible by unbiased observers.

Beliefs that seem extreme to some are not necessarily, in and of themselves, sufficient to trigger a diagnosis. Some think that Joan of Arc was a saint; others think she was psychotic. Some think Ghandi was a great man; others think he was filled with delusions. Some think a violent act is terrorism from a mad man; others think it’s the pathway to eternity.

While we have made much progress in understanding what mental illness is, there remains much that we don’t know. Many people continue to think this one through in the hope that we can further our ability to define mental illness accurately and treat it effectively.

What Do People Mean When They Talk About Emotional Disturbance?

It is normal to be emotional, even excessively so, when a person is in a trying situation or one that is hurtful, sad or otherwise challenging. It’s normal to be disturbed, even deeply so, in difficult circumstances.

When most observers believe that an individual’s emotional reaction to a situation seems logical or reasonable, albeit extreme, that individual’s reaction does not comprise an emotional disturbance. Similarly, when a person experiences emotions and can manage them safely and mostly without failed relationships, lost jobs, serious negative consequences and compromised safety, an emotional disturbance is unlikely.

But when a person’s emotional reaction to a situation makes little or no sense, even when personal values, preferences and other factors central to who that person is are taken into account, emotional disturbance may be present. Additionally, when an individual escalates into an extreme emotional state and loses control over his actions, safety, relationships, livelihood, etc., as evidenced by failure and loss, an emotional disturbance may be the issue.

Emotional disturbance is mainly characterized by two factors: first, the emotion or degree of emotion is out of sync with the situation, with an evaluation of what an appropriate response might be that is both broad and tolerant and, secondly, the person experiencing the emotion is unable to manage himself, resulting in loss, injury, and other negative consequences.
What Do People Mean When They Talk About Developmental Disability?³

The main thing children do as they grow is develop. In this context, develop means to go through a series of changes that result in greater maturity, as evidenced by new skills and insights. Child development is partly about the increasing physical abilities babies and children acquire, from being able to hold their heads up on their own to crawling, walking and so on. It’s also partly about new understanding: that people who go away (i.e., they can’t be seen immediately) come back, like in the Peek-a-Boo game many parents play with their babies; that crying produces a response from caregivers; that smiles lead to hugs and attention from adults and children close by. Babies and children learn and develop through transactions or interactions with their environments and most especially, with their parents and other consistent, responsive caregivers.

Children develop through a variety of phases, defined by decades of studies. These phases are – correctly – broadly defined and are tied to age ranges rather than specific ages. That’s important because children develop differently even when they have the same parents and grow up in the same home – just ask a parent with more than one child. When the genetics and the environments are different, children’s development varies, sometimes quite a bit.

Disability, however, isn’t difference. Disability means that what a child or adult can do has been somehow compromised, to a mild, moderate, severe or profound level. Developmental disability means that the very process of development is compromised. It may be slowed down or limited in scope. New skills – physical and intellectual – may come slowly and then, only through the result of deliberate and repeated intervention. In some instances of Developmental Disability, these skills remain absent despite intervention.

Developmental Disability, historically (for some still) called Mental Retardation, is diagnosed when there is significantly below average intellectual functioning along with problems with at least two important areas of development like life skills, communication, the ability to be safe, work, live independently, maintain social relationships, academic success, self care and others.

What Do People Mean When They Talk About Behavior Disorder?

When behavior is normal, it makes, as the saying goes, one kind of sense or another. It, in a very direct way, “works.” It produces a response or set of responses that meet a need or fulfill a function for a person. If the person needs attention, normal behavior increases the probability that the attention will be received, that it will be satisfying and

that it will take the individual in a reasonably positive direction, as determined by that person’s point of view.

When there is a behavior disorder, the person who needs attention will behave in ways that are unlikely to meet that need for attention or in ways that make the attention unsatisfying and more likely to take the individual in a negative direction.

People with behavior disorders often seem surprised, even shocked, with the world’s reactions to their behavior. They are sometimes unable to connect their actions with the reasonable and logical consequences of those actions. They are startled to learn that their behavior has led to the end of relationships they value, to lost jobs, disciplinary actions and often, major loss. They are unable to predict and understand, in advance, those consequences and therefore (without treatment) are unable to prevent them.

Mental Illness: Facts and Myths

Fact

• For behavior, action or cognition to be central to a diagnosis, there must be dysfunction

Example

Doug is very active and fidgety but successful at school

Myth

• Diagnosis is a straightforward process that leads to answers about exactly what is wrong.

Example

Jill seems depressed to everybody who knows her but nobody can see why? That doesn’t matter. There are a number of things that could cause Jill's reaction, some of which have nothing to do with diagnosis.

Fact

• The presence of unusual thoughts and actions that lead to dysfunction isn’t, by itself, sufficient to warrant a diagnosis if it only occurs in one setting

Example

The child is fine at home, Scouts, the after-school program and with family members but out of control at school

Myth

• Once you get the diagnosis, the treatment for it is identified.

Example

Each child who has a diagnosis of AD/HD will respond equally well to the same behavior management system? No, diagnosis alone doesn’t tell us exactly how to intervene.
Fact

- How well or poorly a medication works on a particular child or adult is at least in part a function of that person’s biochemistry and the severity of his disability.

- Medication provides an opportunity to remediate dysfunctional thoughts and actions through intervention, treatment and rehabilitation

- Neurobiological mental illness is as much a physical illness as diabetes or cancer. It is not a choice. It is not caused by the family or the environment

Example

Jim takes A mgs of medication B everyday and is doing well. Jane tried the same thing and it didn’t work at all. Now Jane takes C mgs of medication D and all is well.

Now that Ben’s bipolar disorder is successfully treated and medicated we can work on mood control tools

Patty has schizophrenia, a serious neurobiological mental illness. Her dad says she needs to get a hold of herself, her mom says she needs to try harder and her Grandma says it’s her mom’s fault. Patty listens to her doctor and when she treats her illness medically, she’s OK.

Myth

- Once you get the diagnosis, medication can be selected and prescribed without error

- Once the medication is on board, the problems stop and the person is cured

- If children (and adults) are motivated, they can overcome mental illnesses like schizophrenia, bipolar disorder and major depression

Example

The child has a conduct disorder and ODD so drug Q will work? No, there’s no magic chart that indicates which medication will work best for each disorder and each person.

We’re treating the AD/HD so why can’t she do seat work in school? Because we now have to teach her, which the medication doesn’t do all alone. It just allows us to teach successfully.

Cady’s Aunt says she just needs to refuse to hear the voices in her head and she won’t need her doctor anymore? Not so. Cady needs medical treatment not a pep talk.

Working with People Who Take Medication

Front line staff often work in partnership with children and adults who take – or are supposed to take – medication. Because of that, they may find themselves in a position to coach or advise the people they serve when medication issues arise.
The decision to use medication is not a simple one. There is no absolute relationship between illness and medicine because of the unique interaction between each person’s body chemistry and each medication. A diagnosis, even a specific one, doesn’t “lock in” a medical solution. Even when people have the same condition, the pharmaceutical remedy that works best varies across individuals. It’s not just that the medicine that’s used differs from one person to another; often the amount or how and when the drug is used changes as well.

Exactly how medicine is taken is important. Some meds are designed to melt on the tongue. Others are supposed to be absorbed in different parts of the digestive system: the stomach, the small intestine or the large intestine. If a medication is designed, for example, to be absorbed in the large intestine, it may not work if the person who needs it chews it instead of swallowing it. Some medicines work best when they are taken at intervals throughout the day and if a consumer takes them all at once, they may be ineffective or even dangerous.

What a person eats and drinks may also have a significant impact on how medication works so careful, scheduling is indicated. Some meds require a completely empty stomach; others work best when the person who uses them has eaten a meal. Certain foods and drinks: milk, fruits and fruit juices, alcoholic and caffeinated beverages, carbohydrates, etc. can have an impact on how well or poorly medication works. Front line staff, along with consumers, their friends, families and other members of their treatment teams, have to educate themselves to ensure that each consumer’s medicine is used as comfortably and effectively as possible.

Front line staff often help consumers and families research and learn about their medication options. They help consumers monitor the effects of their meds and remind them to bring their questions to their prescribing health care professionals. They design medication diaries with consumers and help them note both the positive and negative effects of whatever they are taking. Of course front line staff aren’t doctors but they can have a positive impact on making sure that consumers have all the facts they need to make up-to-date, informed medical decisions.

One of the issues that comes up frequently in the area of medication is what health care professionals call medication or med compliance. These terms refer to whether or not consumers are taking their medicine as prescribed or the degree to which they are using it as intended by the prescriber. For many consumers and families, this is an ongoing issue. Consumers have the right to decide whether or not to take a recommended drug as early as their early teen years, depending on where they live. That’s an important right and it should be respected. Still, many observers suspect that the decision to stop taking their meds or to take them sporadically is part of the ongoing condition that indicated that medication was needed by these consumers. It can be very frustrating.

Front line staff should know that not every consumer has the right to select or reject prescribed medication. Some consumers are required to take meds by courts and
mandated social service providers. This usually happens as a result of risky or illegal behavior on the part of the person who is ordered to take the medicine. Some are even required to submit to random urine or blood testing to prove that they are complying with the orders of the courts that supervise their actions.

Some consumers don’t comply with the medications they are advised to take because of the side effects the meds produce: weight gain, constipation, dry mouth, trouble sleeping, trouble staying awake, the feeling that they are not as creative or energized as they would be without the meds and more. Front line staff, along with other treatment team members, work with consumers to treat or prevent uncomfortable side effects. Sometimes, they also facilitate consumers’ access to ongoing blood testing to ascertain whether or not they have the right level of their medicine in their body. These and other practical supports help ensure that consumers will use medicine as prescribed.

Sometimes consumers, like the rest of the human race, have memory lapses and simply forget to take their medication. Front line staff may end up helping them develop systems to remind them: pills of the day/week cases, beeping watches, etc.

There have been instances in which consumers have made decisions about medication that the people around them find disconcerting. Consumers may come to believe that increasing a medication will help them sleep better or lose weight. They may, after learning that their medicine doesn’t mix well with alcohol, stop taking it so they can have a few drinks. Front line staff help consumers work through these difficult periods in practical ways so they are as healthy as they can be.

It’s important to remember that the course of mental illness doesn’t follow a one way path. Many consumers experience both periods of good health and relapses in which they lose the ability to manage their illnesses effectively. This is troubling for the people who care about them and often dangerous for the consumers. In these situations, front line staff help consumers and families work through relapses, reduce their frequency and the severity of their impact and help prevent them whenever possible.

Schizophrenia

Note: The following content is based on the author’s experience and on material from AllPsych Online. This online information source is a valuable and easily affordable resource for supervisors in programs that serve people who have mental illness.

Schizophrenia is one of the most serious mental illnesses. There are a number of types of Schizophrenia but they share certain characteristics in common, despite the subtypes that differentiate one specific diagnosis from another.

Schizophrenia typically hits young adults, most in their twenties and older teens. Onset of symptoms can occur earlier although it is less common.
A key, definitional element of Schizophrenia is the consistent presence, over time, of delusions and psychosis, usually very extreme. Clinicians consider Schizophrenia to have what are called positive and negative symptoms. Positive symptoms are normal things done to extreme or excess, like thinking, but bizarre thinking or communicating, but doing so in an unusual, called disorganized, way. Bizarre behavior is also a positive symptom whether the behavior involves activity or the complete lack of activity.

The positive symptoms of Schizophrenia are divided into the psychotic or the disorganization categories. Delusions and hallucinations are examples of the psychotic category of positive symptoms. The loss of abilities, like the ability to speak with people, express emotions or behave normally are examples of the disorganization category.

Delusional thinking is part of Schizophrenia. Diagnosticians have to be careful to allow plenty of room for cultures and faiths that are important belief systems for many, but that include visions and similar events. Hallucinations, the most common of which is hearing voices, are also key to a diagnosis of Schizophrenia.

The hallucinations vary among different people who have Schizophrenia and hallucinations change over the course of the illness. Here also it’s important to remember the role of hallucinations in certain faiths and cultures.

If people really have Schizophrenic illness, their lives are changed by it in major ways. They lose different capacities to function: grooming, working, having relationships with people, etc. The problems must be severe and must last about six months, without successful treatment. When treatment works, the diagnosis is still likely to be Schizophrenia.

When Schizophrenia is called Paranoid Type, the main problems are delusions and frequent hallucinations, the Psychotic Category (described above). In this type of Schizophrenia, there are no positive symptoms in the Disorganization Category (also described above).

When Schizo-Disorganized Type is diagnosed, those Disorganization Category symptoms are present in how people show their emotions, act and behave. They behave, though; they are able to move, speak, etc. When Schizo-Catatonic Type is diagnosed, catatonic symptoms are present. They can include the inability to speak or move or the exact opposite – agitated and excited behavior that can be bizarre and inappropriate.

There are other types of Schizophrenia as well as specific terms used to describe how often symptoms occur, how long they last and how well or poorly people are able to return to their normal cognitive and intellectual functioning and behavior. That differentiation is best left to expert diagnosticians. The following two types are among the most common:
**Schizophreniform Disorder**

There are two main things that differentiate Schizophreniform Disorder from Schizophrenia. First, although it lasts longer than a month, it lasts less than six months. Second, the person’s ability to function, while impaired, is far less impaired than in Schizophrenia.

**Schizoaffective Disorder**

Schizoaffective Disorder has the same symptoms of Schizophrenia (delusions, hallucinations, etc.) but the symptoms for Major Depressive Disorder or a Manic Episode (see Bipolar Disorder) are also present.

**Bipolar Disorder**

Bipolar Disorder diagnoses are divided into different types which are differentiated by the frequency of episodes, whether they are mild or severe, and whether they are psychotic or not. It is a mood disorder that involves periods of manic activity that alternate with periods of depression. Manic activity includes excited, disorganized behavior and extreme emotions, including excessive or unreasonable enthusiasm. It can involve altered sleeping patterns with the individual staying up to all hours and starting projects that are unrealistic or extreme. A person in a manic episode may seem cheerful in a determined way and may speak more and/or more rapidly than usual. A manic state can trigger unreasonable spending and planning that is flawed, unsafe and out of the ordinary. A person in a manic state may seem creative and imaginative under very brief observation, but observation over time reveals that there is a real edge, a brittleness to what is actually observed and what the person has or has not actually achieved.

One thing that people find difficult to understand is how rewarding a manic state can be to the person who is in it. Most people who have observed it agree that it looks extremely uncomfortable and unpleasant. Still, after diagnosis is made and treatment is in place, people become manic again when they stop taking the medication prescribed to prevent mania and most do so because the illness pulls them towards the highly disordered and over active manic state. The manic periods invariably end in a state of major depression that seems the exact opposite of the level of activity it follows. This phase of the disorder is what usually brings the person who has it to the attention of medical personnel. By then, the extreme chattiness of the manic state has been replaced with the silence of depression. The person who has it is often not able to provide an accurate and complete report of recent, potentially relevant, behavioral indicators.

Many people believe that Bipolar Disorder is sometimes missed as the most appropriate diagnosis because people who have it typically do not seek medical care during their manic phases. Sometimes, Major Depressive Disorder is diagnosed because the

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diagnosing physician doesn’t have any information about the patient’s behavior prior to the onset of depression. This is less of an issue when family members and friends can report on the behavior of their loved one so the information central to diagnosis is correct and includes all salient factors.

Tourette’s Disorder

Tourette’s Disorder is characterized by the presence of tics, physical and vocal, that occur overtime. According to Drs. Frances, First and Pincus, a tic is a sudden, rapid, recurrent, non rhythmic, stereotyped motor movement or vocalization. According to Merriam-Webster, a tic is a habitual, spasmodic motion of particular muscles… twitching or a frequent, unconscious quirk of behavior or speech. What this all means is that people who have Tourette’s Disorder have movements like facial expressions, head bobbing or arm jerking that occur frequently and are out of what we define as under their control without treatment. They may also make unusual sounds, like barking, or say words they don’t intend to say. All of this happens either every day or nearly every day over the course of about a year.

A Tourette’s Disorder diagnosis is made when the above described events are severe enough to have a negative impact on the person who experiences them. Tics can be suppressed for awhile but eventually become irresistible. Motor tics can be simple, like blinking or shrugging or complex, like jumping. The same is true of verbal tics, which can be simple, like throat clearing or complex, like unintended obscene words used out of context. People who have Tourette’s Disorder often experience more tics when they are tired or stressed. Symptoms usually begin in childhood.

Encopresis

Encopresis is the diagnosis when the individual defecates in unusual places, including bed clothes, clothes and locations other than the bathroom. It is only diagnosed when the person is clearly old enough to be toilet trained, which varies when there is also a developmental disability. For some, encopresis is associated with a lack of control. For others it is at least in part intentional and may indicate the existence of other disorders.

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Enuresis

Enuresis is very like encopresis except the issue is urine rather than feces. The urination again occurs in places, like clothing and in bed. Care is also taken to ensure that the urinary incontinence is not the result of age or development.

Separation Anxiety Disorder

Separation anxiety occurs when a person, almost always a child, becomes unreasonably upset at the prospect of leaving a familiar environment and entering a new one. It occurs also when a child becomes upset leaving the company of a familiar person and sometimes, even when simply expecting to leave the person's company.

Children who have Separation Anxiety Disorder are worriers, often concerned that something terrible will happen to the people from whom they are separating. They may refuse to play in other people's homes and yards or go to daycare or to school. They are afraid of new people and new places without reason.

Sometimes children who experience Separation Anxiety Disorder have nightmares which can be persistent and really scary. The bad dreams focus on actual, anticipated and imagined separations and scary, new places. When the nightmares are severe, children resist going to bed. When they expect to enter new settings and/or leave the company of people with whom they are comfortable, some children report a whole host of symptoms like upset stomach, even vomiting. The function of these reported illnesses is to avoid the anticipated and dreaded separation.

Reactive Attachment Disorder

Reactive Attachment Disorder diagnosis is becoming much more common. It is a great concern for adoptive parents and permanency advocates. It is also a major challenge for public and private social service planning agencies that provide care and support to children who have been victims of abuse and neglect. Abuse and neglect of children is thought to trigger this disorder, often extreme and occurring early in childhood.

These children have very little ability to form relationships – attachments – to parenting figures in particular, but in other care giving relationships as well. They also form superficial relationships and sometimes imagine them to have substance when they don't. They may even make fantasy care figures of distant acquaintances who would be surprised at their role in the child's fantasy.

Children who have Reactive Attachment Disorder behave as though they have no concern at all for the feelings of parents who love them. This lack of concern sometimes extends to siblings and extended family members as well.
Anxiety Disorders

Panic Attacks & Agoraphobia
Anxiety is defined as “a painful or apprehensive uneasiness of mind usually over an impending or anticipated ill; a fearful concern; an abnormal and overwhelming sense of apprehension and fear often marked by physiological signs (sweating, tension and increased heart rate), by doubt concerning the reality and nature of the threat, and by self-doubt about one’s capacity to cope with it.”¹⁰ Most of us have felt it – at least the feeling, not the diagnosis. The rest of us will likely experience this often uncomfortable emotion that comes to all of us eventually.

To be familiar with what the specific anxiety disorders entail, there are two key features to understand. The first is panic attack.

Panic attacks are so acutely and immediately uncomfortable, many people who experience them think they are in the middle of a heart attack (like Jack Nicholson’s character in the film Something’s Gotta Give¹¹). They involve a racing heartbeat, sudden sweats, shakiness, a pounding sensation in the head and temples, chest pains, nausea, sudden diarrhea, dizziness and a few other horrible feelings.

These symptoms come on quickly and are often the most intense at the beginning of an attack, which is usually over in an hour or two.

The second important thing to understand about Anxiety Disorders is agoraphobia, which is fear of a set of elements in environments or more generally, fear of all or most environments. People who have agoraphobia can be afraid to leave their homes or remain in them alone. They may feel extremely anxious about being in crowds or feeling exposed to or out-of-control of the environment.

For some people, agoraphobia is less serious, but still limiting. They may, for example, be able to go to specific places or venture out with certain people. Some victims are afraid of only certain things, like planes or elevators. Their activities may be limited by the inability to drive through a tunnel or over a bridge.

Like everything else in mental health, panic attacks and agoraphobia occur across a continuum of reactions ranging from mild to severe. There are well documented incidents in which people are unable to leave their homes, sometimes for years at a time. There are also people who literally dread flying on planes but still drag themselves on board and sit through a flight, unbelievably tense the entire time. Their hearts pound in their chests and they sweat and shake the whole time.

These two terms and categories of symptoms – panic attacks and agoraphobia – unfortunately join together for some people. Once a person has had a panic attack in

¹¹ Something’s Gotta Give, Film, dir. Nancy Meyers, 2003 (128 mins.).
public, on a plane or wherever, that person may easily slip into agoraphobia in the future, especially in the setting and settings that are similar to those in which the panic attack happened. Similarly, if a person has agoraphobia, a panic attack may occur when the individual thinks about being in a feared environment, approaches it or actually enters it.

**Phobias**
Phobia means fear and phobias, in mental health diagnosis, means fear of certain things, places or situations. Popular movies have focused on phobias like the extreme fear of spiders. In the real world, Social Phobia and School Phobia are of more direct relevance.

In both of these diagnoses, children (in the case of School Phobia) and adults who have them become intensely fearful of going to certain places and being around other people. Their fear can be measured by how hard they try to avoid the settings and the people who trigger it. This is what makes these reactions disorders: they limit what people can easily achieve and deny those who have them normal, productive lives without treatment.

**Generalized Anxiety Disorder**
Generalized Anxiety Disorder has been a controversial diagnosis for a number of years. Diagnosticians have called it too general and too difficult to differentiate it from other, better defined diagnoses. Still, it’s important to acknowledge that some people have anxiety to a degree that it interferes with their day to day lives, sometimes in serious ways.

The symptoms are similar in nature to some of those described for panic attacks and agoraphobia disorder, but are far less serious. As far as thought processes go, people who have anxiety worry a lot and seem nervous. Their minds wander and they have trouble focusing on things that are not central to whatever they are worrying about. There can be physical symptoms, like insomnia or an upset stomach, but they are not as paralyzing as those of panic attacks and agoraphobia disorder.

Since everybody worries, the diagnosis of Generalized Anxiety Disorder is made only when the worries persist over several months and the affected person can not control or stop the symptomatic reactions.

**Other Anxiety Disorders**
There are a number of more specific diagnoses clinicians use to describe anxious behavior. For purposes of people who work directly with children and adults who experience anxiety, it’s sufficient to understand the terms and symptoms described here so they can report accurately to mental health professionals. Front line staff often are uniquely qualified to share their observations which can be crucial to diagnosing specific Anxiety Disorders.
Obsessive Compulsive Disorder

Obsessive Compulsive Disorder is considered an anxiety disorder because anxiety is what triggers compulsive behavior. In Obsessive Compulsive Disorder, the compulsive behavior functions as a way to calm the person down when anxiety hits.

According to the DSM IV, obsessions are persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. Compulsions are repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., counting, repeating words silently, etc.) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation.12

Many people have seen popular examples of Obsessive Compulsive Disorder: As Good As It Gets13 and Matchstick Men14 in film or MONK15 on television. Part of these depictions are accurate: hand washing, rituals with locks, an inability to be unclean and other eccentric reactions can occur in Obsessive Compulsive Disorder.

Obsessive Compulsive Disorder in the real world means that people must deal with extreme anxious reactions and all the discomfort they bring. They use rituals and repeated behaviors that make them feel better even though they don’t make sense to others. People who have Obsessive Compulsive Disorder don’t really feel they have a choice, just extremely distressed emotional states that they can not deal with effectively in normal, typical ways. The “tools” they use to deal with their obsessions instead – their compulsions – can be detrimental. They can be time consuming and socially inappropriate. When these circumstances and symptoms come into play, Obsessive Compulsive Disorder is a logical diagnosis.

Posttraumatic Stress Disorder

Stress is another condition of life that ultimately applies to all of us, so diagnosis of Posttraumatic Stress Disorder is made very carefully. It is also made in the context of a clinical definition, not a common usage definition of the word “stress.”

We hear people refer to others who thrive on stress. We hear people say they’re going to take a “mental health day” off from work because of stress, even that people have “stress attacks.” For clinical purposes, stress is defined as exposure to death, extreme danger, serious injury and other serious, life altering events. It’s not a day-to-day type of stress to which the disorder refers. The first diagnoses of this sort were of soldiers in

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13 As Good As It Gets, Film, dir. James L. Brooks, 1997 (139 mins.).
14 Matchstick Men, Film, dir. Ridley Scott, 2003 (116 mins.).
15 MONK, Television Series, Universal Studios, 2002-present.
times of war, using terms like “battle fatigue.” Now, most Posttraumatic Stress Disorder diagnoses refer to adults and children who have been in similarly serious circumstances: beaten, starved, burned, abused, abandoned, etc. With a world at war, soldiers of all sorts will likely still be diagnosed with Posttraumatic Stress Disorder. They are exposed to real horror and that changes things for people.

People who have Posttraumatic Stress Disorder are touchy and sometimes sleep deprived. Their exposure to the events described above has left them terrified and hopeless. Not only that, they re-live what happened in lots of different ways, like nightmares and awful memories that pop up almost randomly. They may feel like they are reliving what happened to them when certain triggers occur, even minor things like driving by a certain place, hearing a particular sound or smelling certain odors. Like the other disorders described here, Posttraumatic Stress Disorder diagnosis is made when the symptoms interfere with a person’s life in serious and damaging ways. This includes avoiding situations in which a person is likely to expose himself/herself to potential triggers.

For diagnosis to be made, the person usually has the problem for more than a month, persistently. It is not made when a person has a diagnosis of any of the other Anxiety Disorders.

**Borderline Personality Disorder**

Borderline Personality Disorder is considered (as the words state), one of the sets of thoughts, actions and beliefs classified as personality disorders.

This doesn’t mean that people diagnosed with Borderline Personality Disorder are disagreeable or have bad personalities. It means instead that their personalities don’t work in the sense of getting them what they want and where they want to be.

People who are diagnosed with any one of the personality disorders behave considerably and consistently out of sync with what is considered acceptable in their communities and cultures. Their relationships fail, even blow up sometimes. They have a hard time with self control and their thoughts and feelings don’t conform to what’s expected from them.

As with other disorders, these symptoms must persist consistently over time and must cause distress and failure in the day-to-day lives of the people who experience them to be considered the basis of a diagnosis.

Borderline Personality Disorder can be a difficult diagnosis to make and understand. Many people have chaotic relationships with the people around them. We all run “warm” or “cool” towards the people in our lives. In Borderline Personality Disorder, people have extreme chaos in all or most of their relationships. They aren’t warm or cool, they are molten hot or frozen solid, often changing from one extreme to the other very quickly.
People who have this diagnosis will show behavioral extremes, unrealistic judgment or no apparent judgment at all. They may attempt suicide or cut themselves.

People who are diagnosed with Borderline Personality Disorder are sometimes not easy to be around. They may seem to deliberately set off unnecessary conflicts. They are often moody in ways that don’t seem to fit their actual circumstances and their moods can be extreme. Moods can also shift very rapidly without readily apparent triggers.

If this sounds like any of your relatives, friends and acquaintances, you will realize how difficult this diagnosis is to make. Borderline Personality Disorder is a question of degree: utter chaos, not confusion; exploding relationships, not problematic ones; wild, swinging moods, not a little moody sometimes; huge money mistakes, not a little overdrawn. All of these must also exist over time, consistently, for a Borderline Personality Disorder to be diagnosed.

**Attention Deficit/Hyperactivity Disorder (AD/HD)**

Despite the frequency with which we hear it, ADHD has been a controversial diagnosis for many years. The main issues are:
- What level of inattention makes it a disorder instead of the normal distractibility many children experience?
- What level of fidgeting makes it a disorder instead of normal child behavior?
- If the level is too low, children who don’t have the disorder will be wrongly diagnosed and given unnecessary treatment
- If it’s too high, children who need treatment won’t get it and they are at risk for falling behind academically, socially and otherwise

Some children with an ADHD diagnosis lean more towards inattentive; others lean more towards being overly active and impulsive. Some children experience both. Adults can also have ADHD. Their condition must have been present since childhood, diagnosed or not. Like children, adults can also lean more towards inattentiveness or overly active or both.

The “leaning” (described above) may change as children grow up. Children who have had difficulty remaining still may have less problems in that aspect of ADHD as they become teenagers and adults.

ADHD is much more common in boys than girls(4:1), leading some to wonder if there is a bias in the diagnostic process. The children who have difficulty with inattention only are much less likely to be diagnosed with ADHD than children who have trouble with hyperactivity and impulsivity.
ADHD: The Symptoms

Inattention:
Inattention is the tendency to have a difficult time remembering things, paying attention or following through on lengthy tasks or tasks that require concentration. Inattentive children may make careless mistakes or lose things. They may be able to do the first few things that they are instructed to do but not the last things. They may also be easily distracted by other children, sounds or other elements in their environments that most children are able to ignore. Inattentive children may avoid tasks that require concentration, like homework. They may also have difficulty finishing things.

Hyperactivity/Impulsiveness:
Hyperactivity is the tendency to have trouble sitting and/or standing quietly, and instead, moving excessively. Children who are hyperactive fidget and squirm, tap on things and move their feet for no apparent purpose. They have a difficult time remaining still enough to get things done. They are restless and impatient to move when they are required to sit quietly. Hyperactive children tend to talk a lot and interrupt others. They are impulsive and sometimes cannot relax even when they engage in activities they enjoy.

Adults can also be and feel “hyper” (i.e. overly active). When they are, the most important, serious conditions to look into (rule out, in medical terms) are bipolar disorder and any of the psychotic/ delusional disorders. If specific diagnostic criteria for these are not evident, the individual is likely to be experiencing hyperactivity related to ADHD.

Sometimes children and adults who have ADHD will seem noncompliant and oppositional. The likeliest reason for this is the impact of the disorder on attention, task completion and impulse control rather than an additional disorder.

Conduct Disorder

Like ADHD, conduct disorder is a controversial diagnosis. Some people consider it a mental disorder while others see the behavior that leads to the diagnosis as immoral, self centered and sometimes, illegal. The current definition of conduct disorder includes those behaviors and others and many young people, especially boys, are so diagnosed. Other people see it as failed parenting or an unwillingness in young people to take responsibility for what they do.

Young people diagnosed with conduct disorder behave aggressively against people and animals consistently and over time. They are often described as bullies and have strong tendencies toward cruelty, sexual aggression, property destruction and fire setting. Less aggressive, but still relevant problem behaviors include frequent running away, stealing, lying and consistently breaking major rules.

Conduct disorder is described as mild, moderate or severe. The degree of severity is primarily a function of two factors: how many conduct problems are observed and how
much harm they do to others. Conduct disorder is also defined by the individual's age at onset. Childhood onset, which is generally more severe and more predictive of adult difficulties, involves clear symptoms identified prior to age 10. Adolescent onset is considered the appropriate diagnosis after age 10, when there has been no evidence of symptomatic behavior up until that point.

A factor that should be considered in diagnosing conduct disorder, especially among adolescents, is drug use. If the only time the young person exhibits the problem behaviors is when he/she is using drugs, addiction may be the real problem. When addiction is successfully addressed, the problem behaviors will likely fade and even ultimately disappear.

Oppositional Defiant Disorder

It's possible that oppositional defiant disorder is simply a less serious version of conduct disorder, or one that is diagnosed early. Many of the misbehaviors are similar: defiant, angry, argumentative, blaming and so on. Other relevant, symptomatic behavior is less aggressive but still annoying to others including tendencies to be overly sensitive ("touchy") to slights from others, focused on revenge and spiteful.

For an oppositional defiant disorder diagnosis to be made, the problematic behavior has to be frequent and last over six months. There also has to be evidence of serious dysfunction like failure in school or in significant relationships. Sometimes oppositional defiant disorder is diagnosed instead of conduct disorder when the symptoms are present but not sufficient for that diagnosis. Since the behaviors associated with oppositional defiant disorder lead to lots of family problems and arguments between parents and children, the more general diagnostic labels used to describe relationship problems are also possible diagnoses.

Learning Disorders

Learning disorders in children may be subject specific – reading, math, written expression – or not subject specific. The subject specific disorders include lots of different problems in each subject. When children have a Reading Disorder (the most common) they may read slowly or not at all, may not be able to read certain words correctly, may have a hard time understanding the meaning of what is read, or a combination of all or any of the three. A Mathematics Disorder might involve calculations that are incorrect, signals and signs that are not understood and/or numbers that are not copied accurately. If Written Expression is the issue, the diagnosed child may be unable to write a sentence or a paragraph, conform to rules of grammar and/or use punctuation correctly.

The three subject-specific Learning Disorders co-occur in many children and the diagnostic process – testing – is similar. The main things to remember are simple:
- The child is significantly behind grade level despite having been present for instruction.
- The child does not have a developmental disorder that alone causes the delay (mental retardation).
- The child is determined, by testing, to be of average or higher intellectual ability.

Children who are considered developmentally disordered are diagnosed with a Learning Disorder only when they are behind grade level to a degree that cannot be solely explained by their preexisting developmental disorder.

Since Learning Disorders (and Intelligence Quotients) are determined by specific testing, the factors that impact test results are all relevant considerations in diagnosis. These factors include differences in culture and language and other potential explanations for an achievement delay not related to intellectual ability (like ADHD, Conduct Disorder, etc.)

**Major Depressive Disorder**

Major Depression is a mood disorder. It is diagnosed when a person (child or adult) has one bout of depression (Single Episode) or two or more separate bouts that occur after two months in a row when there have been no episodes (Recurrent).

Symptoms of Major Depressive Disorder include lack of motivation, persistent feelings of hopelessness, changes in eating and sleeping habits and pervasive, unmanageable sadness. Like the other diagnoses explained in this document, the degree of the symptoms is an important consideration since everybody gets sad and sometimes people have a hard time getting up and facing the day they're supposed to face. For Major Depressive Disorder to be diagnosed, the feelings and reactions have to exist over enough time and with sufficient depth to cause dysfunction in the individual's life: work, school, relationships, grooming, general health and welfare, etc.

When an individual exhibits only depressed behavior, Major Depressive Disorder is a likely diagnosis. When the person's periods of depression are punctuated by episodes of frenzied and disorganized behavior (manic) or when an individual is clearly responding to elements not within the environment (psychotic, delusional), other diagnoses apply instead. Women are significantly more likely to be diagnosed with Major Depressive Disorder than men.

Major Depressive Disorder can be an event in the life of a person that occurs once and never happens again. It can also be recurrent, i.e., return at intervals throughout the person's life. Sometimes Major Depressive Disorder occurs in women after childbirth (Post Partum Onset). Sometimes, individuals who have depression are unable to move, even speak (Catatonic Features) although this is not typical or necessary for a Major Depressive Disorder diagnosis.
The severity or an episode of Major Depressive Disorder is indicated by a number attached to the diagnosis: 1=mild, 2=moderate, 3=severe but not delusional or psychotic, 4=severe, with psychosis and delusions.

Whether or not a diagnosis of Major Depressive Disorder is made, it’s important to note that for many of the situations life brings to both adults and children, depressed feelings are a logical, fitting response. People experience tragedy and sadness, we lose important relationships and much needed jobs. We face disability in ourselves and those we love and the fact that some dreams simply don’t – and won’t ever – come true. Events that are very much out of an individual's control can trigger depressed feelings: war, terrorism, crime, poverty, etc. Even nature plays a role in depression sometimes: tsunamis, hurricanes and similar events depress many people. An individual may still be diagnosed with Major Depressive Disorder who is responding to issues like these, which doesn’t necessarily make a big difference in the diagnostic process. Despite that, when depression is clearly a function of what happens to a person, it feels a little different to the people around it. It can and may be treated like other episodes of depression. It’s recurrence may be different from that which occurs to people who have an episode/episodes that have no obvious trigger or precursor.

Dysthymic Disorder

When the symptoms of depression are less severe but still significant and have been present for at least two years (at least one year for children), Dysthymic Disorder is diagnosed. The main difference between the two disorders is that people who have Dysthymic Disorder may still have good days from time to time, even in the presence of significant depressed moods. In Major Depressive Disorder, there is little to no relief from symptoms during an episode.

Developmental Disability\(^\text{16}\)

A Developmental Disability is diagnosed when the individual has significantly below average functioning, typically measured by IQ testing and resulting in a score of approximately 70 or below. Even though IQ testing is used to make the diagnosis, serious impairments in the individual’s ability to function are usually the presenting symptoms. In this diagnosis, adaptive functioning is affected which means that people have a hard time coping with day-to-day living and often are not able to meet the standards of personal independence they would otherwise be likely to achieve.

For a diagnosis of developmental disability to be made, there must be concurrent problems in two or more of these areas:

- Communication

\(^\text{16}\) In the DSM-IV-R provided by the American Psychiatric Association and accessed as previously mentioned on their website [www.psychiatryonline.com](http://www.psychiatryonline.com), the term Mental Retardation is used.
• Home living
• Social and interpersonal skills
• Use of community resources
• Safety
• Self direction
• Functional academic skills
• Work
• Leisure
• Health

Scores on IQ tests are typically used to determine the degree of an individual’s disability. It’s important to remember, as the accuracy and utility of IQ scores are considered, that socioeconomic background, native language and communication and motor and sensory handicaps must be taken into account so the score can be understood in a meaningful way. There is also usually a measurement error (this is normal for most types of testing) that means an individual’s score may be around five points higher or five points lower than the actual score.

Most testers classify the levels developmental disabilities as follows:

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<tr>
<th>IQ Range</th>
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<tbody>
<tr>
<td>Mild 50-55 → 70</td>
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<tr>
<td>Moderate 35-40 → 50-55</td>
</tr>
<tr>
<td>Severe 20-25 → 35-40</td>
</tr>
<tr>
<td>Profound below 20-25</td>
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</table>

Severity Unspecified: There is presumption of developmental disability but the individual can’t be tested. i.e., too impaired, uncooperative, too young (babies)

Overall, it is estimated (imperfectly) that about 1% of the total population has a developmental disability or thereabouts, depending on how it is measured.

**Mild Developmental Disability**
About 85% of people diagnosed with Developmental Disability are considered mildly impaired. Most of them develop social and communication skills in preschool years. With the right kind of help, these individuals can achieve up to a sixth grade levels of academic skills, some higher and others lower. They can usually hold jobs but the jobs they normally get provide very limited income. People with mild developmental disability can be independent in many ways but some will need guidance and help part of the time and a network on which they can rely.

**Moderate Developmental Disability**
About 10% of people diagnosed with Developmental Disability are considered moderately impaired. They usually acquire communication skills in early childhood and many learn academic skills typical of the early years of elementary school. Some of these individuals will have difficulty with social relationships and friendships because they haven’t mastered the behavioral rules that relate to initiating and maintaining them.
People with moderate developmental disability adapt well to supervised community living and work settings in which they get the support they need to learn and maintain the needed skill levels.

**Severe Developmental Disability**
About 3-4% of people diagnosed with Developmental Disability are considered severely impaired. This indicates that they don't learn to communicate with others in early childhood, although they may make progress on this skill later on. These individuals are able to learn basic self care skills and perform them with close supervision. They also adapt well to community living settings that provide this degree of constant support and supervision.

**Profound Developmental Disability**
About 1-2% of people diagnosed with Developmental Disability are considered profoundly impaired. Most of them have an identified neurological condition that caused their disability. In addition to the broad range of difficulties these individuals have, they experience considerable impairment in sensory motor functioning which means they have trouble processing information and controlling and integrating their movements within their environments. People with profound developmental disability usually need to reside in highly structured, consistent and predictable settings in which they are able to establish and maintain securely attached relationships with their caregivers.

**Pervasive Developmental Disabilities**

For the diagnosis of one of the pervasive developmental disabilities to be made, there must be severe and pervasive (extensive and serious) impairment in several areas:

- Reciprocal social interaction skills, i.e., give and take with other people
- Communication skills
- Presence of stereotyped behavior, interests and activities: rituals and rules, obsessions with certain activities or things, repetitive behaviors and more

These disorders are sometimes seen with other medical conditions like chromosomal abnormalities, congenital infections or central nervous system problems.

Pervasive Developmental Disabilities include the following:

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disability, not otherwise specified

**Autistic Disorder**
Autism creates problems, described as “considerable and characteristic impairments” that range from mild to serious in three main areas:

- Social interaction
• Communication, both verbal and nonverbal
• Repetitive actions and obsessive interests, often very narrow in range and specific

These problems usually begin before a child turns three, often well before. Autistic Disorder was once thought to be rare (five children affected out of 10,000) but now it is believed to affect one in 150 children according to the Centers for Disease Control. Other studies indicate that the prevalence of Autistic Disorder is anywhere from 2-20 children affected per 10,000. Experts don’t know if these numbers are caused by an increase in the frequency of the disorder or by differences in the methods used to diagnose it. The diagnostic criteria for Autistic Disorder have expanded but it is commonly thought to be unlikely that this alone accounts for the increase in incidence. Some believe that the explanation for this increase in Autistic Disorder is environmental, while others think it could be caused by autoimmune, maternal and obstetric factors that may trigger an innate tendency or genetic flaw that produces the disorder.

A 2006 study, however, in the journal Pediatrics found… that the national increase in identified autism cases, sometimes called Autism Spectrum Disorders these days, in elementary school children between 1984 and 2003 had been paralleled by a similar decrease in the number of children labeled as retarded (sic) or learning disabled. Paul Shattuck of Washington University in St. Louis, the lead author of the study, wrote last year that “in 44 of 50 states, the increase in autism was completely offset by a decrease in the prevalence of children considered ‘cognitively disabled’ or ‘learning disabled’.” In a 2004 study, Lisa Crown of the Kaiser Foundation Research Institute and her team found that the increase in children diagnosed with autism in California between 1987 and 1994 was almost exactly paralleled by a decrease in those diagnosed with retardation (sic). 17

Over the last ten years, there has been a great deal of controversy about what causes or triggers Autism. There are both professionals and parents who support each of the different points of view but overall, parents worry that autism is caused by vaccinations or by what’s in them and professionals worry that concerned parents will refuse to vaccinate their children, resulting in serious illness in those kids. This controversy is unresolved and is likely to remain so until clear and responsible research provides the information needed to address this stalemate.

Early signs of developing Autistic Disorder include:
• No babbling by age one
• No speech by 15 months of age
• No smiling or eye contact
• Lack of ability to play with toys
• The appearance (not the actual presence) of a hearing impairment
• The abrupt loss of language and social skills that were developing normally prior to the loss

17 Mark Roth, Pittsburgh Post-Gazette, 2/6/2008
• Failure to cuddle with caregivers
• Aversion to physical contact with caregivers

Overall, parents and caregivers note markedly, abnormal or impaired development in relationships and social interaction, language and communication as well as a markedly restricted repertoire (or set) of activities and interests.

In terms of relationships and social interactions, the deficits are often called “gross and sustained” which means serious and ongoing. These children often lack facial expressions and as previously mentioned, fail to make and sustain eye contact. Their awareness of other people, including the needs or the distress other people experience is impaired, sometimes to the point that these children seem oblivious to the people around them, including family members. Younger children with Autistic Disorder show little to no interest in friendships with other kids. Older children are sometimes more interested in these relationships, but their peer relationships may fail because they don’t understand how to be or have a friend.

In Autistic Disorder, communication impairments are called “marked and sustained”: and they affect all forms of communication. Some children lack the ability to speak or develop it late. Others engage in speech that is impaired or unusual in pitch, tone, speed or other aspects. For the children who are able to speak, they may have difficulty initiating or sustaining conversation with others or may use immature grammatical structures and repeat words or sounds. They may also be unable to understand and respond to simple questions, humor and symbolism.

The repetitive behaviors seen in Autistic Disorder include preoccupation with one or more patterns of interaction that are abnormal in intensity or purpose. These children may repeat a behavior over and over, line up play things the exact same way or imitate others, even TV actors. They may clap, flick their fingers, rock, dip, hop or sway. They may also become obsessed with a particular interest like baseball statistics or math problems or become uncommonly attached to inanimate objects or parts of objects like door knobs, puzzles or kitchen tools. These kids often find even small changes in routine disruptive, sometimes catastrophically so and many appear to function within a narrow range of internalized “rules” with which no one else if familiar. These rules and routines get comfortable and become so soothing that children who have the disorder require their faithful repetition.

Autistic Disorder is often associated with mild to serious levels of Developmental Disability, referred to as Mental Retardation in some of the source materials used to research this document.

**Rett’s Disorder**
In Rett’s Disorder, affected children are born and develop normally until their head growth slows down between the ages of 5-48 months. These children also lose purposeful (deliberate) hand movements, which are replaced by stereotyped hand...
movements (like finger flicking). Social interaction skills can also be impaired although this impairment is sometimes temporary.

Rett’s Disorder is typically associated with severe or profound Developmental Disability and has only been identified in girls.

**Childhood Disintegrative Disorder**
Children who have Childhood Disintegrative Disorder develop normally for the first two years of life and then experience regression in multiple areas before the age of ten. These areas include language (both spoken and understood), social skills and adaptive behavior, bowel and bladder control, play and motor skills. They also exhibit abnormal functioning in peer relationships, play, interests and activities.

Childhood Disintegrative Disorder is usually associated with severe Developmental Disability. It appears to be rare but is thought to be under diagnosed.

**Asperger’s Disorder**
Asperger’s Disorder looks like Autistic Disorder with a few significant exceptions:
- Language development is not delayed
- Cognitive development is not typically impaired and Developmental Disability is not typically present
- Children develop age appropriate self help skills, adaptive behavior and curiosity about the environment but they experience the characteristic impairment in social interactions.

As with Autistic Disorder, these children exhibit a lack of social and emotional reciprocity. In Asperger’s Disorder, this difficulty with “give and take” in interaction is manifested by eccentric and one-sided social approaches to others and sometimes by social and emotional indifference. In terms of communication, the problems these children experience result from inadequate social skill development and failure to understand and act on social customs around conversation and interaction.

**Pervasive Developmental Disability, Not Otherwise Specified**
This disorder, while similar to the others described here, doesn’t meet the diagnostic threshold (or minimum) for a diagnosis of Autistic Disorder because the child is older when the symptoms develop, the symptoms are not typical and the symptoms are less serious than required for a diagnosis of autism, or all three.
Supervision and Clinical Analysis

Clinical analysis is an important tool for Family and Person Centered Practice. That makes it a priority for supervision.

Supervisors have to assess the level of analytic skill each employee has achieved. They must work with each employee to make sure that their assessments and analyses of situations are accurate and then set clear, specific (hopefully, consensual) goals for growth with each supervisee.

Each growth goal, and we can all grow, must be supported by training, mentoring, observing and modeling. Access to experts, conferences, online resources and literature are also helpful and provide a variety of learning opportunities.

The following analytic format and example may be useful to supervisors, or more likely, the beginning of the development of their own tailored analytic tool that is more specific and therefore more useful. First, key questions are presented with rationales for the inclusion and relevance of each question. A complicated family scenario follows, with a set of possible ideas and considerations. The same format, utilizing the same scenario and analytic questions is presented blank so that it may be used in staff training and discussion.

This analysis is incomplete partly because it is a written scenario and not a real family. It will require the above mentioned tailoring, new questions and more insightful answers that apply to people your employees actually know. Supervisors should adjust the analysis as indicated to reflect the needs of the people their employees serve and the specific missions of their organizations.

A Format for Clinical Analysis

**What is everybody actually doing?**

This may seem like an inappropriately simple question to include in a clinical analysis but it often speaks to the heart of the situation under analysis. People are full of explanations for what they do: true or false, clever or silly. Still, the key to an accurate analysis of even complicated situations is at least partly contained in action, not conversation.

Absent psychotic, delusional states, when it comes to people, there is method to our madness. We do what works, even if the hows and whys seem illogical, even bizarre to others. Often, the clearest path to clinical insight is simply watching what people do and starting the analysis from there.
**What is each person getting out of what he/she is doing?**
What people do – how they behave – is clearly related to what their behavior gets them: attention, the positive regard of others, money, fame, privileges, etc. When we observe behavior, we focus on how exactly it pays off for the person or people at the center of the analysis.

For many, it can be difficult to see what people get with their behavior when what they get is unpleasant or even pretty bad. It defies what most of us think of as conventional logic: why would people act in ways that trigger others to respond to them negatively, even punitively? Decades of research confirm that people are sometimes motivated by the attention paid to them, whether it is negative or positive. Observers must keep this in mind or they risk missing information altogether or interpreting it inaccurately.

**What is each person avoiding by what they’re doing?**
This question, similar to the previous one, helps clinicians see how behavior functions as a way to avoid things rather than get them.

People avoid things. We avoid doing our chores, cleaning up our errors and confronting what needs to be confronted. Consider a child who is required to do homework after school. That child may engage a parent in conversation or even start a conflict to delay or completely avoid the homework. Consider the adult who, having been asked to pick up something at the grocery store, comes back with the wrong thing. Think about the person who is supposed to dry the dishes and breaks one or even a couple of them every time. These behaviors, especially if they are repeated over time, may stop people from requiring the homework or requesting the grocery run or requesting help with the dishes. We therefore say that the behaviors creating a distraction, buying the wrong thing and breaking the dishes are functioning as a way for people to avoid what they are supposed to do.

**Whose actions are risky and how risky are they?**
Safety is always the top priority for consumers, family members and workers. Clinical analysis is an important tool for reducing risk.

The level of risk, usually tied to numbers that indicate the severity or intensity of the risk, is often different for people even when they are in the same situation. These differences can be subtle and easy to miss. Often, people who are acting out are considered to be at high levels of risk but people who are acting in may be even more at risk, for example, as they quietly plan to kill themselves. Safety plans have to be tied to specific levels of risk as measured responses that address what’s actually going on for each of the people at the center of the situation.

An important byproduct of this part of clinical analysis is this differentiation of levels of risk. For clinicians, it allows them to plan individualized responses that accurately reflect the risk. For consumers and families, it can help them see that not all risks are
severe; some are moderate and others are mild. This ranking of situations addresses the very human tendency to see every risk as severe when the situation may not warrant it.

**What do you think this family or this consumer should do next?**
This question reminds clinicians to be practical and address short term issues as quickly as possible. Remembering, however, that people have the right to decide what they should do next, clinicians should answer these questions mentally. It prompts them to think about what supports, resources and possible next steps are available to the people involved so they are at least beginning to consider what they might be able to offer in case the family or consumer asks them.

**Who is angry at whom?**
Many complex situations requiring clinical analysis involve anger. Even when other emotions are involved, anger often plays a key role. It’s sometimes a quiet feeling that is expressed in passive ways rather than the louder way people expect but it’s still anger.

When clinicians are able to answer the question above, their ability to comprehend a situation advances. When the anger is discussed – as calmly as possible – it is more likely to be resolved in a positive way. If it isn’t, it can resurface and angry behavior can recur any time a word or event triggers it.

**What are the alliances?**
Discerning who is allied with whom allows clinicians to both understand and respond to situations. In some situations, the alliances are positive. They are characterized by mutual insight and support. Positive alliances are useful in crisis and intervention planning and conflict resolution.

It’s equally important to observe and understand negative alliances. They can drag people into unnecessary conflicts and unsafe activities. Even at a milder level, people involved in negative alliances bring out the worst in each other. These alliances should be balanced with the development of relationships that support safety, happiness and positive connections. They should also be taken into account in a clinical analysis because they are an influential force in what people do.

**Who is isolated?**
Isolation, the opposite of the alliances described above is also an important factor in understanding situations. People isolate themselves from both individuals and groups and they do it for a wide variety of specific reasons. What the reasons have in common is that these people choose solitude over company. They may want to avoid what
people are likely to say to them or even how people look at them. They might be too embarrassed about their situation to connect with others.

In more extreme situations, isolation can be a sign of depression. It is sometimes an indicator of suicidal ideation that may be moving towards a suicide attempt. Isolation may also be part of Obsessive Compulsive Disorder or the mental disorders that cause psychotic and delusional behavior.

Sometimes, social isolation causes people to develop dependent relationships with service providers. Conversely, isolated people may refuse to interact with service providers even when their needs are desperate. Privacy is important to most people. Isolation can be devastating.

**Are there issues with how each person perceives the events being analyzed?**

Perception is one of the most powerful factors in how people understand the things that happen to them. Even when people have been in the exact same situation together, they may have profoundly different views on what happened, what caused it and what it meant.

In clinical analysis, clinicians can assume nothing. They will have the information they’ve gathered by listening and talking to people and observing their behavior. In some instances, they may have additional information detailing history, diagnoses and specific descriptions of likely current issues.

Still, it’s not just possible but likely, that consumers and family members will have their own “take” on what’s going on. Each person involved may see the situation in ways the others don’t. In family situations or others that involve more than one person, alliances may form around shared perceptions. Perceptual battle is typically not as useful as reconciling relationships and agreeing that it’s normal for people to see things differently even if they love each other. It’s equally useless for clinicians to decide that their perceptions are the most accurate and work to persuade everyone that their point of view is the only true perception. Helping people agree to disagree works better in most situations.

**Are there issues related to developmental factors?**

Developmental factors are as key to clinical analysis as are perceptions. They also trigger multiple ways to view situations that can produce misunderstandings and conflict.

Consider the first time parent trying to deal with a child who is having a tantrum. Depending on the age of the child, the culture of the family or the community and numerous other factors, it may be developmentally normal. On the other hand, it may not.
It’s important to remember, as with perception, that numerous factors influence development. These factors may be physical, intellectual, related to disability or influenced by poverty. They may equally be expressions of a family’s or an individual’s faith, language, values, sense of self and the influences present or absent in the life of an individual or family.

For these reasons, clinicians learn and observe as much as possible about each person’s development. They must notice what information people do or do not process, how they best process it, how they evaluate it, interpret it and store it (or not store it) in memory. This requires in-person discussion and observation and if a family or more than one person is involved, the analysis is most likely to be useful when it includes everybody.

**What are the family systems issues, if any?**

Whenever more than one person is involved in a situation, there are relationships; the more people, the more relationships. Not only are all the relationships different, they change frequently, sometimes day to day, even moment to moment.

Everybody who has ever used a computer knows that systems work better sometimes than they do other times. They can bring salvation or disaster; they may act as predicted or do something completely unanticipated.

Everybody who has both a telephone and a question is also familiar with systems. We press 2 and the pound sign, switch languages and listen to lengthy menus that don’t seem to apply to our particular inquiry. The systems are designed to fit everybody but instead, they don’t fit anybody.

Relationships are systems in and of themselves. In families and groups, multiple relationships, i.e. systems, interact with each other over time, across settings and over an enormous variety of content and situations. There are tests, assessments or snapshot evaluations that can detail how these systems interact and what they produce. Once again, direct interaction and obseravation are a clinician’s most important tools, especially when other useful information is available, like that detailed above.

It’s also helpful to learn both in depth and in advance, about family system theories. That’s typically part of a clinical education. Field placements and other student experiences are also useful, especially when mentor relationships are in place. Supervision, in both field and educational settings, is often key to an emerging clinician’s ability to understand and respond appropriately to family systems and relationship issues.

There are numerous other sources of information about family systems. Most clinicians continue their educations in this area throughout their professional careers. Many also learn from personal experiences and from their own families and other relationships. It’s an extremely complex topic so it warrants ongoing education and insight.
How will this family interact with the community? With local systems of care? How well will their needs match what is available?

Each person, each situation and each family is unique. That’s one of the definitional aspects of Family and Person Centered Practice. Still, many people find themselves in situations that happen to others as well. Common themes include disability, loss, unemployment or insufficient employment. People face death, homelessness and hopelessness. This is the human condition. Each individual and each family faces crisis and challenges eventually.

Systems of care work best when the local systems that are in place match local needs. This applies, among other things, to the types of services available, how access to them is achieved, the capacity available and funding priorities and practices.

When individuals or families have difficulties that are anticipated by their communities to the degree to which they actually occur, services that fit their circumstances, at least to a degree, are more likely to be available. This often makes a good match between needs and strategies more likely and easier to achieve.

When the challenges people face are not local priorities for remediation and intervention, a similar match can be very difficult to achieve. This occurs most frequently when the difficulties experienced by local people are rare, new or otherwise unanticipated. Denial is another factor in this part of the analysis; not personal, but social denial. This is the tendency for citizens to believe things like, “Nobody around here is that needy and desperate” or “They brought it on themselves through personal failure or irresponsibility” or “Those mentally ill people need to get a hold of themselves” or “They just need to say no to drugs and they’re all set.” Many people fall in between the fissures in care networks when wishful denial replaces prevalency research and practical planning.

The other aspect of this part of the analysis is the degree to which an individual or family participates or is willing to participate in informal community support networks. These supports can be valuable. They tend to be culturally competent in terms of language and often in terms of values and faith as well. Still, a bad match is a bad match and not every family fits into these networks well. Clinicians will likely see both the relief that characterizes a good match and the distress people in need experience. When a match is particularly bad, people may object to false assumptions made about them by resource people who are trying to help. Clinicians are advised to be cautious when informal helpers attempt to make families and consumers conform to expectations that are not consistent with their own values and beliefs.

No matter what the source or intention of the helpers, one size really doesn’t fit all. When peoples’ needs don’t match what’s available, strategies must be created and new programs developed. It takes longer and it’s more difficult, but nothing else works.
Do people have a responsive network of support?  
This question is a continuation of the previous one in the analysis, with the clinical focus shifted to a person’s or a family’s personal resources. These resources – including family, friends, non-blood kin, neighbors, partners in faith and colleagues – can provide critical support in hours of need.

What clinicians must establish here are two things: #1- is there a support network? And #2- will it be helpful (i.e., responsive to the specific situation at hand)? This is a two part question because an existing network may be able and willing to respond to some issues but not at all to others. For example, people may gather around a family during a relatively short term health crisis, even of a serious nature. The same people may disappear if the situation continues over time. They may also be less responsive in other situations because they begin to blame or resent the people who need their support. They may misunderstand the situation or find it too sad, depressing or difficult to be around.

All of these factors and others must be considered in an analysis of a person’s or family’s resources and how well or poorly they are likely to support people – even people they love – in the specific, current challenges they face.

Do people have coping skills that are specific to the situation at hand?  
On the surface, this may seem like a yes or no question, but life is not that simple. Like support networks, coping skills are situation specific. A person who is able to cope with personal problems may have little or no ability to cope with barriers faced by his or her children or parents. People may be able to embrace chemotherapy but still fall apart at baldness. Even when people can stoically face a job loss, a broken heart still may have the potential to lay them low and render them unable to cope.

Since coping skills are specific to people and circumstances, clinical analysis must be equally specific. Clinicians must avoid over generalizing their observations and what they learn from other information sources. Assumptions in this area are dangerous. It’s important to determine how people are coping as well as how they could cope in the specific situations they face. That way, interventions can be put in place to increase coping skills when improvement is necessary and/or possible. Equally important, increased supports can be put in place when people face losses that are unacceptable and therefore, not amenable to intervention. Sometimes, the only strategy that fits is to help people find decent, safe ways to live with things with which they will never be truly at peace.

18 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
19 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
What might each person see as important to resolve over the next few days (short term outcomes)?

People don’t just want closure, they need it. We seek it in lots of situation. When we are uncomfortable, we want change; and we want it now or, at the very least, soon.

Many people believe that their feelings of discomfort would best be resolved if the people around them would change. It’s easier for most of us to identify dysfunctional behaviors and attitudes in others than it is to see them in ourselves. This attitude would work if each person was completely alone. When people interact with each other – in families and relationships, at work places, etc. – it becomes necessary for them to focus on what they can do and what they can actually control to make things more comfortable.

One of the roles clinicians play is to listen to what people want from each other. When they know this, they can help families and others negotiate new expectations and boundaries in their relationships that are more effective and more comfortable.

It is equally important to guide people back to what they can do, personally, to resolve difficult emotions and troubling situations. In the end, human beings are more likely to produce change by changing themselves: what they think, how they understand situations and what they do about them. We can always hope that others will also change but over that, we have very little real control.

Short term outcomes, i.e., next steps, are most useful when they are clear and practical. Clinicians help people see what they can do right now, tomorrow or next week. It’s also important to help people make long term plans and establish larger outcomes that can be achieved over time. However, without practical thinking in the here and now, it is difficult for people to see progress and sustain hope.

We may want, one day, to have family relationships that are peaceful, supportive and full of joy. For now, it may be more important to stop hitting each other or yelling at each other for the next couple of days. We may want to have jobs that allow us to both shine and make important contributions to others. In the short term, waking up on time and going to work everyday may be the most useful areas on which to focus.
Allyson’s Story

Allyson and her children, Anna (11), Billy (10), Jaime (8), Max (5), and Ben (2) came to the attention of child protective services due to repeated calls from neighbors and two of her children’s teachers. An investigation was initiated. The children were found to be hungry and poorly clothed. There was very little food in the house. Fecal matter was found in the bedroom, the bathroom, and the kitchen. Paraphernalia was evident in the living room, but no drugs were visible. Allyson awakened when the protective services workers banged on the door, and was clearly high. Neighbors who started watching the house when the workers parked their county car in front of it, reported that four men fled the premises just as they had arrived. The workers took temporary emergency custody of all of the children, and gently but firmly took Ben from his crying Mother. At the shelter hearing, the children were placed in the custody of Allyson’s sister, Amari, who became their temporary guardian. Allyson told the judge that her goal was to get her children back, even if it meant giving up drugs for good. The court ordered her to enter rehabilitation to address her addiction. The judge also ordered immediate physical and dental examinations for the children, a psychological assessment of Allyson, and a social history of the family. Offered several choices, Allyson and her children voluntarily entered the Wraparound Process.

Ensuring the safety of the children’s home life was not achieved by simply removing them from their mother’s custody. There were still grave concerns. Anna was removed from Amari’s home just one day after her placement there. When Amari went to get her up for school, she found her niece crouched in the bedroom closet with her arms cut to ribbons. She called 911 and got the little girl into an ambulance. Anna was treated at a local ER and placed in a psychiatric setting to keep her safe during the needed observation and assessment period.

Amari arranged for Ben and Max to stay with their Pastor, Jon and his wife, Moira because there were only two bedrooms in her apartment. Her hands were full already with Billy and Jaime as well as a full time job. Amari was also spending as much time as she could with Anna at the hospital and with Allyson at the rehabilitation center. Their mom, Regina, and youngest sister, Chris, lived halfway across the country so Amari tried to keep them up to date by phone. They called as often as they could afford.

Amari knew how much her sister valued education. Allyson had always taken her children’s schoolwork very seriously, and needed Amari to keep in touch with their teachers. Both sisters were concerned when they heard that Billy was behaving disruptively in school. Ms. Swanson, his teacher, reported that Billy was talking out of turn and refusing to do his seatwork. She actually had to pull him off of another classmate because the child laughed at Billy. The boy was unkind, Ms. Swanson said, but Billy’s reaction was pretty extreme and very physical. Billy faced a three-day suspension and getting him back into school wouldn’t be simple. The family, Billy, his
teachers, and others at the school would have to come up with a plan to make sure there were no future incidents.

The news about Jaime was okay at school, but things were not great at her Aunt Amari’s. Jaime was spending way too much time alone in her room. She seemed depressed, but whenever Amari asked her what was wrong, she said nothing. She also said little to Allyson during their phone calls, and her mom was worried about her tone of voice and reluctance to talk.

Moira and Pastor Jon were almost as busy as Amari. Ben was keeping pretty quiet. He didn’t seem to miss anyone but Anna. Ben didn’t even care who held him. Moira was distressed that he talked so little and that he frequently reverted back to crawling. He seemed to think he was on a great adventure, sort of an extended slumber party. They fostered that picture whenever they could to keep the little guy going. Max was as loud as Ben was quiet. He was acting impulsively, without fear, and was physically on the move. In just two days, Max fell when he was jumping on his bed, broke a plate and a cereal bowl, and rammed his head against the headboard of his bed.
Clinical Analysis: Thinking Through a Family’s Situation

Directions: Think through the following analysis for all 6 family members, using the time frame of a week before the removal through the first week of placement.

<table>
<thead>
<tr>
<th></th>
<th>Allyson</th>
<th>Anna</th>
<th>Billy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is everybody actually doing?</strong></td>
<td>• Getting high</td>
<td>• Protecting her brothers &amp; sister</td>
<td>• Talking out of turn</td>
</tr>
<tr>
<td></td>
<td>• Neglecting her children</td>
<td>• Cutting herself</td>
<td>• Being physically aggressive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Being non-compliant</td>
</tr>
<tr>
<td><strong>What is each person getting out of what he/she is doing?</strong></td>
<td>• Escape</td>
<td>• At least some control over the safety of her brothers &amp; sister</td>
<td>• Probably expressing anger</td>
</tr>
<tr>
<td></td>
<td>• Withdrawal symptom relief</td>
<td></td>
<td>• Frustration</td>
</tr>
<tr>
<td></td>
<td>• Burst of pleasurable feelings</td>
<td></td>
<td>• Trying to have a sense of control</td>
</tr>
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<td></td>
<td>• False feeling that she is coping</td>
<td></td>
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</tr>
<tr>
<td><strong>What is each person avoiding by what he/she is doing?</strong></td>
<td>• Responsibility</td>
<td>• The feeling that her life is completely out of control</td>
<td>• Verbal expression &amp; confronting painful feelings</td>
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<td><strong>Whose actions are risky, &amp; how risky?</strong></td>
<td>4</td>
<td>3 – 4</td>
<td>3</td>
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<tr>
<td>1= minimum risk, 4= maximum risk</td>
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<td></td>
</tr>
</tbody>
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20 Namcy Lubars, MSW, Center for Family Services, Camden, New Jersey
<table>
<thead>
<tr>
<th>Allyson</th>
<th>Anna</th>
<th>Billy</th>
</tr>
</thead>
</table>
| **What do you think this family should do next?** | • Stay at detox center  
• Get clean  
• Get help | • Assessment for sexual abuse & placement in a safe, therapeutic environment | • Assessment for possible sexual abuse  
• Support for safe behavior |
| **Who is ** **angry** **at whom?** | • At self/CPS/family for pushing her  
• At neighbors for calling CPS | • Allyson  
• CPS | • Allyson  
• Anna  
• Aunt Amari |
| **What are the ** **alliances** **?** | • Her boyfriend  
• Her dealer & drugs | • Her brothers & sister | • Anna |
| **Who is ** **isolated** **?** | • Her altered consciousness isolates her | • Very much so | |

<table>
<thead>
<tr>
<th>Jaimie</th>
<th>Max</th>
<th>Ben</th>
</tr>
</thead>
</table>
| **What is everybody ** **actually** **doing?** | • Spending time alone and is sad | • Being loud  
• On the move all the time  
• Breaking things | • Crawling instead of walking  
• Seems indifferent to those around him  
• Very quiet |
| **What is each person ** **getting** **out of what he/she is doing?** | • Trying to be good to keep her family together  
• Withdrawing from the things that hurt & depress her | • Probably expressing anger & testing to see if adults will set & maintain limits (seeking a limit to feel safe) | |
| **What is each person ** **avoiding** **by what he/she is doing?** | • Talking about what is troubling her (talking may make it worse - if you say it, then it'll come true) | | |
### Risk Assessment

<table>
<thead>
<tr>
<th>Whose actions are risky, &amp; how risky? (1= minimum risk, 4= maximum risk)</th>
<th>Jaimie</th>
<th>Max</th>
<th>Ben</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 - 4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think this family should do next?</th>
<th>• Assessment for possible sexual abuse, depression, &amp; degree of suicide risk</th>
<th>• Assessment for possible sexual abuse</th>
<th>• Assessment for possible sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is angry at whom?</th>
<th>• Allyson</th>
<th>• Anna</th>
<th>• Probably Anna</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Herself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| What are the alliances? | • Anna | • Anna | | |
|---|---|---|---|
| | | | |

<table>
<thead>
<tr>
<th>Is he/she isolated?</th>
<th>• Yes</th>
<th>• Yes, now that he is separated from his brothers &amp; sisters</th>
<th>• Yes, because he’s separated from Anna, his brothers &amp; Jaimie</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

### Perception of Events

<table>
<thead>
<tr>
<th>Are there issues with how people perceive the events at the center of the crisis?</th>
<th>Allyson</th>
<th>Anna</th>
<th>Billy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Self-centeredness is the core of addiction</td>
<td>• Angry &amp; cheated</td>
<td>• Feels angry &amp; cheated</td>
<td></td>
</tr>
<tr>
<td>• She sees life through the lens of what she wants &amp; needs</td>
<td>• Sees herself as a failure</td>
<td>• Failure at being the “man” of the family</td>
<td></td>
</tr>
</tbody>
</table>

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21 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
<table>
<thead>
<tr>
<th>Allyson</th>
<th>Anna</th>
<th>Billy</th>
</tr>
</thead>
</table>
| **Are there issues related to developmental factors?**                 | **Active addiction curtails normal development**                     | • Has lost trust in adult’s ability to help & protect him  
• Increasingly defiant & aggressive (regression)                                     |
|                                                                        | **Older than her years**                                             |                                                                                                                                          |
| **What are the family system issues, if any?**                         | **Her family dumped her**                                            | **Feels out of control**                                                                                                           |
| • Her family dumped her                                                | **Very young adult**                                                 |                                                                                                                                          |
| • Has abdicated maternal role                                            |                                                                      |                                                                                                                                          |
| **How will this family interact with the community?**                 | **Skeptical, blaming, disdain**                                      | **School is likely to be a problem. The suspension is the 2nd to last step in the school’s progressive discipline policy**       |
| With local systems of care?                                            | **The community reported her for neglect**                          | **Needs psycho-educational work on substance abuse**                                                                                 |
| How well will their needs match what’s available?                      | **The rehab facility is likely to meet her needs as will the N.A. fellowship** | **Needs psycho-educational work on substance abuse**                                                                                 |
|                                                                        | **Needs a safe setting**                                             |                                                                                                                                          |
|                                                                        | **Needs trusted people to talk to**                                  |                                                                                                                                          |
|                                                                        | **Needs psycho-educational work on substance abuse**                 |                                                                                                                                          |
|                                                                        | **Probably needs treatment**                                        |                                                                                                                                          |
| **Do people have a responsive network of support?**                    | **No – her family refuses contact due to her active addiction**      | **Anna (in hospital)**                                                                                                              |
| **Do people have coping skills that are specific to the situation at hand?** | **Aunt Amari**                                                       | **Aunt Amari**                                                                                                                      |
|                                                                        | **Aunt Chris**                                                       | **Aunt Chris**                                                                                                                      |
|                                                                        | **Grandma Regina**                                                   | **Grandma Regina**                                                                                                                  |
| **What is each person likely to want to resolve the situation, right now.** (immediate outcome) | **Prefers to be left alone, but agreed to treatment to begin the process of getting her children back** | **A caring mom**                                                                                                                    |
|                                                                        | **A caring mom**                                                     | **Someone to care for him & his family**                                                                                             |
|                                                                        | **Someone else to be in charge**                                    |                                                                                                                                          |
|                                                                        | **Escape from the “bad” situation**                                  |                                                                                                                                          |

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<tr>
<th>Allyson</th>
<th>Anna</th>
<th>Billy</th>
</tr>
</thead>
</table>
| **What might each person see as important to resolve over the **next few days**?** (short-term outcome) | **What she needs to do to get out of the system** | **Relief & safety**  
**Someone to take care of her family** |
| | | **Relief & safety**  
**Someone to take care of him & his family**  
**Not being picked on at school** |

<table>
<thead>
<tr>
<th>Jaimie</th>
<th>Max</th>
<th>Ben</th>
</tr>
</thead>
</table>
| **Are there issues with how people perceive the events at the center of the crisis?** | **Hopelessness & depression govern how she interprets her world**  
**Angry & cheated**  
**Failure to be good enough** | **Totally confused**  
**Left out**  
**Not cared for by adults or older siblings** |
| **Are there issues related to developmental factors?** | **Still a concrete thinker: things are right or wrong, good or bad- not much in between** | **Probably sees most adults as interchangeable & unresponsive to his needs** |
| **What are the family system issues, if any?** | **Feels that she doesn’t matter & it’s her fault**  
**Feels out of control** | **Doesn’t know where mom is**  
**Has lost connection with Anna** |
| | | |  

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24 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
<table>
<thead>
<tr>
<th></th>
<th>Jaimie</th>
<th>Max</th>
<th>Ben</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will this family interact with the community? With local systems of care? How well will their needs match what’s available?</td>
<td>• Needs a qualified child psychiatrist &amp; there aren’t many in the area • Therapist</td>
<td>• Needs pediatric psychologist to work with Jon, Moira &amp; Max, but long waiting list • Special needs kindergarten and child care are not available</td>
<td>• Needs pediatric psychologist to work with Jon, Moira &amp; Ben, but long waiting list</td>
</tr>
<tr>
<td>Do people have a responsive network of support? 25</td>
<td>• Aunt Amari</td>
<td>• Rev. Jon &amp; Moira • Aunt Amari • Brothers &amp; sisters</td>
<td>• Rev. Jon &amp; Moira • Aunt Amari • Brothers &amp; sisters</td>
</tr>
<tr>
<td>Do people have coping skills specific to the crisis? 26</td>
<td>• No</td>
<td>• No</td>
<td>• No</td>
</tr>
<tr>
<td>What is each person likely to want to resolve the situation, right now. (immediate outcome)</td>
<td>• Doesn’t believe it can be resolved</td>
<td>• A caring mom • Access to loving brothers and sisters</td>
<td>• Aunt Amari • A caring mom • Access to loving brothers &amp; sisters</td>
</tr>
<tr>
<td>What might each person see as important to resolve over the next few days? (short-term outcome)</td>
<td>• Whether to talk about what’s going on &amp; confront her sadness or to remain silent &amp; avoid talking</td>
<td>• A home that is loving &amp; stable • When he’ll see his brothers &amp; sisters again</td>
<td>• A home that is loving &amp; stable • When he’ll see his brothers &amp; sisters again</td>
</tr>
</tbody>
</table>

25 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
26 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
**Directions:** Think through the following analysis for all 6 family members, using the time frame of a week before the removal through the first week

<table>
<thead>
<tr>
<th>Allyson</th>
<th>Anna</th>
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</tr>
</thead>
<tbody>
<tr>
<td>What is everybody <strong>actually</strong> doing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is each person <strong>getting</strong> out of what he/she is doing?</td>
<td></td>
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<tr>
<td>What is each person <strong>avoiding</strong> by what he/she is doing?</td>
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<tr>
<td>Whose actions are risky, and <strong>how risky?</strong> 1= minimum 4= maximum risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What do you think this family should do next?</td>
<td></td>
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<tr>
<td>Who is <strong>angry</strong> at whom?</td>
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<tr>
<td>What are the <strong>alliances</strong>?</td>
<td></td>
<td></td>
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<tr>
<td>Who is <strong>isolated</strong>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Jaimie</td>
<td>Max</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
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<td>Who is <strong>isolated</strong>?</td>
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<td>Question</td>
<td>Allyson</td>
<td>Anna</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>Are there issues with how each person <em>perceives</em> the events at the center of the crisis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there issues related to <em>developmental</em> factors?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the family system issues, if any?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will this family interact with the community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With local systems of care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well will their needs match what's available?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do people have a responsive network of support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do people have coping skills <em>specific</em> to the crisis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What might each person see as important to resolve over the <em>next few days</em> (short-term outcome)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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27 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
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<table>
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<tr>
<th>Question</th>
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<tr>
<td>Are there issues with how each person <em>perceives</em> the events at the center of the crisis?[^30]</td>
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<tr>
<td>Are there issues related to <em>developmental</em> factors?</td>
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<td>How will this family interact with the community?</td>
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<tr>
<td>How well will their needs match what’s available?</td>
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<tr>
<td>Do people have a responsive network of support?[^31]</td>
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<tr>
<td>Do people have coping skills that are specific to the situation at hand?[^32]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is each person likely to want to resolve the situation, <em>right now.</em> (immediate outcome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What might each person see as important to resolve over the <em>next few days</em>? (short-term outcome)</td>
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</table>

[^30]: Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
[^31]: Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
[^32]: Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
Introduction to Applied Behavior Analysis

Old or young, woman or man, rich or poor, we all behave in ways that seem, sometimes without even thinking about it, aimed at allowing us to meet our needs. According to psychologist Abraham Maslow, Ph.D. (1908-1970), people operate from a hierarchy, or sequence, of needs which range from basic survival all the way up to more complex needs, like knowledge and self-improvement.

Maslow’s Hierarchy of Needs

- **Self-Actualization** (Self-esteem, wisdom, knowledge)
- **Social Status** (Respect, Position, Authority)
- **Belonging** (Family, Community, Culture)
- **Safety** (Physical, Sexual, Social)
- **Basic** (Food, Shelter, etc.)

The idea is that people can act to meet their needs at the higher levels, like social status, only after they have first met their needs at lower levels. (This theory doesn’t apply to people who have untreated psychotic or delusional illness.) Free from circumstances that jeopardize their own and their family’s well-being and safety, healthy adults strive toward meeting their self-improvement needs (such as being more spiritual, patient, kind, or generous).
But as we all know only too well, life isn’t a one-way street toward self-actualization! Consider how our needs drastically shift when a crisis occurs in our lives, such as loss of a job, a fire or natural disaster, divorce, prolonged illness or becoming a victim of a violent crime. We are likely to be snapped back to worrying about how to meet basic and safety needs again, if only for a short period of time.

Children operate primarily at the lower levels of the needs hierarchy because they are dependent on adults for basic resources. Infants and young children primarily behave to meet their needs at the basic and safety levels. School-aged children increasingly behave to meet their belonging needs, as well as their safety and basic needs. Adolescents explore their needs at the social status level as peer groups become very influential while they continue to focus on belonging and safety. Adults also operate within several levels of Maslow’s Hierarchy, many working on the complex skills that comprise self-actualization.

Regardless of how inappropriate, strange or unfamiliar a person’s behavior is, it is still an attempt to meet some need that he/she has. Use this hierarchy to remind yourself that all behavior – even rude or self-destructive behavior – is probably meeting a need for the person exhibiting the behavior. Along with learning desirable ways of meeting their needs, people learn undesirable ways. The undesirable ways people choose to meet their needs are oftentimes perceived as problem behaviors by others. Although such behaviors are effective for the people who act them out, problem behaviors can produce a lot of stress for them, as well as for family members, friends, neighbors and others who are affected by their behavior.

First, let’s review the basic terminology in applied behavior analysis:

**Defining Terms**

**Antecedent:** Something that happens *before* the behavior in question.

**Antecedent Control:** Term used when the behavior seems to be primarily influenced by whatever happened before it occurred.

**Behavior:** Anything a person says or does (words, actions, gestures, thoughts, etc.)

**Consequence:** Something that happens *after* the behavior in question.

**Consequence Control:** Term used when the behavior seems to be primarily influenced by what followed its occurrence.

**Setting:** The environment or context in which the behavior occurs (place, time, people and things present, etc.)
Setting Control: Term used when any element of the setting seems to influence the likelihood of the behavior occurring.

Topography: The exact physical appearance of the behavior.

Duration: How long a behavior lasts.

Intensity: The amount of effort required to perform the behavior.

Severity: The amount of risk for physical or other types of harm caused by the behavior.

Frequency: How often the behavior occurs.

Reinforcement: A consequence that increases the likelihood of the behavior occurring. Positive reinforcement is something people try to access by engaging in a specific behavior. Negative reinforcement is something people try to escape or avoid by engaging in a specific behavior (e.g. buckling up to silence the seatbelt buzzer). Rewards are the most common form of positive reinforcement.

Punishment: Anything that clearly results in a decrease of the behavior.

Extinction/Planned Ignoring: Planned, consistent removal of attention to a behavior.

Extinction Burst: An initial sharp increase in the target behavior after extinction is used as an intervention.

Target Behavior: A behavior, or class of behaviors, selected as the priority for intervention.

Goal: Desired achievable outcome stated in observable and measurable terms.

Objectives: Small, measurable and observable steps, that achieved and added together, comprise achievement of the goal.

Shaping: Achieving a target behavior by reinforcing pieces or subparts of a behavior that are present and gradually adding more pieces until the entire behavior is mastered.

Task Analysis: The creation of a specific step-by-step list of all the things a person will have to do or have to learn, to complete the “task” (e.g., skill, action, behavior, project) that is being analyzed.
Functional Analysis: Assessment of what a person’s behavior gets him/her and what it helps him/her avoid.

Strength-Based Behavior Intervention: A plan that addresses problem behavior by building replacement, alternative behaviors on the strengths, preferences and values of the person who is exhibiting the problem behavior.

Direct Modeling: Performing or engaging in a new or changed behavior, often repeatedly, in the presence of a child as a strategy to teach the child the behavior.

Deliberate, Targeted Modeling: Similar to direct modeling, a new or changed behavior is demonstrated, often repeatedly, in the presence of a child, while specifically pointing out the behavior, discussing it, etc., with the child as a strategy to teach the behavior.

Indirect Modeling: Exposing a child to new or changed behaviors through verbal reports, written reports, pictures, movies, music and other key elements of culture.

Deliberate, Indirect Modeling: Similar to Indirect Modeling, the behaviors being “modeled” through verbal reports, written reports, pictures, movies, music and other key elements of culture, are specifically pointed out, discussed, etc., with the child being taught.

Teaching Curriculum: A list of diverse teaching activities that address what is learned about a target behavior in a task analysis. The curriculum includes as many sensory tracts as possible and effectively fosters mastery of the target behavior.

Teaching Strategies to Change Behavior

There are several important tools in the art of understanding behavior. As you read through them, you’ll probably find that you know more about behavior than you think.

People learn behavior through repetition and contrast. Repetition refers to the opportunities to engage in the behavior. Contrast refers to what the person experiences and the intensity of that experience as a result of engaging in the behavior. The clearest example- most of us need to touch a hot burner only once to learn not to touch things that are hot.

We teach behavior in three main ways:
(1) Modeling: demonstrating the behavior
(2) Direct instruction: deliberately teaching specific action or behavior
(3) Consequences: rewarding a person for a behavior, punishing a person for a behavior, or simply ignoring the behavior

The most powerful behavior interventions allow people opportunities for repetition with sufficient contrast and employ all three of these teaching methods.

Modeling: We Learn What We See

**Direct Modeling**
People teach people. We have a powerful role in teaching and modeling behavior for the people around us. Young people especially watch us constantly, soaking up what they see and hear like sponges. The important thing to remember is that whether or not we’re aware of it, we’re always modeling behavior and therefore, always teaching. Because of that, we sometimes model the exact opposite of what we intend to teach. People learn how and when to manage anger from what they see. They learn how to communicate, solve problems and how to treat each other. Things as simple as greeting a guest and as complicated as entering a conversation are learned largely through modeling.

Modeling works best when it is deliberate. If you want the people around you to learn to tell the truth, don’t just tell them the truth; point out that you are telling the truth. Make sure they notice it and notice it repeatedly. Point out when the guy at the gas station is telling the truth and the next door neighbor is not. Prompt them to notice when they have the chance to either lie or tell the truth. Let them know that you respect them for making the right choice. Talk to them about people they see on TV, at school, at work and elsewhere around the community, and whether they tell the truth or lie.

Modeling can lead to some unfortunate results when it’s accidental. Very few people set out to teach a person to lie, but many of us have inadvertently modeled dishonesty. Jamie learned about lying from her budget conscious parents when they purchased airline and movie tickets at lower rates by misrepresenting her age. Mathew learned about lying when his dad asked him to say he wasn’t home when a talkative neighbor called to speak to him.

**Indirect Modeling**
People don’t just model their parents’, their colleagues’ and their peers’ behavior. They watch famous people, like athletes, actors and musicians. For many individuals, these folks become heroes. People watch TV, movies and especially each other. They are online, they read books and they listen to the radio.

People hear and model good things from the majority of these sources. They also learn about scandals and corruption. They watch people cheat and sometimes they see enormous rewards go to the cheaters. They see people treat themselves and each
other with disrespect. The whole time they’re watching, like it or not, they are learning behavior.

Parents and others who are concerned about behavior can use indirect modeling of both the good and the bad actions of well known people to help children and adults change a behavior. Good actions from stars can be read about, watched in videos and discussed. Even embarrassing and negative actions can have a place in indirect modeling. They provide the contrast that is essential to learning – this is what to do and this is what not to do.

For the sports fan who has trouble controlling his temper, Mohammed Ali and Mike Tyson provide a real contrast for a discussion about anger management. The former is revered as a moral, courageous man and one of the greatest athletes of the century. The latter will likely go down in history as the convicted criminal who tried to bite off Evander Holyfield’s ear. If the issue is cheating, talk about what happened to Nancy Kerrigan’s career, as opposed to Tanya Harding’s, whose name is now often preceded by the words “disgraced former Olympic skater”.

When people argue that, temper or not, Mike Tyson made a lot of money and Tanya Harding is in celebrity boxing matches, let it go and try again another day. Sometimes people insist on antiheroes, and arguing against them can cause the person to become even more devoted to them. Keep listening and you will probably find something the person likes or someone he/she looks up to who can help you teach. Think these examples over ahead of time and make sure you don’t choose indirect models who will encourage the individual to engage in problem behaviors.

Direct Instruction: Teaching Them How

Many of us teach important things to the people around us. How to spell, how to answer the phone, how to politely address others and how to work the cable TV are familiar themes for teaching. It’s less common for us to teach others exactly how to say no to a sexual advance or how to walk up to a group of peers and say hello. We tell them to say no and to just walk over there and say hi, but we don’t really teach them how. Telling alone works for some people, but others do better when they are systematically instructed.

Teaching interactions should be positive and if possible, fun. Plan a low stress time and make a “date” with the person to try something new. Consider some of the approaches listed in the section entitled Selecting Learning Approaches, also in this Introduction to Applied Behavior Analysis. If you can use popular books, movies and music as part of a lesson, it’s more likely that the individual will be successful in learning new ways to think and act.

When it comes to learning about behavior, we learn the desired actions, at least in part, by learning about the not so desirable actions. Contrast is an important tool in skill
acquisition. We know how to act at the mall by also knowing how not to act at the mall. Include contrast in your teaching interactions: how to apologize to an authority figure and how not to; how to manage anger and how not to. Try role playing both “how to” and “how not to” with the individual. Take turns doing it both ways and feel free to laugh. Laughter can be good for learning.

When a new skill is complicated, or just subtle, consider breaking the skill down into small steps and documenting them. Write them down, draw or cut out pictures of the steps or videotape them so you will have the steps in front of both you and your child as you teach. What you produce, either with your child, alone or with a partner or spouse, is called a task analysis. It can be a powerful teaching tool.

Consequences: The Power of Motivation

The following strategies have been used successfully by many people to address problem behavior. As you review them, consider how well or poorly they fit the people in your life.

We are all familiar with rewards and punishments, both of which are consequences, as long as they follow behavior. We are, ourselves, both praised and criticized. We are rewarded and punished at home, at work and most other places we go. People are motivated by money, but that’s only part of it. We are motivated by extra privileges and access to companions and activities we enjoy. People are also motivated by punishment or the need to avoid it. Most people don’t want to get fired, dumped, or in trouble.

Research has long suggested that combining rewards and punishments is more likely to change behavior than either one used alone. Many people would prefer that those around them behave as they wish them to just because it’s the right thing to do. They’ve told the individual what needs to be done so the person should just do what he has been asked to do.

If that works, go with it. There’s no need for a behavior change plan when simply asking the person produces the desired result. Sometimes, when the behavior issue is skill acquisition, a concerned individual can tell the person what to do in a tricky situation – like figuring out how to act in changing social circumstances – and the person will be able to do it. Normally, though, people learn social and cognitive skills through teaching and teaching works better when there’s a plan in place to motivate positive actions and choices.

Using rewards and punishments in behavior interventions for people requires clear, accurate definitions. A reward is something that, when it’s delivered after a particular behavior, increases the likelihood that the behavior will be repeated in the future. In other words, if it doesn’t work, it’s not a reward, no matter what it is. A punishment is something that, when it’s delivered after a behavior, decreases the likelihood that the
behavior will be repeated. Punishment can also help slow the behavior down, or make it less intense. You have to pay attention and make sure that the reactions or consequences following the behavior are working the way you expected.

Look for examples of the shifting definitions of rewards and punishments in your own life:

- Thanks for coming in to work during your time off, especially on a holiday. You'll be the first person I call to fill in next time we’re short staffed.

- You work well with irate customers. We’ll be diverting them all straight to you from now on.

- Young lady, you have been disrespectful to your teacher. Now, you’re suspended for three days, no school for you!

- Thanks for washing my car. I just wish you had done the interior and the wheels.

In the end, the only way to be sure that you’ve found an effective motivational solution is by finding out whether or not it works.

Rewards and Punishments: They’re Supposed to Work

Jody, 9, is pretty shy. Despite that, she was so excited about a gymnastic meet that she did a great job on her class Special Interests presentation. When she was finished, everybody clapped and called out her name.

Reward? Punishment?

Of what behavior? _________________

Ralph is the director of the Behavioral Health Care Department at a not-for-profit agency. At the annual meeting, the Executive Director of the agency shook his hand and said “Ralph, thanks for your hard work. You exceeded expectations and spent under your budget. Congratulations. We’re going to transfer your surplus to the residential budget because they lost the money for next years’ budget. We’ll adjust you down.”

Reward? Punishment?

Of what behavior? _________________
Sandi, 16, came home one hour and twenty minutes late for curfew, leaving her dad pacing the floor and extremely anxious. When she got to the door, he asked her where she had been. Sandi explained that they had an accident – hit a dog with the car – so they had to stop and find the dog’s owner. It was so late and he was so tired, her dad just waved her up the stairs.

Reward? Punishment?

Of what behavior? ______________________

Jane was pretty sick of her mother-in-law. She decided to tell her husband Jack exactly what she thought over dinner at a restaurant. Jane told him about several incidents she had with his mom, but Jack just kept eating. He had nothing to say. So Jane said, “Okay then. If you won’t listen, I just won’t tell you anymore” and gave him the silent treatment.

Jack’s behavior to Jane:         Jane’s behavior to Jack:
    OR
Did he ignore her?           Did she ignore him?

Who controlled this situation?
   Jack? OR Jane?

At worship services, the brother, 12, was making silly faces at the sister, 8. Their mom gave them a “cut it out” signal and then, another one, more urgent. The sister giggled more each time he made a new face and each time, his mom glared at him.

Mom’s behavior to Son:         Sister’s behavior to Brother:

Who is having the most impact on the brother’s behavior?
   His mom? His sister?

Austin, 4, loved going grocery shopping with his Aunt Carmen. He rode in the cart and pointed out everything he thought she should buy. When they were waiting to check out, Austin saw his favorite candy, a Snickers bar. He asked Aunt Carmen to buy it for him but she said no. He asked again, saying “Please, please, please!” but still got a no.
He started to whine and cry a little. Aunt Carmen looked all around at the people looking at them, grabbed the candy and put it in his hand saying, “Here, now be quiet.”

**What did Aunt Carmen do to Austin’s behavior?**
- Reward?
- Punish?

**What behavior and with what possible results?**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Possible Results</th>
</tr>
</thead>
</table>

**Will it likely:**
- Increase?
- Decrease?

Tasha, 14, told her parents she was going to study with a girlfriend when she really met Timmy, 15, so they could hook up a little. They made out on a park bench for 20 minutes, then spent another 10 minutes “saying” goodbye. Tasha got home a few minutes early, said she was finished with her homework and went to bed.

**Was Tasha’s behavior:**
- Rewarded?
- Punished?

**Was Tasha’s “time with Timmy” likely:**
- Rewarding?
- Punishing?

How? ___________________________

Jules complained to his wife Julie that they never did anything special together. He griped that he was tired of staying home, being bored. Julie surprised him with a special dinner at home and three rented DVDs. Jules walked in smelled the dinner cooking and said “Are we eating at home again tonight?” Julie said yes and handed him the DVDs. Jules looked through them, saying “Seen it, seen it, heard it sucks.”

**What did Jules do?**

__________________________________________

**Was it:**
- Rewarded?
- Punished?

How? ___________________________

With what likely result?

__________________________________________
What did Julie do?
___________________________________________

Was it:
Rewarded?  Punished?
How? _________________________

With what likely result?
_______________________________________

Perception and Bias: It’s A Weird World

Please read the following letter to Dear Abby (by Abigail Van Buren) a while ago, that appeared in the Pittsburgh Post Gazette (and, no doubt, elsewhere). Analyze the behavior changes described and answer the simple questions that follow. (Dear Abby was just about always right, so her sensible reply has been omitted):

“My family is having problems with my brother’s wife. They have been married about eight years, and my brother seems like a different person today. Before marrying, “Eric” was a nice and compliant person. When the family got together on something, he would always participate. Our mother was particularly fond of Eric, as he would accompany her to concerts or church since my father did not like to go to these events. Eric never argued or spoke up to any of us, but now he has an opinion on everything and lets it be known. He used to always put his family first, but now he favors his wife and children.

Eric has told us that he has been seeing a counselor for a long time. He has invited all of us to join him, but we don’t believe in that sort of thing. We all know Eric would have never started seeing a counselor if it weren’t for his wife. Our parents are especially devastated that Eric has changed so much. What can we do to stop his wife and get our old Eric back?”

- What is wrong with this picture?

- What is right?
How can positive change be reinforced?

How can it be punished?

What do you recommend for Eric and his family?

Putting It All Together

A Reasonable Approach to Changing Behavior
This section provides an overview or step by step guide for changing behavior. Following the brief overview is detailed information for completing each step and component.

The following steps can be used to address problem behaviors. Please remember to modify these steps as needed, based on your knowledge of the culture and values of the person at the center of the intervention, the cultures and values of the community in which the person resides and the individual needs of the people at the center of the intervention.

**Step 1**
Review available sources of information about the behavior.

**Step 2**
Assess the need for medical evaluation and intervention, and make sure people who need medical services get them **promptly**.

**Step 3**
Collect initial information about the problem behavior by talking about it with the person (if possible and appropriate) and with the people who know the person best and by observing the problem behavior.

**Step 4**
Choose which of the individual's problem behaviors represent your initial priorities for intervention. Define the problem behaviors, in detail, without emotional bias and
describe the settings in which they occur. Define each problem behavior so that it can be observed, measured or counted accurately. An effective definition is one that several people who see the person’s problem behavior will reliably recognize and count it as an occurrence of the behavior.

Step 5
A careful analysis of what happens before the problem behavior (i.e., antecedents); in order to increase the individual’s ability to control his/her own reactive behavior, antecedents may be altered or redefined. An analysis of the setting in which the behavior occurs (i.e., who is present, location, time, etc.) also occurs here.

Step 6
A careful analysis of what happens after the problem behavior (i.e., consequences). Consequences may need to be changed in order to increase the occurrence of positive, alternative behaviors and decrease the likelihood that the person will engage in the problem behavior.

Step 7
Learn about the person’s strengths, assets, cultures and choices. Find out what the individual can do and what he/she has successfully changed in the past. Learn also about what the person feels he/she needs to maximize the likelihood of behavior change.

Step 8
Ask yourself: “Do I have a reasonable understanding of why this behavior is happening? Do I know how it is functioning for the person?” If your answer is “YES”, then go to Step 9. If it is “NO”, then go to Step 10.

Step 9
If “Yes”, then develop and implement a plan that includes-

A. The generation of several alternative, positive behaviors that the individual will find functional and appealing.

B. A specific definition of the alternative behavior. If the alternative behavior is even moderately complex – do a task analysis.
C. A detailed curriculum that allows you to select one or more approaches for teaching the alternative behavior that capitalizes on the person’s skills, strengths, faith, culture and interests.

D. Strategies for teaching and, if necessary, re-teaching the alternative behaviors.

E. Deliberate direct and indirect modeling of the alternative behaviors.

F. A motivational strategy that is clinically accurate (e.g. it works), based on more positive than negative consequences.

G. A way to document and measure the individual’s progress toward outcomes and, if needed, the frequency, duration, topography, intensity and severity of the problem behavior. This should also allow for revision of the intervention as needed.

H. A method to fade the intervention and give control of it to the individual with and for whom it was designed.

**Step 10**
If “No”, troubleshoot your information collection methods and collect additional data from all sources, including in-person observation, functional strengths and needs assessment and discussion with those involved.

**Step 11**
Again, ask yourself: “Do I have a reasonable understanding of why this behavior is happening? Do I know how it is functioning for the person?” If the additional data you collected in Step 10 allows you to say “Yes”, go back to Step 9 and develop a plan.

*If the answer is still “no,” or if nothing seems to be working:*

**Step 12**
Take your best informed guess on what type of intervention is most likely to work, based on the available data. Agree on an intervention that is based on that educated guess. Implement the plan consistently, carefully collecting observational data and other information.

If the situation improves, you have guessed correctly. If it does not, try again. Try changing (one at a time) your teaching methods, your modeling of alternative behaviors, the nature of the rewards and punishments, and the manner in which they are delivered. Continue collecting observational information about the individual, and you will eventually develop a plan that works.
Step 1: Reviewing Sources of Information about the Behavior

Review verbal and written reports:

Interviewing consumers and the people who know them well

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows you to hear from the real experts</td>
<td>Requires scheduling and travel</td>
</tr>
<tr>
<td>You can directly observe the person’s affect and behavior</td>
<td>Requires interviewing skills</td>
</tr>
<tr>
<td>You can identify additional information sources</td>
<td>You have to identify &amp; correct for interviewer bias</td>
</tr>
<tr>
<td>Antecedents, learning history &amp; developmental trends may be clearer</td>
<td></td>
</tr>
</tbody>
</table>

Formal assessments of consumers and people who are significant to them

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available norms and standards for comparisons</td>
<td>Assessments may not be as tailored to your inquiry as desired</td>
</tr>
<tr>
<td>Can access results of previous assessments via mail or email</td>
<td>Can’t ask additional questions as they arise</td>
</tr>
<tr>
<td>Can complete some instruments via phone or mail</td>
<td>Reports may be biased</td>
</tr>
</tbody>
</table>

Record review (e.g. educational, medical, psychological)

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A variety of reporter’s observations and access to multiple perspectives</td>
<td>Accuracy of reports is difficult to assess</td>
</tr>
<tr>
<td>May provide information on previous interventions and outcomes</td>
<td>Current targets may not have been previously addressed</td>
</tr>
</tbody>
</table>
Measurement of behavioral by-products:

Define and count what the behavior produces.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective evidence of the current status of the behavior</td>
<td>No information on antecedents, consequences and setting effects</td>
</tr>
<tr>
<td>Observers need not be present</td>
<td>May not reflect subtle changes</td>
</tr>
</tbody>
</table>

Step 2: Assessing the Need for Medical Intervention

It’s important to remember that even the best behavioral interventions will not work if the person at the center of the intervention is actively psychotic, delusional, intoxicated or addicted. These issues must be dealt with first, with an eye to remediation and treatment. Behavioral interventions are created under the assumption that the person is behaving in keeping with the rules of logic, at least as far as we understand them. When signs of intoxication or untreated mental illness are present, the first priority for intervention design is a thorough medical assessment and responsive treatment.

As interventions are developed, the people involved must also assess for and ascertain whether or not an illness that directly impacts behavior is present. Hyperthyroid disease, for example, can mirror the symptoms of ADHD; hypothyroid disease can look a lot like depression. Similarly, high blood glucose may be mistaken for a depressive illness, while hypoglycemia may resemble an anxiety disorder.

Look for evidence of the following:

- Moods and emotions that don’t match actual circumstances
- Fatigue without apparent visible physical cause
- Lack of ability to either focus or follow through
- “Jittery” feelings that produce significant physical discomfort
- Any other signs that all is not well for the person.

When these concerns arise, the first priority is medical assessment and treatment. Only when treatment is in place and effective will behavior interventions be successful.
Step 3: Collecting and Reviewing Initial Information About Behavior

Behavioral Assessment Interview
We can learn quite a bit of useful information about behavior by discussing it with key people who have seen, heard, felt or otherwise experienced the behavior directly. Ask people who know the person well for their opinions and insights.

- What, exactly, is the problem behavior?
- Does it help the individual get or avoid anything?
- Why do you think the person behaves that way?
- Is the person rewarded, deliberately or not, for the problem behavior?
- Is the individual punished, deliberately or not, for positive behavior that could replace the problem behavior?
- How did the person learn to act like this?
- What outcomes (friendship, academic or social success, safety, personal affirmation, confirmation of negative self esteem, etc.) seem most likely to be achieved/furthered by the problem behavior?
- What can the individual do to achieve the outcomes without engaging in the problem behavior?
- What does the person want?
- What external, controls and forces may be important to the individual (approval, probation, promotion, etc.)?
- What internal controls and forces may be influential for the person (faith, ethical priorities, self interest, etc.)?
- Who else knows the person well and can provide potentially useful information?

Step 4: Issues in Defining Target Behaviors

Targeting Behaviors
People who are concerned about a person’s behavior sometimes see a lot of behaviors in need of intervention, particularly in complex situations. It’s tempting to design interventions that address every problem behavior. Practitioners can’t yield to this
seemingly reasonable notion. It’s impossible to achieve significant results simultaneously across lots of different problem behaviors. Choose one or two of the most pressing behaviors for immediate intervention and follow up with additional behavior change plans when the current interventions have succeeded, as evidenced by mastery of the current behavioral targets.

**Where to Begin:** When determining priorities for intervention, consider the following:

- What behavior does the person in question want to change? He/she is your “customer,” and you may need to convince your customer that behavior change is possible and that strength-based behavior interventions can assist him/her in accomplishing it.

- Where will the person’s strengths produce results that are more easily or quickly achieved?

- Is there an issue that so thoroughly provokes the people who are important to the individual that there is a risk of disruption in key relationships?

- Are there any concerns that, if remediated, will make an important difference in the quality of this person’s life?

- Are you helping the person choose a target behavior that is broadly applicable across normal settings and that will enhance his/her ability to function in the family, community or wherever?

- Can you identify a target behavior that, if mastered, is likely to result in other positive changes without additional intervention?

- Are you focusing on building skills that replace problematic behavior rather than just making behavior go away?

- Are you starting in the right place? Are there any prerequisite skills that have not been mastered?

- Have you selected a target behavior that will result in the person’s increased access to “good stuff”, in terms of social, material and relationship consequences?

**Defining Target Behaviors**

Consider the following questions as you analyze a problem behavior and define, as precisely as possible, what the behavior is:
**What is the person doing?**  
First, physically: state the individual’s actions, not intent or motivation

| “Paul is throwing things at the wall” | “Claire stamps her feet and shouts NO” | “Terry and Sherry take each others’ things without permission, one snatching it from the other, at times” |

---

**Step 5: Antecedent and Setting Analysis**

**What happens just before the problem behavior?**

| Paul can’t figure out how to do what he’s working on: the car, his checkbook, new electronic games, etc. | Claire is told that she has to do something: chores, bed time, get back in the car; etc. | Terry and Sherry get bored with their own things |

---

**Possible emotional triggers:**

| Paul feels frustrated, stupid and embarrassed | Claire feels rebellious, controlled and annoyed | Terry and Sherry are bored, competitive and jealous |

---

**The setting in which the behavior occurs:**

What is the setting in which the problem behavior occurs, or occurs most frequently? What time is it? What day? Who is present, if that seems to be a factor? All of these factors can play a role in whether or not a problem behavior occurs.

| At home, especially when his girlfriend is there | Her Mom; at home and twice at the mall | Mostly between dinner and bed time on weekdays, also on long car rides |
Step 6: Consequence Analysis

What happens just after the problem behavior?

| Paul’s girlfriend, Annie, picks up his things | Claire and her mom get into an argument | Terry and Sherry’s parents put up with it as long as they can and then tell them to be quiet and keep whatever they have |

Possible emotional triggers:

| Paul feels relieved. | Claire feels better and in control. | Terry and Sherry blame each other and want to get back at each other. |

Step 7: Strengths Assessment
See pages 92-101.

Step 8: Understanding Behavior and Function

Generating Functional Alternative Behaviors

1. After getting some agreement on how the behavior may be functioning for the person, sit down with him/her (and people who hold significant relationships) and consider what the person could do instead that will meet the need effectively with fewer negative repercussions.

2. Generate a list of options that are, to one degree or another, acceptable within the context of the person's neighborhood, culture, development, gender, etc.

3. For each option, create a descriptive list of steps that when completed demonstrate mastery of that option (i.e., task analysis). Try to emphasize as many of the person's strengths as possible in your formulation of each task. Keep this interaction lively, and if possible, enjoyable. Act out each step as stated to identify any adjustments that need to be made.

4. Ask the individual to select the most useful option/s.

5. Plan a teaching/practice schedule and implement.
6. Ask the person what would help him/her get or stay motivated to participate. Wherever possible, focus on consequences that are as close to natural, logical, “real world” responses to positive and negative behaviors.

Format for Functional Analysis
If you ever get “stuck” analyzing just how a certain behavior is working for an individual, get together with the person and the people who know the person best (family, friends, people who live with the person, etc.) and consider these questions to facilitate your insight and intervention planning:

1. What EXACTLY is the behavior people are concerned about? (frequency? topography? duration? intensity?)

2. Does it seem to occur as a part of an ongoing chain of behavioral events?

3. What immediately precedes and follows it?

4. What does the person get? What does he/she avoid?

5. Is this behavior ever NOT an issue? Under what conditions?


7. If you wanted to “set off” the individual, e.g., have them perform the behavior in question, what would you do?

8. When asked, what does the person say he/she is getting or avoiding? What does the person say he/she wants to achieve?

9. How might an individual have learned to act like this? How did this person get into this habit?
Behavior, Function and Alternatives

**Functions:** Sometimes the function statements will be the same as what the person gets and/or avoids, like “she gets attention, and getting attention is the function. Other times, they won’t: “she avoids taking needed medication, which is functioning as a suicide attempt.

<table>
<thead>
<tr>
<th>Problem Behavior</th>
<th>Get/Avoid: Possible Functions of the Problem Behavior</th>
<th>Functional, Alternative, Replacement Behaviors</th>
</tr>
</thead>
</table>
| “Snitches,” i.e., reports the problem behavior of someone else to an authority | - to be the “favorite” for awhile  
- to get back at somebody | - have the person do favors for people based on strengths and assets and reward him/her for doing them  
- write feelings in an email, pray, talk to a trusted person, etc. |
| Fakes an illness or medical condition | - to get attention  
- to avoid school, work, chores, etc. | - plan a special “date” alone with the individual to do something you both enjoy  
- plan earned “vacations” |
| Does what he/she is certain will result in people yelling at him/her | - to avoid success and people’s expectations  
- to get attention/emotional verbal stimulation  
- to get a reputation just so peers know the person is alive | - work with the person to spell out what he/she defines as success across the areas of his/her life and tie them to present day actions and their real and probable results  
- help the person identify his/her talents & preferences and work on how those strengths can be best used to connect with peers |

**Step 9: Developing a Plan**

**Task Analysis**
Task analysis is an important teaching tool, especially when the skill to be taught is complex. Doing the analysis can be a real eye-opener for parents, teachers and others concerned about behavior. It allows them to see that behaviors that seem simple, even obvious, are actually complicated. Task analysis – the deliberate, step-by-step description of behavior – provides specific content for direct instruction.

How a particular task is defined depends on each person’s values and priorities. The sample task analysis that follows - Clean your room – is detailed to allow readers to select the components that, for them and their families, comprise what they consider a
clean room. Some families, for example, believe that a clean room includes a bed that is made how they like it while others don’t really care if the bed is made as long as kitchenware is returned to its usual place and the trash is dumped into the appropriate container. A well-thought out task analysis adapts to and includes these specific family views and values.

Similarly, even when a number of families agree on an element in the task analysis – like making the bed – what making the bed looks like from family to family can vary widely. Some people define a “made bed” as specifically as hospital corners. Others are fine with simply having the comforter or spread pulled up to conceal tumbled sheets. Task analyses have to be individualized in order to reflect these differing opinions.

As you review our sample task analysis, choose the elements of a clean room that reflect the consumer’s or family’s goals and customs. When you have finished reviewing the elements of the task analysis, you will have their definition of exactly what constitutes a clean room to use as a teaching tool.
# Clean Your Room

## Potential Elements and Definitions

<table>
<thead>
<tr>
<th>Clean Your Room</th>
<th>Potential Elements</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make bed neatly, smoothly with good corners</td>
<td>Yank the comforter up and it’s made</td>
<td>Only people who have no imagination make beds</td>
</tr>
<tr>
<td>Clean things folded neatly in drawers that shut tight</td>
<td>Clean clothes in general area of dresser</td>
<td>No visible clean clothes</td>
</tr>
<tr>
<td>No food or food service items</td>
<td>Eat the food and return service items to where they belong while still recognizable</td>
<td>No noticeable rotting smell</td>
</tr>
<tr>
<td>Appropriate (not stolen, obscene or bigoted) wall ornaments, hung straight and neatly dusted</td>
<td>The content of wall ornaments must not be obscene or bigoted, they must be purchased or given as gifts, it’s okay if they’re a little dusty</td>
<td>Isn’t it sweet that people give him these road signs?</td>
</tr>
<tr>
<td>Dirty clothes are in the identified hamper which is neatly shut</td>
<td>Dirty clothes are piled separately from clean clothes</td>
<td>On laundry day, separate your own dirty clothes from clean clothes with a “smell test”</td>
</tr>
<tr>
<td>Books are displayed neatly on shelves, right side up, spine side out</td>
<td>Owned books are in the room and library or otherwise borrowed books are in the hall around when they are due to be returned</td>
<td>Bless her heart! She read a book!</td>
</tr>
<tr>
<td>The Bed</td>
<td>Make it</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Make it | ▪ Just pull up the spread/comforter.  
▪ Hospital corners.  
▪ Something in between the two (above).  
▪ Plump up pillows and place them at the head, over the spread or comforter.  
▪ Plump up pillows and tuck the spread or comforter over them.  
▪ Fix décor as indicated by previous instruction (shams, pillows, etc.) | | | | | | | |
| Don’t care how the bed looks | | | | | | | | |
| Don’t care how the bed looks except for | | | Add to the end of the sentence how you wish the bed to look | | | | | |
| | | | | | | | | |
| Change it | ▪ Use clean top and bottom sheets, tuck both in well.  
▪ Use clean top and contour sheets, tuck in top sheet.  
▪ Put the spread or comforter back on, over the top sheet.  
▪ Remove used pillow cases and replace with fresh ones.  
▪ Air the mattress before making the bed for ______. how long?  
▪ Put dirty sheets and pillow cases ______ where? | | | | | | | |
| Details | ▪ Fix dust ruffle/bed skirt (how?)  
▪ Roll up sleeping bag.  
▪ Make sure that spread/comforter covers sheets. | | | | | | | |
<table>
<thead>
<tr>
<th>The Stuff</th>
<th>Make sure that sheet is even on all sides.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Turn the mattress (how?) (when?)</td>
</tr>
<tr>
<td>Don’t care where the stuff is except for</td>
<td>Identify any specific things you want put away</td>
</tr>
<tr>
<td>Put stuff and/or identified stuff in agreed upon locations</td>
<td>(Identified Stuff)</td>
</tr>
<tr>
<td>Put stuff and/or identified stuff in agreed upon locations with all drawers/doors/lids closed without stuff sticking out</td>
<td>Put stuff that has small parts in bags, boxes (or however you’ve agreed)</td>
</tr>
<tr>
<td>Display only agreed upon items in agreed upon places</td>
<td>Stack books on shelves as agreed</td>
</tr>
<tr>
<td>Return other people’s stuff to them or their areas</td>
<td>Put games/toys in agreed upon locations</td>
</tr>
<tr>
<td>Kitchen items returned to kitchen</td>
<td>Return it clean, dry, folded, replaced, ______________. etc.</td>
</tr>
<tr>
<td></td>
<td>Return it clean and ready to use</td>
</tr>
<tr>
<td></td>
<td>Tell them it’s been returned</td>
</tr>
<tr>
<td></td>
<td>Thank them for the use of their item</td>
</tr>
<tr>
<td></td>
<td>Soaked</td>
</tr>
<tr>
<td></td>
<td>Washed &amp; dried</td>
</tr>
<tr>
<td></td>
<td>Put in agreed locations</td>
</tr>
<tr>
<td></td>
<td>Loaded into dishwasher, etc.</td>
</tr>
<tr>
<td><strong>The Clothing</strong></td>
<td>Don’t care where or how it is</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Put clothes where they can't be seen</td>
<td>Neatly folded</td>
</tr>
<tr>
<td>Put clothes in drawers that are neatly shut</td>
<td>In agreed upon drawer</td>
</tr>
<tr>
<td>Put clothes in closet, neatly shut</td>
<td>Put clothes on hangers</td>
</tr>
<tr>
<td></td>
<td>Hang shirts up with top buttons buttoned and centered on hangers</td>
</tr>
<tr>
<td></td>
<td>Hang pants on pant hangers</td>
</tr>
<tr>
<td>Put some clothes, (like ________) in drawers neatly shut. Put others (like ________)</td>
<td>Separate clothes into clean &amp; dirty and put only dirty clothes in agreed upon spot, and only clean ones where agreed, folded, hung &amp; neatly shut</td>
</tr>
<tr>
<td></td>
<td>Put underwear in agreed location</td>
</tr>
<tr>
<td></td>
<td>Put underwear as agreed: socks folded, socks rolled, underwear stacked, underwear folded neatly &amp; stacked</td>
</tr>
<tr>
<td></td>
<td>Fold and stack pants</td>
</tr>
<tr>
<td></td>
<td>Fold T-shirts neatly and stack</td>
</tr>
<tr>
<td></td>
<td>T-shirts in drawer</td>
</tr>
<tr>
<td></td>
<td>Hang ________ on what?</td>
</tr>
<tr>
<td>Parts of the Room</td>
<td>Stuff not on floor (See Stuff) and clothes not on floor (See Clothes)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>garment hooks</td>
<td></td>
</tr>
<tr>
<td>Fold other clothes like__________</td>
<td></td>
</tr>
<tr>
<td>which ones__________</td>
<td></td>
</tr>
<tr>
<td>how_____________________________</td>
<td></td>
</tr>
<tr>
<td>Hang other clothes like__________</td>
<td></td>
</tr>
<tr>
<td>which ones__________</td>
<td></td>
</tr>
<tr>
<td>how_____________________________</td>
<td></td>
</tr>
<tr>
<td>Floor is clean</td>
<td>▪ Rug arranged on the floor as agreed</td>
</tr>
<tr>
<td></td>
<td>▪ Floor swept, mopped, dusted (choose relevant items)</td>
</tr>
<tr>
<td></td>
<td>▪ Carpet vacuumed</td>
</tr>
<tr>
<td>Only authorized items on the walls</td>
<td></td>
</tr>
<tr>
<td>Only authorized items on the ceiling</td>
<td></td>
</tr>
<tr>
<td>Furniture is dusted</td>
<td></td>
</tr>
<tr>
<td>Furniture is polished</td>
<td></td>
</tr>
<tr>
<td>Stuff is dusted:</td>
<td></td>
</tr>
<tr>
<td>which stuff?______________________</td>
<td></td>
</tr>
<tr>
<td>Trash can emptied into___________</td>
<td></td>
</tr>
<tr>
<td>where? when?______________________</td>
<td></td>
</tr>
<tr>
<td>Lights turned off/left on</td>
<td></td>
</tr>
<tr>
<td>No paper or fabric on lamps or lights</td>
<td></td>
</tr>
<tr>
<td>Light fixtures are dusted</td>
<td></td>
</tr>
<tr>
<td>Door knob is polished</td>
<td></td>
</tr>
<tr>
<td>Windows &amp; Window Dressings</td>
<td>No need to do anything with window dressings</td>
</tr>
<tr>
<td>Blinds</td>
<td>▪ Blinds - dusted, open, closed, drawn/not drawn</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Curtains</th>
<th>Curtains - drawn/not drawn, laundered, pressed, dry cleaned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Window/s washed:</td>
<td>how? &amp; when?</td>
</tr>
<tr>
<td>Neat desk top:</td>
<td>Desk drawers are shut</td>
</tr>
<tr>
<td>what’s allowed to be out?</td>
<td>...organized as agreed or put away as agreed</td>
</tr>
<tr>
<td>...organized as agreed or put away as agreed</td>
<td>what isn’t allowed to be out?</td>
</tr>
<tr>
<td>Art/hobby supplies put away closed and clean</td>
<td></td>
</tr>
<tr>
<td>Only school stuff on desk; additional supplies in drawers</td>
<td></td>
</tr>
<tr>
<td>Electronics dusted as taught</td>
<td></td>
</tr>
<tr>
<td>Other people’s stuff returned and stored appropriately</td>
<td></td>
</tr>
<tr>
<td>Kitchen stuff returned and stored appropriately (See Stuff)</td>
<td></td>
</tr>
<tr>
<td>Potentially dangerous items stored safely and put away</td>
<td></td>
</tr>
</tbody>
</table>
Selecting Learning Approaches

Effective behavioral interventions are, at least in part, the function of detailed plans to teach and model new behavior. These instructional curricula contain a wide variety of activities that, when implemented, are likely to generate new, healthy and functional behavioral responses.

People are most likely to learn new behaviors when we use a variety of tools to teach them and a variety of ways to reach out to them. Changing the location of the actual activities and who’s involved in a behavior intervention encourages generalization of the new behavior. Variety in teaching strategies also helps you preserve the individual’s interest in learning the new skill, something that’s vital to the acquisition of new skills.

Use as many of the methods suggested as you can to help the person you’re concerned about learn.

<table>
<thead>
<tr>
<th>See</th>
<th>Hear</th>
<th>Draw</th>
<th>Listen to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record</td>
<td>Think about</td>
<td>Talk about</td>
<td>Write about</td>
</tr>
<tr>
<td>Act out</td>
<td>Analyze new information</td>
<td>Read about</td>
<td>Watch on TV or online</td>
</tr>
</tbody>
</table>

Choose strategies that encourage him/her to:

Direct Instruction

For each teaching/rehearsal interaction, include the following elements of good instructional practice:

- A positive start (gesture, name, gratitude for participation).
- An exact description of the new behavior.
- A demonstration of the new behavior.
- Practice, with ongoing feedback and adjustments.
- Rationales for the alternative behavior being practiced.
- A positive closing.
- Implementation of whatever motivator has been agreed on and selected.

Remember, good teaching includes the senses of the learner. Whenever you can, arrange for the new skills to be seen, heard and “touched” as new behaviors are practiced. It’s also based on the fact that we know what something is, in part, by knowing what it isn’t.

---

33 Dr. Robert P. Hawkins, Ph.D., West Virginia University, personal communication.
Expect to teach a new skill many times, and to really teach it, not just describe it or require it. Try teaching it in different ways and different settings. Expand your teaching curriculum to address subtle elements of a new behavior, like tone of voice or friendly eye contact. Find different examples of the new behavior you are teaching in stories, TV shows, in your family, in your community: wherever you can. Talk up the new behavior, hopefully without nagging. When you see it, in whole or in part, acknowledge it briefly but sincerely. Ask the person if any opportunity to try the new behavior occurred in the course of his/her day. Consider bragging about the person’s progress on the new behavior to others who care about him or her, when the person can hear you.

Teach new behaviors at a neutral time. That is, practice at a planned time when the problem behavior is not occurring. Be positive and have fun. When you’re teaching “live,” i.e., during the problem behavior, at least be positive in a serious way. Try asking the individual to participate in your teaching intervention, thank him/her for participating and if appropriate, use light, approving physical contact like a touch on the shoulder or hand.

**Combining Strategies for Effective Intervention**

Let’s revisit Paul, Claire, Terry and Sherry to demonstrate the remaining components of an effective plan. So far, we have determined the following:

- **Paul** throws things at the wall when he is embarrassed or frustrated because he can’t figure out how to do something, especially when his girlfriend Annie sees his inability.
- **Claire** stamps her feet and refuses to do what her mom tells her to do at home and in the community.
- **Terry** and **Sherry** take each other’s things, sneaking or by force, when they’re bored, tired and sick of each other.

<table>
<thead>
<tr>
<th>Direct Modeling Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paul</strong></td>
</tr>
<tr>
<td>Paul’s favorite uncle will role play ways to get help when you need it and ways to joke about it that reduce embarrassment</td>
</tr>
</tbody>
</table>
### Indirect Modeling Strategies

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul likes sports so he'll listen to, read about and watch athletes and how well or poorly they manage poor performances and frustration. He'll share what he learns with his uncle.</td>
<td>Claire loves <em>The Lord of the Rings Trilogy</em> so she'll watch the films and with her adult helper, critique how each character responds to authority and when necessary, suggest better or worse responses, whatever works best for justice and freedom in Middle Earth.</td>
<td>Terry &amp; Sherry are Christians so with help from their Youth Pastor, they'll find Biblical commands that relate to sharing and not stealing and make posters out of them for their rooms.</td>
</tr>
</tbody>
</table>

### Antecedent Analysis

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul’s problem behavior is usually preceded by frustration from not immediately being able to figure something out, especially when others are present.</td>
<td>Claire’s problem behavior is preceded by expressions of adult authority, particularly her Mom’s.</td>
<td>Terry &amp; Sherry’s problem behaviors are preceded by boredom, fatigue and too much time together.</td>
</tr>
</tbody>
</table>

### Consequence Analysis

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul feels relieved after he throws his things. His girlfriend Annie picks up what he throws which he seems to like to a degree</td>
<td>Claire’s mom gets into a power struggle with her, which makes her mom miserable and makes Claire smile a little</td>
<td>Terry &amp; Sherry’s parents ignore them as long as they can and then, tell each of them to be quiet and play with whatever each currently has</td>
</tr>
</tbody>
</table>

### Motivational Strategies

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Paul throws things, Annie will leave immediately. She will return only when he calls her, apologizes and has picked the stuff up. When Paul goes a week without throwing anything, Annie will play</td>
<td>Claire earns points, on her behavior management plan when she does what she is told. She loses them when she doesn’t. When she has enough points, Claire will earn a copy of <em>The Hobbit</em> and/or other</td>
<td>Terry &amp; Sherry will have to go to their rooms when they take each others’ things or face (each of them) a different window in the car. After this brief time out, each must let the other play with whatever the other wants</td>
</tr>
</tbody>
</table>
an electronic sports game with him. related books, games or movies. for a half hour. When they share, they earn IOU’s for future “reservations” for sharing.

### Documentation of Progress

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul’s progress will be recorded on a chart featuring the NBA with the title Win or Go Home.</td>
<td>Claire will use a map of destinations from the Shire, to Rivendell, to Mordor and back again to chart her progress. Her mistakes – Gollum Moments – will set her back one or more destinations while her successes will lead her closer to a successful return to the Shire (like Sam)</td>
<td>Terry &amp; Sherry have a Golden Rule chart – Do Unto Others as You Would Have Them Do Unto You. If they – individually or jointly – have a good week, they pick a restaurant (or take turns picking) and have a family dinner there on Sunday after church.</td>
</tr>
</tbody>
</table>

### Fading the Intervention and Transferring Control

<table>
<thead>
<tr>
<th>Paul</th>
<th>Claire</th>
<th>Terry &amp; Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul will keep his own chart without help and share his progress with Annie and his uncle.</td>
<td>Claire will keep track of when she follows directions, especially from her mom, and email her mentor or worker about her success and failure, with the worker responding appropriately within 72 hours.</td>
<td>Terry &amp; Sherry will report their sharing progress to the Youth Pastor every Sunday morning and pray in gratitude for their results before the service with other youth group members.</td>
</tr>
</tbody>
</table>

### Step 10: Troubleshooting Ineffective Interventions
See page 72.

### Step 11: Replanning Interventions
See page 72.

### Step 12: Trying it again with measuring new ideas
See page 72.
Assessment in Family and Person Centered Practice

Assessment is the first step of the treatment and service planning process. It takes many forms and sometimes involves several professionals in order to provide a comprehensive assessment.

If your staff’s role (in part, or otherwise) is to plan or coordinate treatment or service planning for families and consumers, they’ll need to know what assessments to get and from whom to get them. They don’t have to do a psychiatric evaluation, just make sure people who need one, get one. The same is true of many other frequently needed assessments. Supervisors should make a point to be both knowledgeable about and up-to-date on providers of whatever assessments your customers need most often.

This includes how much providers charge for each service and who pays for it. Eligibility issues are important here, both in terms of who gets which assessment and who can be paid to perform it. It’s important to know who needs what degree or license to be reimbursed from each funding source. There are also specific referral, reporting and documentation requirements, on all of which staff will need training and guidance.

Language, culture and development are also important factors for supervisors to consider in reference to assessment. When assessments are conducted in a language the consumer or family doesn’t know well, the assessment is likely to result in less information. Culture often governs how people communicate so assessment results are more accurate and informative when the assessment is culturally competent. Assessments must be adjusted to reflect the development of the individual assessed, so level of development is another key factor in arranging for needed assessments.

Supervisors should evaluate the quality, the availability of assessments and resulting reports carefully. Quality, accuracy, logic, usefulness and timely receipt of documentation must be monitored. It’s equally important for consumers and families to find the assessment process as comfortable as possible.

If the services your organization provides are ordered, reviewed and monitored by courts, the credibility of the assessor in that environment is yet another consideration. Advanced credentials are helpful but so is the ability to communicate effectively.

In some circumstances, the assessment tool or method itself is critical. For some services, the capacity to compare a person to statistically reliable norms is critical. In others, it isn’t significant. If for example, the person seems to be
developing slowly, a comparison with normal development is useful. If the question to be resolved is whether or not a person is depressed, a comparison with the general population adds little to the process, except in actually making the diagnosis. The diagnosis itself involves comparing the person to diagnostic markers that differentiate between people who have mental illness and those who don’t and people who have depression rather than another condition.

Key Terms: A Reminder for Supervisors

For assessment results and service and treatment plans to be easily discussed and reviewed, common terms have to be defined exactly and used accurately. Help staff learn them and add to this incomplete list other terms common in your work with consumers and families.

**Strength:**
A strong attribute or inherent asset/s; what people are good at, what they value and what they choose; social and recreational preferences; important belief systems; hobbies; skills; favorite activities. Note: We do not equate faith and belief systems with hobbies and social activities. We learn with respect and without judgment, any information that lets us best support consumers and families.

**Need:**
A lack of something requisite, desirable or useful; a physiological or psychological requirement for the well being of an organism; the absence of something that’s necessary to achieve the desired outcome/s; impediments that block achievement of the outcome/s; necessary but missing skills, insights, strategies or behaviors.

**Outcome:**
Something that follows as a result or consequence; the intended product of activity throughout planning and intervention processes; the change that’s desired or required, stated in measurable terms; that which will be different after intervention, from how it is now, specifically described.

**Life Domain Areas:**
Areas in which each human being has needs that are met or unmet, to one degree or another, every day of our lives; a practical planning tool that helps ensure the development of comprehensive, flexible plans.

**Resource People:**
[People who are] sources of supply or support; (people who) enhance the quality of human life; (people to whom) one has recourse in difficulty; (people who can be) a source of information and expertise; (people who bring) a possibility of relief or recovery; (people who have) an ability to

meet and handle a situation; (a person) one turns to in the absence of the usual means or source of supply

**Informal Resource People:** As above, but not paid services providers; family members, friends, partners in faith, neighbors, mentors, sponsors and others who reach out to people for little or no compensation (little compensation refers to people like foster parents, leaders of the faith community and others who help for rewards beyond what is often at the low end of financial compensation)

**Formal Resource People:** As above, but professional service and support providers who are formally trained and/or licensed to deliver certain types of supports and services; people who are paid (albeit often poorly) to assist consumers in a wide variety of ways, like teachers, counselors, officers of the court, social workers, doctors, nurses, etc.

The assessment questions presented here are not meant to be comprehensive. They will help with the following assessment issues central to Family and Person Centered Practice.

- Identification and definition of desired, required or intended results (outcomes) and how progress/achievement on them will be measured
- Identification and definition of what needs must be met in order to achieve the outcomes defined above
- Identification of specific and significant strengths, values, preferences, culture and relationships.

There are several things these questions don’t provide:

- Psychiatric or psychological diagnosis
- Comparison of how the individual being assessed is doing in specific areas to how others in similar circumstances, ages, developmental factors, etc. are doing.
- Recommendations on what type of services or programs should be utilized.

The questions may also be useful in the context of other types of assessments or adapted to what your program offers. The rationales presented for the questions may help supervisors think about the assessments they review and what they
contribute to a family and person centered planning process. If the information gained from other sources is inadequate or if it’s just the wrong information, it is part of a supervisor’s leadership function to address those deficits. Deficits in assessment cause serious mistakes in treatment or service planning.

Sample Assessment Questions for Adults in Person Centered Practice

- Is there anything you believe in that gets you through tough times? Anything that you value?

  Belief systems – like faith, definitions of acceptable and unacceptable conduct and ethical priorities – are important to many people. Most people believe in something and govern their lives by principles they were raised with, that they encountered on their own or that they hold dear for whatever reason. They may value contributing to their communities, worshipping in both personal and public ways and keeping their families safe.

  Beliefs give people guidance, motivation, comfort and inspiration, all of which may be important in achieving changes in their day-to-day lives. They function as codes of conduct that sanction certain actions and not others. They are clearly relevant to how people live their lives and as such, to service/treatment planning in Family and Person Centered Practice.

- How do you blow off steam?

  Many people work with service providers for help with very serious situations like anger management, depression, disability and many more. Most, if not all, are under pressure. The source of pressure may be coerced participation in protective services and court. It may be the circumstances that people are in that produce stress and pressure. Regardless of the source, supervisors have to help staff understand the pressures that the people they serve experience.

  Treatment or service planning addresses the stress and pressure consumers experience by helping them find strategies to end it or at least alleviate it. That’s why this is an important question. Because Family and Person Centered Practice is individualized, strategies are unique to each consumer including how they may best reduce the pressure they confront. Rather than referring everybody to therapy as a general rule, assessors look for what consumers can and will do as the platforms on which to build individualized interventions.
• How would you spend your leisure time if you could choose freely?

*What people choose to do reflects their values, priorities and favorite activities. This can be useful in helping consumers address risk by engaging in preferred activities in lieu of risky ones. Favorite activities can help troubled consumers build something to look forward to in each day. They may help motivate people, even help them learn new skills and insights.*

• How have you managed to cope with (whatever he/she is coping with) so far?

*This question adds an acknowledgment to the inquiry, i.e., that the consumer or family is or has been coping with whatever situation has triggered the assessment. That’s an important point. Many times service providers get involved with consumers when they have reached the proverbial end of their ropes. Despite that, they may have managed their situations on their own prior to needing outside intervention. This means there are coping skills that may be renewed or revisited. Clinically, it’s easier to help people build on past skills than it is to help them acquire new ones.*

*If new skills are needed, that is the service or treatment planning priority. Even then, past coping skills may provide important clues as to what those new skills may be.*

• What would give you and/or your family a happier life? Describe as exactly as possible how that happier life will look.

*Defining the outcomes – results- to be produced by intervention is a key definitional aspect of Family and Person Centered Practice. Since all activity and funding is controlled by what and how outcomes are defined, knowing the outcomes is clearly necessary.*

*In Family and Person Centered Practice, consumers and families – whenever possible – are asked what they would like to achieve. Sometimes outcomes are dictated by state and local governments via the courts. Even then, it’s important to ask people what they want in terms of results. This builds ownership of the resulting plan, which makes it more likely that the outcomes will be achieved.*

*We ask for the exact description of what will be different so planners can measure progress. It’s also a better way to really personalize the plan and ensure that everybody knows what success looks like to this consumer or family.*
• What is getting in the way of that actually happening?

Family and Person Centered Practice is based, in part, on the assumption that when unmet needs that relate to the achievement of priority outcomes are met, people are more likely to achieve the outcomes. This is consistent with Dr. Abraham Maslow’s writing about basic, unmet needs and the impact they have on how able people are to participate in society.

It’s also a practical way to proceed in service or treatment planning. Vulnerable children and adults are safe when those who care for them have the means to limit access to them by offenders. People will be more likely to remain clean and sober if they have the support they need to do so.

Stating needs instead of services allows families and consumers to be specific. It allows planners to individualize a plan rather than draw from whatever options the system of care offers.

• Who do you consider family?

The time when professional service providers and representatives of governmental agencies told people who is in their families is over. We all have different degrees of relationship or closeness with relatives. Many of us have intimate relationships with some family members but prefer to keep a certain distance from others. Many also have non blood kin who are chosen as family members. All of these people can be important resources in the treatment or service planning process.

Family and Person Centered Practice plans include both formal and informal resource people. Informal resource people are important because their relationships are durable over time. They are also more likely to help consumers and families become or remain independent.

• Did you/do you look up to somebody? Do you have a hero? Is there someone you admire?

When you know who a person admires, you have important information on what that person values. People look up to those who reflect how they’d like to be, at least in some small part. Knowing this helps planners know where and how behavior modeling may be helpful.

If someone admires their grandmother, find out why. What choices, with what reasons, did she make? If someone looks up to the Reverend Dr. King, how would the individual emulate his actions if that helps that person be safer, happier and more at peace?
• Who do you call when...? (Adapt a potential, locally relevant crisis, A/C broken, ice storm, broke, fired, dumped, angry.)

"This is a follow up on a previous question. It’s a common practice in assessment to ask a question a second time, from a different angle. The question helps people think of resource people by posing a specific situation in which they would need one. Assessors should make sure to select a reasonably common local situation that most people could experience. In other words, don’t ask people in the desert who they’ll call in an ice storm."

• What kind of mom or dad do you want to be (or) What kind of person do you want to be? (or) What do you want for yourself and your loved ones?

"This question addresses the very heart of who people want to be, at their best. It also asks them what they want and what they deeply hope to achieve. The questions are useful because they help people firm up their vision of what they’d like to change and how they’d like to improve their circumstances."

"This is similar to the above question in two ways: first, it’s a previously asked question asked in a different way; second, it requires the assessor to select the specific question of those presented that best fits the actual circumstances."

Sample Assessment Questions for Children in Family and Person Centered Practice

• What was the best day you ever had? Why?

"Children remember special days better than periods of their lives. Special days are marked by traditions, celebrations and times of joy. There are many elements of special days that evoke memory: who is there, what everybody does, prayer, food, music and so on. There may even be games, special treats and gifts. All of these elements are meaningful to children and capture their memories."

• Who is your hero (actual or fictional)?

"Children, like adults, seek to emulate their heroes. When planners know who their heroes are, they can help children learn new skills and ways of coping with situations by including those heroes in interventions in various"
ways. They may, for example, be motivated to pursue important changes by studying the choices their heroes made or make.

Heroes can be local or global; actual or fictional. Supervisors have to make sure staff know how to build on what children admire. It doesn’t matter what your staff thinks of Harry Potter\(^{38}\). It matters if a child served by your organization can, by talking about the young wizard, learn to value him/herself more, learn that difference can be wonderful or select friends more wisely.

- What are the best things about your life right now? About school? About your parents? Your family?

Planners need to know as much as possible about childrens’ lives, not just their problems. When children tell us what works best in their lives, we have information about how they want things to be more frequently or consistently. This question may also identify elements in different environments that help them succeed: who is present, where they are, what is expected of them, etc.

These environmental elements are key to planning effective interventions. This information allows planners to design or alter environments that match possible parts of a child’s life. It’s easier to help children change their behavior in this type of environment. It also lets us know under which conditions children are more likely to communicate and learn best.

- How do you blow off steam?

Like adults, children can sometimes feel enormous pressure and stress. They worry about measuring up to the expectations of their families and teachers. They worry about their skills in everything they do: sports, dance, art, drama, humor and so on. They get anxious about who likes them and who doesn’t and who their friends are or aren’t. Children are emotional beings, some more obviously so, but still, emotional. They feel angry, sad, ashamed and more. Of course they have positive feelings too but that typically doesn’t trigger entry into assessment and treatment or services.

Negative emotions, like pressure and stress build up on children, just like adults. They need outlets for these feelings that are safe, useful and legal.

\(^{38}\) Harry Potter series, written by J.K. Rowling, Arthur A. Levine Books
• Who can you count on, no matter what? What do you believe in, no matter what?

Treatment and service planning works best in Family and Person Centered Practice when both informal and formal resource people participate. The purpose of this question is to find out who they trust and may be willing to include on a team.

We ask what children believe in because it helps planners understand their values. Belief systems are important potential sources of motivation, comfort and insight. They also spell out what is good conduct and what is not. The purpose of using the words “no matter what” in the question is to find out what children believe they can depend on regardless of their circumstances.

• What do you want to be when you get older? What do you want to be like?

It’s useful to ask children how they’d like their grown up lives to be because their responses help them focus on the future. This can provide a format for a behavior change strategy by tying a child’s current activity to how likely it is or isn’t that the future will become reality.

Children can attach the future to their performance, participation and attendance at school. Criminal behavior or substance abuse may not be likely paths to a child’s vision of a positive future. Unsafe sexual activity now may make the type of marriage, relationship or family a child envisions for the future very difficult to achieve.

• Who admires you? Why?

This is another question about resource people who might be helpful in designing and implementing a family/person centered plan for a child. The question is worded differently because it may trigger different answers. Having admirers means that there are people whose company children enjoy and who the children believe see them in positive ways. People who have relationships like this may be mentors, skill coaches or motivational supports to children who are trying to achieve important changes.

• Who do you think understands you best?

Understanding is different from admiration. Understanding implies a relationship that is close but also very honest. Children tell their secrets
and most perplexing feelings to the people who are most likely to respond both helpfully and with compassion. These people, when identified, can be part of the change process, as detailed above.

- What do you (or would you) do with free time and the choice of how to spend it?

  This question lets people know what the child wants to do, which helps planners design skill building, insightful and motivating interventions. The child who likes basketball may communicate more readily on the court with a family member or mentor. The same may be true of the child who likes to cook, at the grocery store or in the kitchen.

  Many children need to be motivated by rewards to achieve improved behavior or academic performance. The child’s favorite activities may be used as motivational strategies. They may also comfort a sad child or give a highly active child positive things to do in lieu of getting in trouble.

  Supervisors should make sure that staff are trained to look beyond response cost strategies that have children exclusively earn or lose favorite activities contingent on behavior. Activity can be therapeutic. Some activities are so therapeutic they should not be earned or lost, but instead a part of a treatment or service plan. Shared activities also help children develop positive relationships.

- If you could change anything about your life, what would you change?

  This is the outcome question, a follow up to the future question, above. Children don’t always participate in services voluntarily. They also don’t typically have control over what is or should be happening. Still, most children have opinions about their lives and what they would like to change.

  This is also an opportunity to show children that we value and respect them. It gives them an opportunity to own their own plans and as much as possible, participate actively in their own change process.

Assessment and Treatment or Service Planning: Positive & Negative Evidence*

*see also Safety Planning

An effective family or person centered service or treatment plan is based on a thorough assessment. If the information is inaccurate or incomplete, the chance
that the plan will help the family or the consumer achieve important outcomes diminishes.

When protective services workers intervene with families and consumers it is because there has been evidence of risk and compromised safety. Normally, though, even when the evidence points to risk, signs of safety are also present\(^{39}\). It is possible to find a family that is completely unsafe but it’s rare. The parent who strikes a child may be careful about having a car seat installed properly. The parent who has used poor judgment in supervising children may be really good at telling them bedtime stories and making sure they get adequate rest.

These positive signs are also important pieces of evidence. They speak to a parent’s or caregiver’s protective capacity for doing something right. They are also the best places to begin interventions that keep vulnerable children safe. The families served by protective services, just like every family, are better able to build on what they can do then on what they can’t. Often the best plan to address a parent’s or caregiver’s deficits is to build on their strengths and capacities.

But where there has been evidence of risk, protective services workers are well within their rights to require evidence of positive change. That change is safe children in safe families. When workers talk with families, they can not base their protective responses on what people say, only on what they actually do.

Instead, they require parents who have behaved in ways that put their children at risk to show direct evidence that they are now behaving differently. If the plan is to call grandma for a ride to the food bank when they run out of food, to avoid neglecting their children, workers can and should require that they engage in that new behavior and report it when it occurs. The measure of success here isn’t about not needing grandma. It’s about calling her sooner, before the food is gone.

The things parents and caregivers are required to do show positive evidence, like the example above, will feel unnatural to people, especially when they are required to report them. Still, the evidence that determines the level of risk must be balanced with the evidence of new safe behavior that relates to the prior level of risk that led to protective services intervention and monitoring. Even when parts of the protective services mandated intervention are practiced, like new ways of communicating, that practice gives workers important information about the capacity of the family to keep children safe. That positive evidence should exist in proportion to the negative evidence that determines the level of risk (history, frequency, intensity, etc.). Protective service workers can then create safety plans that are measured and accurate responses to the levels of risk involved.

Assessment and Cultural Competence

Finding ways to build on family and consumer strengths is the heart and soul of Family/Person Centered Practice. These strengths are often the best path to increasing peoples’ safety and ability to participate in their families and their communities. Faith and culture are important strengths for many consumers and families. A good assessment lets people know enough about them to understand their values and priorities. Cultural competence is a hallmark of respectful behavior and impeccable manners, values we embrace in practice.

Culture and faith are also important strengths for employees. As your team provides services, your staff will encounter many values, cultures and religions in this work. There will be many with which they are not personally familiar. There will be others with which staff will be uncomfortable. In Family/Person Centered Practice, staff are required to manage their subjective impressions of the values embraced by families and consumers. Those impressions may come from people whom they have encountered personally in the past. They may also be based on reports from others, or from movies, television, the news, the world of sports, etc.

Staff have the right to their opinions in their personal lives. At work, these impressions and opinions are not useful. They may lead people to make assumptions that interfere with their ability to intervene in, or even to correctly assess and understand a situation. These subjective impressions are especially problematic when they lead staff to draw conclusions without adequate information. They may even cause staff to inadvertently gather only the facts that fit a theory that matches their subjective impressions.

Supervisors have to hold staff accountable for meeting each family and consumer with respect, neutrality and impeccable manners. Whatever their prior perceptions or experiences, they are required to let consumers and families teach them their faiths and cultures. This gives them a strong basis on which to design a treatment or service plan that actually fits people and that actually makes sense to them. That’s how we make sure that nobody gets hurt and it’s the best chance we have to ensure that nobody dies.

Assessment and Bias

Bias causes people to be wrong about what they observe and how they interpret information. Bias puts an extra lens over our eyes that interferes with how we understand situations. If your employees think that certain types of people are violent, they will have a “these people” lens on as they gather evidence about alleged violence. If they think that certain types of people are lazy, they will look at people through a “lazy” lens when they evaluate their efforts to be financially independent. If they believe that certain people are sexually irresponsible the “sex” lens will have an impact on how they respond to people who have sexually
transmitted diseases. These lenses will almost certainly skew the information your employees collect to reflect the bias that is inherent in each lens.

It is normal to have certain biases and beliefs. Working with people, however, necessitates leaving those biases at home and not bringing them to work. Supervisors are expected to talk with staff about their biases and help them manage them appropriately so that they can see each family as clearly as possible. These ongoing discussions must be managed carefully so that they never deteriorate into group griping which hardens the biases and may cause them to spread. The expectation in Family and Person Centered Practice is that supervisors will fill a leadership role in combating and managing bias. They should model managing bias and as much as possible, normalize both the expectation of biases and the expectation that they will be proactively managed to neutralize their impact.

Assessment Rapport

Supervisors may wish to spend some time with staff discussing these and other elements key to Family and Person Centered Practice that make assessment information accurate and useful.

- Ask the people what they would like you to call them and use those names consistently. Don’t use generic parent titles like Mom and Dad.

- Introduce yourself as you would like to be called and show your ID without being asked to do so.

- Smile, unless the situation requires a more solemn manner. If it does, make sure your behavior, gestures and tone are in keeping with what the person/people is/are experiencing.

- Assessments that are delivered in keeping with the standard of impeccable manners and respectful behavior produce better information and hope for the future. They also are less onerous for consumers.

- Consider using carbon paper or forms that create instant copies so that the responses of those who are being interviewed are available for them to keep for later discussion, further reflection or whatever other purpose suits the situation and the people being assessed (unless doing so would endanger the safety of anyone involved).

- Look around, if you are in the person’s home, and ask about what you see in the environment. A lighthouse collection may make you aware of a sailor or a navy veteran. Art and artifacts may indicate religion or culture and other important values.
- Note also what people wear that may indicate faith, style, a preference for a certain sport, a team, a particular value, etc.

- If you are conducting this assessment with a family, consider using both the adults’ and the child’s version, selecting the one that seems to best fit each family member. If you’re assessing a young adult, select questions from both versions of the assessment. Be prepared to shift from one version to another when the responses you’re getting indicate the need for a more adult or a more youthful approach.
Research in Family and Person Centered Practice

The role of research in Family and Person Centered Practice is to help workers move from just learning about faith, strengths, assets, culture, choices, etc. to turning them into therapeutic strategies. When workers know at least some specifics about the things that are important to consumers and families, they can design better interventions.

There are lots of examples of strength-based strategies in the Treatment and Service Planning section of this Curriculum. All of them are based on a worker or supervisor following up on reported strengths and getting to know what could help someone in need do or change.

It’s important to note that assessors and planners do not equate a person’s or a family’s faith with their bowling ability. They do not equate an ethical code with being a football fan; a belief system with prowess in the kitchen.

Still, all of the above examples can play an important part in helping people achieve important changes in their day-to-day lives. Because of that, Family and Person Centered planning is based not just on assessment but also research. Assessment helps planners learn about priority outcomes and unmet needs, as well as strengths. Research expands the information in the specific detail required for strategy design and information.

Most research these days is done online. Newspapers, magazines, television and other media are still useful tools as well. It’s not necessary for staff to become experts on each strength. The research needed here takes minutes, not hours. In the interest of efficiency, though, if you don’t know how to use the Internet, ask the people around you for direction. It’s fun and it really adds a lot to the resulting treatment or service plan.

Here are some examples of research done to support Family and Person Centered strategy design.

NOTES ON THE HISTORY OF HIP HOP
“Busta Rhymes,” Scott Mervis, Pittsburgh Post-Gazette, February 15, 2004

25 years since 1st rap single

50 Cent (Curtis Jackson)
- 2003
- Top selling artist
- Rap is about ½ of the Top 20, according to Billboard Hot 100
“When we started, they said none of this would last 6 months”… Grand Master Flash, 2003

Outkast won '04 Grammy: Album of the Year

Hip hop artists have influenced product development:
- Reebok G6 sneaker – 50 Cent
- “Crunk” energy drink – Lil Jon and the East Side Boyz
- Roca Wear - Jay-Z
- Vokal line - Nelly

Rap Culture is “freeing… the minds of inner city people” …KRS-One

Some see "pimping" as a style of clothes- not, according to Bakiri Kitwana, author Hip Hop Generation: Young Blacks and the crisis in African American Culture
  - same with n-word

Nelson George Hip Hop America and Post-Soul Nation
  - Themes repeated, including offensive ones
  - Now hit records more important than being a great MC
  - All becomes dance music, less message and centered

Sounds scam: 70% paying audience is white, suburban youth
Originator credit usually goes to Clive Campbell, aka DJ Kool Herc (turn table scratching and MCs, 1973: lots of community settings)

Sugar Hill Gang became an overnight sensation

Run DMC
  - Was middle class
  - Looked “street”
  - Everything was for sale, even Adidas, their shoe choice

Russel Simmons and Run DMC (producer) - brothers

Run, LL Cool J, Public Enemy- also suburban, extended the style and lyrical content, maybe because they had more distance from “inner city chaos”

Public Enemy
  - became “prophets of rage”
  - most political- compare with Huey Lewis and Jon Bon Jovi in pop
  - controversy was calling Farrakhan a prophet

At the time, KRS says it was “…50% glamorizing of thug life and 50% was to bring light to thug life with some possible solutions”

LL Cool J
  - part of early challenge of East and West coast “gangstas”: Biggie and TuPac, Nas and Jay-Z, 50 Cent and JaRule, etc.

Salt-n-Pepa: first girls to make it

NY- East Coast scene thrived, then NWA’s “Straight Out of Compton” more decadent

NWA
  - led by Ice Cube and Dr. Dre

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- exalted gang life- from street violence to denigration of women
- F the Police
- use of “n word”
- was groundbreaking in that it identified political dissatisfaction with paramilitary policing in ghettos and high incarceration rates before media and leaders did

IceT got tough with Original Gangster in Cop Killer, today plays a cop on Law and Order

Snoop Dogg next big star: Doggystyle was 1st ever debut to hit charts as #1, now a pee wee football coach

TuPac
- born in jail
- Son of a Black Panther
- Hit with 2pacalypse Now
- Dan Quayle, then VP, said it (i.e, the hit album) “has no place in society”

TuPac and Biggie Smalls (aka Notorious B.I.G.)
West Coast   East Coast
- Biggie aligned with Sean Combs who made him focus on his new Bad Boy Label
- Biggie’s career troubled (although Mary J. Blige featured him in some of her singles)
- TuPac song “Hit ‘Em Up” claimed to have slept with Faith Evans, Biggie’s wife
- September, 1996: TuPac shot and killed exiting Mike Tyson fight in Las Vegas.
- 6 months later, Biggie drive by; thought to be retaliation for TuPac
- 6 months later, Combs produced his own solo debut No Way Out

“Gangsta thing bec. a pose” Nelson George, Hip Hop America

Wu Tang Clan
- NY
- Popular in the ‘90s

Next 2 big east coast MC’s to step into Biggie/TuPac void:

DMX
- Gangsta style
- Spiritual
- Complexity of guilt and remorse

Jay-Z
- Reasonable Doubt, Blueprint, The Black Album
- Rapper, entrepreneur, freestyler: “I dumbed down for my audience, doubled my dollars”

Nas
- A worthy rival
- wordy street poet
- had classical debut as well in 1994 Illmatic
- struck back at Jay- on Stillmatic followed by God’s Son

Nelson George
music was about crack in neighborhoods. Didn’t create it/reacted to it

Diversity in Rap:
“i’m tired of people judging what’s real hip-hop/half the time, it be some [n_____s] whose album flopped” … Nelly
St. Louis is home to Nelly and the St. Lunatics

Don’t forget: Ludacris and “What’s Your Fantasy?” and “Stand Up”

Chingy “Right Thurr” “Howdee Inn”

Lil Jon and the East Side Boyz and crunk: call and response party rap like “Get Lois” with the Ying Yang twins

Outkast: the biggest rap, rock, soul

Southern Funk, Parliament and Prince

Big Boi and Andre 3000

Females:
- Little Lace
- Sweet and Sour
- Lady B
- Salt N Pepa
- MC Lyte
- Queen Latifah: sick of women being called “hos and bitches”
- Mary J. Blige (not a rapper) “What’s the 4-1-1ys”
- Lil Kim (assoc. with Biggie’s associated Jr. M.A.F.I.A.)
- Lauryn Hill- more sophisticated
- Missy Elliott

Crossovers: Kid Rock, Rage Against the Machine, Limp Bizkit, Cypress Hill

MC Hammer
- pop potential/folly
- no need for “clean” re-writes

Will Smith
- bubble gum rap like “Parents Just Don’t Understand”
- TV/film career

Native Tongues movement: positive, spiritual side of hip-hop

Signing on to Native Tongues: Brand Nudian- so Afrocentric, branded as nevuese racist

The Fugees
- Socially conscious side of hip-hop

Lauryn Hill: 5 Grammys as solo in 1999

Common, Mos Def, Talib Kweli, Black Eyed Peas “Where is the Love?” – more political

Eminem- Dr. Dre heard him and said find him “Slim Shady LiP” and “The M.M.L.P”
- Violence, homophobia, misogyny proliferated

50 Cent stabbed/shot:became back story “Get Rich or Die Trying” album produced by Eminem

Said by some to push black people into offensive stereotypes in P.I.M.P.
Religious Adherents as a Percentage of World Population in 2000

- Christians: 33%
- Muslims: 19.6%
- Hindus: 13.4%
- Non-Religious: 12.7%
- Chinese Folk: 6.4%
- Buddhists: 5.9%
- Ethno Religionists: 3.8%
- Atheists: 2.5%
- New Religionists: 1.7%
- Sikhs: 0.4%
- Jews: 0.2%
- Others: 0.4%

Source: http://www.adherents.com/rel_USA.html
SPORTS MOVIES FOR INTERVENTION PLANNING

For all, preview, check content for age and decide in advance exactly what you will teach. Write your outcomes and unmet needs down and think strategically about when you will stop the tape and how you will illustrate, elicit and interact around the film.

| **Baseball** | The Natural  PG  
|             | Bull Durham  R  
|             | The Sandlot  PG  
|             | A League of Their Own  PG  
|             | Angels in the Outfield  Not Rated  
|             | Rookie of the Year  PG  
|             | Pride of the Yankees  Not Rated  
|             | Major League & Major League 2  R  
|             | The Rookie  G  
|             | Little Big League  PG  
|             | For Love of the Game  PG-13  
|             | Field of Dreams  PG  |

| **Basketball** | Hoosiers  PG  
|                | The Air Up There  PG  
|                | One on One  PG  
|                | Hoop Dreams  PG-13  
|                | Blue Chips  PG-13  
|                | Love & Basketball  PG-13  
|                | Space Jam  PG  
|                | Like Mike  PG  |

| **Football** | The Replacements  PG-13  
|              | Brian’s Song (2 versions)  G  
|              | Remember the Titans  PG  
|              | Rudy  PG  
|              | Varsity Blues  R  
|              | The Longest Yard  (2 versions) 2005: PG-13, 1974: R  
|              | Any Given Sunday  R  
|              | Bad News Bears  PG-13  |

| **Hockey** | The Mighty Ducks Series  PG  
|           | Miracle  PG  |

| **Soccer** | Kicking and Screaming  PG  
|           | Ladybugs  PG-13  
|           | Bend It Like Beckham  PG-13  |

| **Cycling** | Breaking Away  PG  
|            | American Flyers  PG-13  |

| **Boxing** | Rocky- The Series  PG  
|           | Ali  R  
|           | Raging Bull  R  
|           | Million Dollar Baby  PG-13  
|           | Cinderella Man  PG-13  |

| **Golf** | Tin Cup  R  
|          | Happy Gilmore  PG-13  |

| **Figure Skating** | Ice Castles  PG  
|                   | The Cutting Edge  PG  |

41 www.imdb.com
SONG LYRICS
"Who Says You Can't Go Home"
Sung by Bon Jovi with Jennifer Nettles
Written by Jon Bon Jovi and Richie Sambora, 2005

I spent 20 years trying to get out of this place
I was looking for something I couldn't replace
I was running away from the only thing I've ever known
Like a blind dog without a bone
I was a gypsy lost in the twilight zone
I hijacked a rainbow and crashed into a pot of gold
I been there, done that and I ain't lookin' back on the seeds I've sown,
Saving dimes, spending too much time on the telephone
Who says you can't go home

[Chorus]
Who says you can't go home
There's only one place they call me one of their own
Just a hometown boy, born a rolling stone, who says you can't go home
Who says you can't go back, been all around the world and as a matter of fact
There's only one place left I want to go, who says you can't go home
It's alright, it's alright, it's alright, it's alright, its alright

I went as far as I could, I tried to find a new face
There isn't one of these lines that I would erase
I lived a million miles of memories on that road
With every step I take I know that I'm not alone
You take the home from the boy, but not the boy from his home
These are my streets, the only life I've ever known,
who says you can't go home

[Chorus]

I been there, done that and I ain't looking back
It's been a long long road
Feels like I never left, that's how the story goes

It doesn't matter where you are, it doesn't matter where you go
If it's a million miles aways or just a mile up the road
Take it in, take it with you when you go,
who says you can't go home

[Chorus]

It's alright, it's alright, it's alright, it's alright, its alright
Who says you can't go home [x2]
Research Activities for Supervisors

Faith
- Research a faith not your own and present it.
  - Code/s of conduct
  - A hero/leader
  - A teaching story
- Read a sacred text revered by members of a faith not your own
  - At least 25 pages
  - Organized notes to share and discuss

Cultural Icons
- Choose a famous person and learn what that person’s life could teach a person

Music
- Research song lyrics at Lyrics.com or elsewhere
  - Choose a lyric and use it therapeutically

Homelands
- Research a country from which someone you work with comes
  - Holidays and customs
  - Government

Film
- Choose one and detail how it can be used therapeutically

Games
- Research popular games of any kind and plan how to use them therapeutically

Heroes
- Research a hero you don’t know, real or fictional, and summarize his/her important actions, character and decisions

Sports
- Research a sport you don’t know well
  - How it works
  - Famous participants
Treatment or Service Planning: Outcomes, Needs & Strategies

Families and consumers participate in programs and interventions because they want things to be different. Nobody reaches out to professional helpers because they are happy with the way things are. Therefore, the most important aspect of treatment or service planning is the specific definition of changes to be achieved through treatment or services. These changes are often referred to as outcomes.

Outcomes are results. Outcome statements define results and how progress on them will be measured. Everything else in the intervention or change process is directed by outcomes: what is funded, what staff do, agency policy, etc.

One of the central assumptions of Family and Person Centered Practice is that consumers and families are often not able to achieve outcomes that are important to them and their communities because their needs are not met. When a person’s – child or adult – needs aren’t met, outcomes related to those needs will not be achieved.

In Family and Person Centered Practice, and other similar practice models, life domain areas are used to ensure comprehensive planning. Participants in Family and Person Centered Practice are asked to select which life domain areas represent their priority outcomes. Life domain areas are areas in which people want to change the way things are (the outcomes) and in which they have needs that are unmet, to one degree or another, everyday of our lives. For purposes of treatment or service planning, life domains function as a checklist to prompt consumers and families to consider all the areas in which they seek changes (outcomes). The life domain areas that are used most frequently follow (although many others are used as well, depending on the specific circumstances that trigger treatment or service planning):

- Safety
- Family
- Health
- Culture
- Psychological/Emotional
- Education
- Work
- Spirituality
- Social
- Behavior
- Legal

The next important aspect of treatment or service planning in Family and Person Centered Practice is the clear statement of the above referenced needs. Everybody has unmet needs. Governments and tax payers are not in the business of meeting everybody’s unmet needs. When individuals have disabilities or when they are dealing with stressful life events, they are or may be eligible for professional assistance. In Family and Person Centered Practice, the
assistance that begins with the definition of important outcomes next focuses on the unmet needs that impede the achievement of those defined, priority outcomes.

Many human service professionals are both trained in and accustomed to thinking in terms of services rather than needs. A service statement might be “She needs therapy” or “He needs foster care.” This type of thinking, while convenient and much in evidence in other practice models, impedes creativity and specificity in Family and Person Centered Practice. The two service statements above lead immediately to yes and no responses. Further, the responses are often determined by what is available regardless of how well or poorly the available services match the actual needs.

In Family and Person Centered Practice, the statement “She needs therapy” is replaced by a more descriptive one: “She needs someone to whom she can reveal her most intimate thoughts and fears without worrying about judgment, gossip or reprisal. She also needs a listener who will use his/her own insight and experiences to help her process them in ways that allow her to live a safer, more successful life.” This needs statement may trigger a referral to therapy but it may also occasion increased opportunities to talk to her best friend, Grandpa or faith leader. It allows more choices than a simple yes or no while not eliminating the service – therapy – described in the previous service statement.

“He needs foster care” is equally restrictive. If it is altered or translated, more choices become available: “he needs a safe place to live outside of his current home where he will be nurtured, protected and supervised. He needs a structured schedule overseen by one or more benign authority figures to ensure that he engages in needed, age appropriate activities.” The choice of foster care is still available, but with this more specific statement, so is a stay with a relative, close family friend, mentor, favorite teacher, scout leader and so on.

Once the needs that relate to the achievement of the defined outcomes are clearly stated, strategies are the next priority for treatment or service planning in Family and Person Centered Practice. The idea is that strategies meet the unmet needs, which when met, allow the person to achieve the outcomes.

The design, selection and implementation of strength-based strategies is a hallmark of Family and Person Centered Practice. The reasoning behind this practice is forthright and clear: strategies based on people’s values, faith, positive characteristics and treasured relationships “fit” them. When the strategies fit, implementation is less of a struggle even when circumstances are complex. Family and Person Centered Practice is based firmly on the notion that one size never really did fit all and never will.

Supervisors have to remember that while strength-based strategies are important in Family and Person Centered Practice, not every strategy can be or should be
strength-based. Sometimes there are practical strategies like getting someone bus vouchers to get to therapeutic contacts or a list of food pantries in the area. Some supervisors add a place to indicate these types of strategies on the plan. They should also encourage staff to make even these strategies strength-based by having a relative or friend provide the transportation and getting the food from a faith organization.
The following examples will clarify the use of Outcomes, Needs and Strategies in treatment planning for Family and Person Centered Practice.

### Life Domains, Outcomes, Needs and Strategies

<table>
<thead>
<tr>
<th>Life Domain Areas</th>
<th>Outcome Statements</th>
<th>Needs</th>
<th>Strength-Based Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help people remember all of the different parts of their lives, so that they don’t leave anything out of the picture, like:</td>
<td>Help people picture how they want things to be, like:</td>
<td>Are barriers to achieving Outcomes, like:</td>
<td>Are strength-based actions taken to achieve specific results by meeting Needs, like:</td>
</tr>
<tr>
<td>Emotional</td>
<td>- To be less depressed</td>
<td>- Having someone listen to you</td>
<td>- A phone card to call your best friend when you absolutely have to talk to someone you trust</td>
</tr>
<tr>
<td>Safety</td>
<td>- Keep yourself safe</td>
<td>- Learn how to be safe</td>
<td>- Someone to give you “safety lessons” that match you, your risks, your strengths (i.e., she always calms down when she prays)</td>
</tr>
<tr>
<td>Legal</td>
<td>- Completes probation</td>
<td>- Controlling your temper</td>
<td>- Make a CD featuring your most engrossing, distracting tunes, to listen to when you are angry</td>
</tr>
<tr>
<td>Family/Safety</td>
<td>- To have enough food</td>
<td>- Free food</td>
<td>- Bus vouchers and a Food Pantry list (not strength-based)</td>
</tr>
</tbody>
</table>
Sample Outcome Statements\textsuperscript{42}

\textbf{Jamie}

Jamie, age 15, has schizophrenia and bipolar disorder. She struggles with delusions that frighten her and cause her to act in ways that alienate others. She is lonely and longs to connect with people but she believes that the people she knows are stalking her and hurting her. Her constant accusations against them isolate her further.

\textbf{Life Domain:} Psychological/Emotional

\textbf{Outcomes:}
1. Jamie will be able to control her troubling thoughts and emotions.
2. Jamie will report that she is happier, safer, and more in control of herself.
3. Jamie will connect with others in satisfying ways at least 3 times a week.

\textbf{Measurement:}
Verbal report at planned intervals\textsuperscript{43}, no police contact, schedule submitted by Jamie

\textbf{Shawn}

Shawn, age 16, was arrested after he badly beat up Erin, his girlfriend, age 14. Investigation revealed that he has also repeatedly assaulted his mother, resulting in three ER visits during which she required medical treatment for a broken nose (twice), a broken wrist, a concussion and extensive rug burns from being dragged. A single mom, she is too afraid of her son to press charges against him because of his ongoing threats. Shawn’s dad is in prison for armed robbery and battery. They’ve met several times but have no relationship. Shawn blames his mom for his Dad’s incarceration, although nobody knows why. Shawn is using alcohol and who knows what else. At school, he has been suspended for bullying, terroristic threats and defying adult authority. Because of the seriousness of his criminal behavior, the court ordered him to spend up to a year at a corrections/residential treatment program.

\textbf{Life Domain:} Legal/Behavior/Safety

\textbf{Outcomes:}
1. Shawn will not threaten to harm or harm anyone.

\textbf{Measurement:} Completion of his corrections/residential treatment program in good standing. Eligibility for release; Critical incident reports.

\textbf{Note:} Before Shawn returns home, another plan will be developed that specifically addresses safety issues in his home, school and community and how he will develop

\textsuperscript{42} Brenda Finlayson and David Derbyshire, Peel Children’s Centre, Peel Wraparound Process, Peel, Ontario. 1999.

\textsuperscript{43} Mike Epstein, Ph.D., Barkley Memorial Center, University of Nebraska, Lincoln, Nebraska
relationships that will support him in keeping his activities safe and legal. His probation will be continued for at least a year post-release. This plan will be developed as early as possible in his placement so that community resources will be in place back home when he needs them.

Tammy
Tammy, age 31, lost custody of her daughters Kim, age 13 and Karlie, age 10, for neglect, caused by her abuse of and addiction to crack cocaine. The girls were placed in a series of foster homes until Kim got into a fight at school and was sent to a group home. From there, she ended up in a training school for girls after assaulting a staff member. Tammy has completed drug and alcohol treatment and has about 2 ½ months clean time. Her recovery appears “shaky,” particularly because she is back in her own place, minutes away from her dealer and drug-using friends. She says “the rock keeps singing to me” and “it’s tough to say no”.

Life Domain: Health/Safety/Family

Outcomes:
1. Tammy will remain clean and sober.
2. Tammy will regain custody of her daughters.

Measurement:
Random urinalyses, girls living with Tammy

Tom
Tom, age 41, is a stressed out, single parent who has a tough time managing his temper effectively. When his son, Jonathan, misbehaves, he loses control and strikes him. Tom was reported for abusing Jonathan when the boy’s teacher noticed a pattern of new bruises every Monday, for which Jonathan’s explanations were inadequate. Child protective services investigated and it was determined that Tom was disciplining his son in unsafe ways.

Life Domain: Safety

Outcomes:
1. Tom will keep Jonathan safe by using only non-physical discipline.
2. Tom will remove himself from situations when he loses control.
3. Tom will successfully complete involvement with protective services.
Betty
Betty, age 36, has three children and has depended on public assistance since the birth of her eldest child. Aside from several part time jobs she had when she was in high school, she has never worked outside the home. Welfare reform has intruded on her expectations to continue as she began, as the pressure to work increases and laws that limit her eligibility define her changed reality.

Life Domain: Work

Outcomes:
1. Betty will find and secure at least 20 hours of work each week that puts her in contact with the public and allows her to eventually earn a net salary of at least $X/month and eventually qualify for needed or extended medical benefits.

Measurement:
Time cards, verbal report at planned intervals and salary/benefit analysis, also at planned intervals.

Max
Max, age 42, has a developmental disability and generalized anxiety disorder. He lives with his mother, age 70, who is his social security payee and who would like to be his legal guardian. Max’s current guardian is his dad, age 68, who has been divorced from his mom for 12 years. In this bitter divorce, Max is the number one issue between his parents. In accordance with his mom’s background and preferences, Max is Catholic. He is also gay and very interested in having a sex life that suits his orientation. Max’s dad is okay with that but his mom considers same sex contact a mortal sin. Max’s mom has made every effort to limit his sexual contact, but Max actively resists her efforts. He approaches people to whom he is attracted at the mall, at the post office, at the park and elsewhere. When his efforts are declined, Max goes ballistic and acts out enough to risk arrest.

Life Domain: Safety/Family

Outcome:
1. Max will have safe (i.e., no STDs, no arrests, no assaults, no rape allegations) sexual expression that he finds timely, sufficient and appropriate.

Measurement:
Incident reports, Max’s verbal report, arrest records.
Outcomes and Needs

Jamie

Jamie, age 15, has schizophrenia and bipolar disorder. She struggles with delusions that frighten her and cause her to act in ways that alienate others. She is lonely and longs to connect with people but she believes that the people she knows are stalking her and hurting her. Her constant accusations against them isolate her further.

Outcomes:
1. Jamie will be able to control her troubling thoughts and emotions.
2. Jamie will report that she is happier, safer, and more in control of herself.
3. Jamie will connect with others in satisfying ways at least 3 times a week.

Measurement:
Verbal report at planned intervals, no police contact, schedule submitted by Jamie

Possible Needs:
- Effective ways to stop troubling thoughts
- Effective ways to control troubling emotions
- People who are potential candidates for companionship
- Ways to approach potential companions that are likely to result in shared activities
- Activities to share and participate in
- Logistics of shared activities: cost, transportation, etc.
- A system to decide who is stalking her or likely to hurt her and who isn’t

Shawn

Shawn, age 16, was arrested after he badly beat up Erin, his girlfriend, age 14. Investigation revealed that he has also repeatedly assaulted his mother, resulting in three ER visits during which she required medical treatment for a broken nose (twice), a broken wrist, a concussion and extensive rug burns from being dragged. A single mom, she is too afraid of her son to press charges against him because of his ongoing threats. Shawn’s dad is in prison for armed robbery and battery. They’ve met several times but have no relationship. Shawn blames his mom for his dad’s incarceration, although nobody knows why. Shawn is using alcohol and who knows what else. At school, he has been suspended for bullying, terrorist threats and defying adult authority. Because of the seriousness of his criminal behavior, the court ordered him to spend up to a year at a corrections/residential treatment program.

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44 Mike Epstein, Ph.D., Barkley Memorial Center, Lincoln, Nebraska
Outcomes:
1. Shawn will not threaten to harm or harm anyone.

Measurement: Completion of his corrections/residential treatment program in good standing. Eligibility for release; Critical incident reports.

Note: Before Shawn returns home, another plan will be developed that specifically addresses safety issues in his home, school and community and how he will develop relationships that will support him in keeping his activities safe and legal. His probation will be continued for at least a year post-release. This plan will be developed as early as possible in his placement so that community resources will be in place back home when he needs them.

Possible Needs:
- A moral/ethical code that guides him away from violence and illegal activities.
- Anger and frustration management strategies
- A plan to get himself out of situations that trigger frustration and anger
- To verbalize his feelings without acting out against others

Tammy

Tammy, age 31, lost custody of her daughters Kim, age 13 and Karlie, age 10, for neglect, caused by her abuse of and addiction to crack cocaine. The girls were placed in a series of foster homes until Kim got into a fight at school and was sent to a group home. From there, she ended up in a training school for girls after assaulting a staff member. Tammy has completed drug and alcohol treatment and has about 2 ½ months clean time. Her recovery appears “shaky,” particularly because she is back in her own place, minutes away from her dealer and drug-using friends. She says “the rock keeps singing to me” and “it’s tough to say no.”

Outcomes:
1. Tammy will remain clean and sober.
2. Tammy will regain custody of her daughters.

Measurement:
Random urinalyses, girls living with Tammy
Possible Needs:
- A way to successfully “sing back” to crack cocaine
- Alternate things to do when she feels like using
- To remain connected to her daughters as she starts a new life for her and for them
**Tom**

Tom, age 41, is a stressed out, single parent who has a tough time managing his temper effectively. When his son, Jonathan, misbehaves, he loses control and strikes him. Tom was reported for abusing Jonathan when the boy’s teacher noticed a pattern of new bruises every Monday, for which Jonathan’s explanations were inadequate. Child protective services investigated and it was determined that Tom was disciplining his son in unsafe ways.

**Outcomes:**
1. Tom will keep Jonathan safe by using only non-physical discipline.
2. Tom will remove himself from situations when he loses control.
3. Tom will successfully complete involvement with Protective Services.

**Measurement:**
Child protective services closes Tom’s case, no new bruises or marks on Jonathan

**Possible Needs:**
- Anger management strategies
- Effective ways to deal with stress
- Non-physical discipline methods
- A place/protocol for separating himself from his son safely
- A clear understanding of what is required to successfully complete protective services involvement

**Betty**

Betty, age 36, has three children and has depended on public assistance since the birth of her eldest child. Aside from several part time jobs she had when she was in high school, she has never worked outside the home. Welfare reform has intruded on her expectations to continue as she began, as the pressure to work increases and laws that limit her eligibility define her changed reality.

**Outcomes:**
1. Betty will find and secure at least 20 hours of work each week that puts her in contact with the public and allows her to eventually earn a net salary of at least $X/month and eventually qualify for needed or extended medical benefits.

**Measurement:**
Time cards, verbal report at planned intervals, salary/benefit analysis, also at planned intervals.
Possible Needs:
- A resume
- Skills related to completing job applications and interviews
- Improved self esteem
- Reliable transportation
- Child care
- Work clothes
- Job skills
- Education

Max
Max, age 42, has a developmental disability and generalized anxiety disorder. He lives with his mother, age 70, who is his social security payee and who would like to be his legal guardian. Max’s current guardian is his dad, age 68, who has been divorced from his mom for 12 years. In this bitter divorce, Max is the number one issue between his parents. In accordance with his mom’s background and preferences, Max is Catholic. He is also gay and very interested in having a sex life that suits his orientation. Max’s dad is okay with that but his mom considers same sex contact a mortal sin. Max’s mom has made every effort to limit his sexual contact, but Max actively resists her efforts. He approaches people to whom he is attracted at the mall, at the post office, at the park and elsewhere. When his efforts are declined, Max goes ballistic and acts out enough to risk arrest.

Outcome:
1. Max will have safe (i.e., no STDs, no arrests, no assaults, no rape allegations) sexual expression that he finds timely, sufficient and appropriate.

Measurement:
Incident reports, Max’s verbal report, arrest records.

Possible Needs: Max
- Potential romantic/sexual partners
- "Gay-dar," i.e., ways to figure out or ascertain who is and who isn’t also gay and possibly interested in companionship
- Safe approach strategies that are more likely than not to lead to a social connection
- Information about sexual safety

Possible Needs: Max’s Mom
- To be realistic about her son’s reality, most cherished hopes and current behavior
- Support to allow her son to be himself.
Strength-Based Strategies:

Jamie
Strengths:
Jamie can do just about anything with a computer and loves visiting a wide variety of websites, especially political sites. She’s been interested in history and governments all over the world since she was little. Reflecting her Jewish faith, Jamie attends synagogue and likes her Rabbi a lot. She can draw well and enjoys all sorts of craft activities. Jamie also enjoys movies and her current favorites are The Lord Of The Rings Trilogy\(^{45}\), Bend It Like Beckham\(^{46}\), Saving Private Ryan\(^{47}\) and The Patriot\(^{48}\). She also likes pop music, especially anything by Matchbox 20.

Situation:
Jamie, age 15, has schizophrenia and bipolar disorder. She struggles with delusions that frighten her and cause her to act in ways that alienate others. She is lonely and longs to connect with people but she believes that the people she knows are stalking her and hurting her. Her constant accusations against them isolate her further.

Life Domain: Psychological/Emotional

Outcomes:
1. Jamie will be able to control her troubling thoughts and emotions.
2. Jamie will report that she is happier, safer, and more in control of herself.
3. Jamie will connect with others in satisfying ways at least 3 times a week.

Measurement:
Verbal report at planned intervals\(^{49}\), no police contact, schedule submitted by Jamie

<table>
<thead>
<tr>
<th>Needs</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Effective ways to stop troubling thoughts and to control troubling emotions</td>
<td>• With help from a volunteer from the League of Women Voters, Jamie will research (online) successful and unsuccessful political candidates, how they managed their thoughts and emotions and with what results</td>
</tr>
<tr>
<td></td>
<td>• With help from a retired internist identified by her Rabbi, Jamie will interview several psychiatrists and</td>
</tr>
</tbody>
</table>

\(^{45}\) The Lord Of The Rings, Film Trilogy, Dir. Peter Jackson, with Ian McKellan, Viggo Mortensen, Elijah Wood, et. al., New Line Cinema, 2001 - 2003  
\(^{46}\) Bend It Like Beckham, Film, Dir. Gurinder Chadha, with Keira Knightly, Parminder Nagra, et. al., 20th Century Fox, 2002  
\(^{47}\) Saving Private Ryan, Film, Dir. Maxn Spielberg, with Tom Hanks, Matt Damon, Edward Burns, et. al., DreamWorks, 1998  
\(^{48}\) The Patriot, Film, Dir. Roland Emmerich, with Mel Gibson, Heath Ledger, et. al., Columbia/TriStar, 2000  
\(^{49}\) Mike Epstein, Ph.D., Barkley Memorial Center, Lincoln, Nebraska
• People who might be candidates for companionship

choose the doctor with whom she feels most comfortable.
• After her own online research, Jamie will keep an online medication journal and meet weekly with a nurse practitioner to review her medication, determine how well or poorly it’s working and learn how to deal with any side effects that make her uncomfortable.
• Jamie will talk with her Rabbi, learn of potential friends in the congregation and be introduced to them.
• With help from family members, Jamie will watch her favorite movies, listen to favorite songs, like “Unwell” and analyze the friendships and feelings in each.
• Jamie will make a form and divide movie characters into the following categories: Potential Friend, No Way Friend, Maybe Friend and Why/Why not. She’ll review these charts with either her nurse practitioner or a therapist, selected like her doctor

Shawn
Strengths: Shawn is extremely coordinated, physically fit and athletic. He’s interested mainly in boxing, but plays baseball, football and basketball quite well. He has been fascinated with the military since he was little. Shawn watched the “Shock and Awe” campaign in Operation Iraqi Freedom and gets pretty passionate about military movies, especially Black Hawk Down, Jarhead and We Were Soldiers. His heroes are Special Forces troops, the Rangers and the SEALS. The only person Shawn likes at school is the vice principal, a former marine, who is all too often the person he sees when he gets into trouble.

Situation: Shawn, age 16, was arrested after he badly beat up Erin, his girlfriend, age 14. Investigation revealed that he has also repeatedly assaulted his mother, resulting in three ER visits during which she required medical treatment for a broken nose (twice), a broken wrist, a concussion and extensive rug burns from being dragged. A single mom, she is too afraid of her son to press charges against him because of his ongoing threats. Shawn’s dad is in prison for armed robbery and battery. They’ve met several times but have no relationship. Shawn blames his mom for his dad’s incarceration, although nobody knows why. Shawn is using alcohol and who knows what else. At school, he has been suspended for bullying, terrorist threats and defying adult authority. Because of the seriousness of his criminal behavior, the court ordered him to spend up to a year at a corrections/residential treatment program.

50 “Unwell” by Matchbox 20, Album: More Than You Think You Are, 2002
**Life Domain:** Legal/Behavior/Safety

**Outcomes:**
1. Shawn will not threaten to harm or harm anyone.

**Measurement:** Completion of his corrections/residential treatment program in good standing. Eligibility for release; Critical incident reports.

Note: Before Shawn returns home, another plan will be developed that specifically addresses safety issues in his home, school and community and how he will develop relationships that will support him in keeping his activities safe and legal. His probation will be continued for at least a year post-release. This plan will be developed as early as possible in his placement so that community resources will be in place back home when he needs them.

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<thead>
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<th>Needs</th>
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<tr>
<td>• A moral/ethical code that guides him away from violence and illegal activities.</td>
<td>• Shawn, with staff assistance at his Residential Treatment Center, will research the codes of conduct in place at the Citadel, West Point, Annapolis, etc. for cadets and future officers and adapt them as his own</td>
</tr>
<tr>
<td>• Anger and frustration management strategies</td>
<td>• With assistance from the teachers at the residential treatment center/corrections program, Shawn will watch his three favorite movies Blackhawk Down, Jarhead and We Were Soldiers and add any insights and ideas they give him to his developing moral/ethical code.</td>
</tr>
<tr>
<td>• A plan to get himself out of situations that trigger frustration and anger</td>
<td>• With therapeutic assistance, Shawn will triage frustrating and angry feelings as mild, medium and severe and for each level, implement an appropriate level of physical exercise</td>
</tr>
<tr>
<td>• To verbalize his feelings without acting out against others</td>
<td>• Shawn will study the careers of Mike Tyson, Rubin “Hurricane” Carter, Mohammed Ali, Oscar De La Hoya and others to decide how well or poorly each athlete got himself out of bad, potentially life-altering situations and consequences.</td>
</tr>
<tr>
<td></td>
<td>• With staff supervision, Shawn will email the vice principal at his home school three times a week about what he feels, how he feels like acting and how he thinks he should act instead, with the support of the vice principal via emailed responses.</td>
</tr>
</tbody>
</table>
Tammy

Strengths:
Tammy’s hero is her mother, who passed away a couple of years ago but who is still frequently in her thoughts. They played the piano together when Tammy was a little girl, her favorite and most comforting memory. She also fondly recalls her mom storming bravely into crack houses, dragging her out and getting her into treatment. When she feels like using, Tammy reads the Book of Daniel and sings along with Gospel tapes. When nothing else works, she meditates.

Situation:
Tammy, age 31, lost custody of her daughters Kim, age 13 and Karlie, age 10, for neglect, caused by her abuse of and addiction to crack cocaine. The girls were placed in a series of foster homes until Kim got into a fight at school and was sent to a group home. From there, she ended up in a training school for girls after assaulting a staff member. Tammy has completed drug and alcohol treatment and has about 2½ months clean time. Her recovery appears “shaky,” particularly because she is back in her own place, minutes away from her dealer and drug-using friends. She says “the rock keeps singing to me” and “it’s tough to say no”.

Life Domain: Health/Safety/Family

Outcomes:
1. Tammy will remain clean and sober.
2. Tammy will regain custody of her daughters.

Measurement:
Random urinalyses, girls living with Tammy

NOTE: Tammy, in addition to participating in Wraparound, is required to find a sponsor, attend 90 Narcotics Anonymous meetings in 90 days with signed slips proving that she attended and submit to random urinalyses.

<table>
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<tr>
<td>• A way to successfully “sing back” to crack cocaine</td>
<td>• Tammy will take piano lessons with a volunteer teacher who has more than three years clean time, using a keyboard rented at a discount.</td>
</tr>
<tr>
<td>• Alternate things to do when she feels like using</td>
<td>• Tammy’s favorite quotes from the Book of Daniel will be printed on one side of little laminated cards made for her use, with her mom’s name on the other side along with the words “Think about it.” She’ll carry one or several in her pocket and will read them when she needs to.</td>
</tr>
</tbody>
</table>
To remain connected to her daughters as she starts a new life for her and for them  
Three copies of Just For Today recovery meditation books will be purchased, one each for Tammy, Kim and Karlie. They will all work on the same meditation every day and share what they learn with each other via letters and visits.

Tom

Strengths:
Tom is a former athlete (always liked to work out when he was younger) and a huge sports fan, especially professional football. He likes baseball too but only “live,” not on TV. A follower of Dale Earnhardt, he likes NASCAR and has switched his loyalty to Dale Earnhardt Jr, since his dad passed away. Tom also likes country western music, especially Toby Keith, Alan Jackson and Willie Nelson. When he has a chance, he also likes to watch Poker on TV.

Situation:
Tom, age 41, is a stressed out, single parent who has a tough time managing his temper effectively. When his son, Jonathan, misbehaves, he loses control and strikes him. Tom was reported for abusing Jonathan when the boy’s teacher noticed a pattern of new bruises every Monday, for which Jonathan’s explanations were inadequate. Child protective services investigated and it was determined that Tom was disciplining his son in unsafe ways.

Life Domain: Safety

Outcomes:
1. Tom will keep Jonathan safe by using only non-physical discipline.
2. Tom will remove himself from situations when he loses control.
3. Tom will successfully complete involvement with protective services.

Measurement:
Child protective services closes Tom’s case, no new bruises or marks on Jonathan

<table>
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</thead>
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<tr>
<td>• Effective anger management and stress reduction strategies</td>
<td>• With help from a protective services social worker, Tom will triage his anger – lots, medium, mild – and use NASCAR-like “flags” to remind him when to “cool his engine” in his room</td>
</tr>
<tr>
<td></td>
<td>• Tom will adjust his schedule, get someone to take care of his son(^{51}) and with a buddy, watch at least one sports</td>
</tr>
</tbody>
</table>

\(^{51}\) Kathy Carter, Protection and Safety Administrator, HHSS, Gering, Nebraska
A protocol for separating from his son safely

- Tom will join the local YMCA and work out several times a week.
- Tom will make and use a cassette tape or CD with his favorite music on it and/or videotaped TV Poker matches and use them to calm down (in his bedroom or in the cellar) when he feels like he’s escalating beyond his control.

Betty

Strengths:
Betty is a lifelong Christian who attends church 3 times a week. Every summer, she’s a volunteer instructor at vacation bible school where she is recognized as an informal authority on all matters biblical. She sings in the choir and can handle more secular music just as beautifully. Her favorite TV shows are The Today Show, American Idol and Extreme Makeover.

Situation:
Betty, age 36, has three children and has depended on public assistance since the birth of her eldest child. Aside from several part time jobs she had when she was in high school, she has never worked outside the home. Welfare reform has intruded on her expectations to continue as she began, as the pressure to work increases and laws that limit her eligibility define her changed reality.

Life Domain: Work

Outcomes:
1. Betty will find and secure at least 20 hours of work each week that puts her in contact with the public and allows her to eventually earn a net salary of at least $X/month and eventually qualify for needed or extended medical benefits.

Measurement:
Time cards, verbal report at planned intervals, salary/benefit analysis, also at planned intervals.

<table>
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</thead>
<tbody>
<tr>
<td>A resume</td>
<td>Betty’s Pastor will help her connect with people in the congregation who can help her design a resume and get it typed and printed for her.</td>
</tr>
<tr>
<td></td>
<td>With the help arranged above, Betty will list the personal qualities that make her a potential Working American Idol and the qualities and habits she has that are in need of an Extreme Makeover</td>
</tr>
</tbody>
</table>
• Skills related to completing job applications and interviews
• Improved self esteem

• With the help arranged above, Betty will critique interviews from her favorite TV shows and list effective and ineffective responses to questions.
• With her pastor’s help, Betty will review the women of the Bible and list strengths she shares with these brave women of faith

Max
Strengths:
Max likes studio wrestling, Superman, Batman and the X-Men (comics and movies). When he needs to relax, Scooby Doo almost always helps him, as does The Simpsons and SpongeBob SquarePants. He loves his mom and his dad and he would like to have them both be “on his side,” as he perceives it. He’s extremely adept with Legos and can make motorized vehicles and cranes and comprehensive towns, villages and entire cities. Max also likes the TV shows *Queer as Folk*, *Queer Eye for the Straight Guy* (although he isn’t allowed to watch them at his mom’s home). He also likes *Pokemon* and *Yugioh*.

Situation:
Max, age 42, has a developmental disability and generalized anxiety disorder. He lives with his mother, age 70, who is his social security payee and who would like to be his legal guardian. Max's current guardian is his dad, age 68, who has been divorced from his mom for 12 years. In this bitter divorce, Max is the number one issue between his parents. In accordance with his mom’s background and preferences, Max is Catholic. He is also gay and very interested in having a sex life that suits his orientation. Max’s dad is okay with that but his mom considers same sex contact a mortal sin. Max’s mom has made every effort to limit his sexual contact, but Max actively resists her efforts. He approaches people to whom he is attracted at the mall, at the post office, at the park and elsewhere. When his efforts are declined, Max goes ballistic and acts out enough to risk arrest.

Life Domain: Safety/Family/Sexuality

Outcome:
Max will have safe (i.e., no STDs, no arrests, no assaults, no rape allegations) sexual expression that he finds enjoyable, timely, sufficient and appropriate.

Measurement:
Incident reports, Max’s verbal report and arrest records.
### Max's Needs

- Potential friends and romantic/sexual partners
- “Gay-dar” (i.e., ways to figure out or ascertain who is and who isn’t also gay and possibly interested in companionship
- Safe approach strategies that are more likely than not to lead to a social connection
- Information about sexual safety

### Strength-Based Strategies

- Max will join the Lego club and look for people around his age for possible partnerships and/or friendship
- Max will watch *Queer as Folk* and *Queer Eye for the Straight Guy* with his dad and they will note signs that will help Max figure out who is gay and who is straight
- Max will watch and practice successful approach strategies from the above mentioned shows plus *Scooby Doo* (for friendship-related approach strategies)
- Max will, in his X-Men/superhero persona, delineate what is and isn’t safe (what is Kryptonite, etc.)
- Max will identify what weapons and attributes (i.e., like Yugioh, Pokemon and studio wrestling moves and strategies) he has to keep himself safe.

### Max’s Mom’s Needs

- To be realistic about her son’s reality, most cherished hopes and current behavior and support to allow her son to be himself.

### Strength-Based Strategies

- Max’s mom will talk to members of Dignity (gay Catholic spiritual organization) and PFLAG (Parents and Friends of Lesbians and Gays) to explore life as the mother of a gay son
Crisis Planning in Family and Person Centered Practice: An In Depth Look for Supervisors

Crisis

“…the turning point for better or worse…”

“…an emotionally significant or radical change of status in a person’s life…”

“…an unstable or crucial time…in which a decisive change is impending…”\(^52\)

Very few things can be guaranteed in Family and Person Centered Practice but one is inevitable: there will be crises. The crises will take many forms. They may be specifically related to transition; they may be related to compromises in the basic safety of the people involved. Still, they will occur and that simple fact should be central to treatment planning.

With that reality in mind, we have a choice: to plan for crisis events or to be surprised and unprepared for them. Clearly, the correct choice is to predict likely crises and prepare for them as much as possible.

The first issue for crisis planning is the recognition that crises that have occurred in the past may recur. It’s important for planners to review the history of the consumer and/or family at the center of the potential crisis. It’s even more important, when even remotely possible, to ask the person/s at the center of the potential crisis what has precipitated or caused crises in the past. History does in fact repeat itself and families and consumers are often more able than others to predict what crises may occur in the future.

Crises are often triggered by risky behavior and risky circumstances. Planning to change those behaviors and circumstances is sometimes key to appropriate crisis response and that’s a problem. This is simply because people are not very good at change. This applies to changes we choose and those we can’t. Ask anybody who has tried to change: diet, exercise, better financial decisions, a smoke free or a fat free lifestyle and all the rest. We aren’t stupid, just bad at change. That’s why we include the issue of change specifically in crisis planning.

Supervisors both take the lead and set the expectation for all types of crisis planning. Staff should be able to observe that planned crisis responses are a crucial part of treatment planning but more importantly, that they are intrinsic to the intervention process. They are required, not voluntary; they are essential, not added features like the options popular on DVDs.

Factors that determine if an event will become a crisis:
- Network of responsive support
- Coping skills
- Perceptions

According to crisis theorists, we are all walking around in the state of equilibrium, as exhibited in the diagram above. Certain events then occur that have the potential to become crises.

The most important thing to understand at this point is that events, in and of themselves, do not predict the development of crises. Instead, whether or not events become crises is best predicted by analyzing three factors: the existence of responsive support networks; the presence of situation specific coping skills and the degree to which crisis participants perceive the unfolding events as crises.

First among these variables is whether or not the person/s at the center of the potential crisis have a network of social and emotional support. The presence of such a network provides more than convenience to the crisis experience. It can provide real physical

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53 Neil Brown and Patricia L. Miles, Brown Miles Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
54 Neil Brown and Patricia L. Miles, Brown Miles Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
55 Neil Brown and Patricia L. Miles, Brown Miles Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present

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and emotional supports like help with child care, finances, food, friendship, prayer and problem solving.

For this to happen, the network has to be able to respond to the specific crisis circumstances at hand. This isn't always guaranteed. People who respond compassionately and helpfully to a loss, illness or disability may be unable to duplicate that response if the circumstances involve serious problem behavior, addiction or mental illness. The support network has to not simply be there, but be there to respond to whatever occurs. Otherwise, this preventative element is absent and events are therefore more likely to become crises because of that absence.

Coping skills also play a part in determining whether or not events become crises. Like support networks, coping skills are situation specific. People can easily have both lots of skills that apply well to certain situations and fewer – even none at all – that apply to other situations. The presence of coping skills that are helpful in the exact situation at hand for a person or family is a key determinant of whether or not a particular situation becomes a crisis.

Perception is the third major variable in crisis planning and response. When families and consumers believe that they're in crisis, it's best to act on that belief instead of trying to talk them out of it. That just pushes people to further argue that they are, in fact, in crisis. When this happens, their position "hardens" and backing off from it becomes difficult. Instead, crisis planners help the people in crisis to triage – or differentiate- different levels of crisis: severe, moderate and mild. This provides a way to develop proportional responses.

**Initial Crisis Planning**

The main missions for staff in crisis planning in Family and Person Centered Practice are to:

**Predict** possible crisis events based on history and information from the person, the family, and others who know them well.

**Protect** children, adults, kin and non-blood kin, neighbors, and anyone who could be at risk of harm of any sort.

**Plan** so that the risk from any type of crisis exposure is limited in frequency, duration, and intensity (proactive crisis planning).

**Prevent** the occurrence of possible crises by proactively addressing the unmet needs that trigger them (preventative crisis planning).
Reactive Crisis Plans

When the family or consumer is concerned that an event or chain of events will push a family/individual into crisis, staff in Family and Person Centered Practice plan how to react immediately and responsively to the event/s at hand.

Reactive Crisis Plans:
- Are practical and realistic.
- Capture how the people involved feel, what they value, and what they will actually do in distress.
- Include informal supports as much as possible.
- Keep everybody involved safe.
- Capitalize on positive relationships and/or help build them.

The need for a reactive crisis plan should always trigger proactive crisis planning.

Proactive Crisis Plans

When consumers or family members and those who assist them decide that a reactive crisis plan is needed, their next step is to develop a proactive crisis plan aimed at reducing the frequency, duration, and intensity of crisis events and, ultimately, the likelihood that the identified crises will occur. The main reason for designing proactive crisis plans is to eliminate the need for reactive crisis responses.

Proactive Crisis Plans:
- Prevent crises in many circumstances.
- Build on family/individual strengths to achieve enduring change.
- Focus on what to do instead of what not to do.
- Reflect a practical attitude about situations in which ongoing crises are likely to continue, despite intervention. (i.e., neurobiological mental illness, disability, lengthy history of recurring crises, etc.)

Crisis Planning: Tips for Supervisors in Family and Person Centered Practice

When risks are present, crisis plans are needed. If consumers and families decline them, that decision should be documented.

When a crisis seems likely because of history or when risks are potentially serious, supervisors must teach staff to recognize that and respond accordingly. If consumers and family members disagree or deny the risks and refuse to address them in crisis plans, staff should make sure to document both the suggestions and the refusal. The consumer or family should actually sign a statement – hand written if necessary – that
they have been advised to plan for likely crises and have declined to do so. Supervisors should make sure these documents are accurate, dated, signed and included in the record. They may also sign off on these refusals as evidence that they have appropriately monitored the activities of their staff.

Crisis plans are developed as early in the process as circumstances allow, with the caveat that they will be reviewed and fine tuned as they are implemented.

Supervisors must encourage staff to start the dialogue about potential crises as early as possible in their relationships with families and consumers. This is problematic in terms of the actual crisis plans but it represents an important precedent and an important expectation. It creates the expectation that crisis will be part of the intervention and that it will be addressed proactively. It also creates the expectation that reducing the severity, frequency or duration of the crisis is a top priority in Family and Person Centered Practice.

1. **Remember Murphy’s Law.**
   In case you don’t, it goes like this: Anything that can go wrong, will. It’s a better idea to plan for crises that don’t occur than it is to not consider those that do. This requires a thorough history and a relationship with the consumer or family at the center of the potential crises.

2. **Risks must be addressed cautiously and thoroughly.**
   Crisis planning is no time for unqualified optimism. Sober reflection on what has happened in the past and what is currently happening is more useful.

   Crisis planning is also not a one shot opportunity. Staff are likely to learn additional information about the consumers and families they serve as they get to know them better and develop relationships which allow for more thorough planning.

3. **“Those who cannot remember the past are condemned to repeat it.”**
   Mr. Santayana had the right idea here, even back in 1962. No wonder his book is named after both reason and common sense. Mr. François Marie Arovet Voltaire, a French philosopher from way further back, commented in 1764 in his *Dictionnaire Philosophique* that “Common sense is not so common.” The two quotes, together, sum up the rationales central to crisis planning.

4. **Triage crisis responses to help the family or consumer decide if each potential crisis is likely to be mild, moderate, or severe.**
   The word triage comes from the medical field. It refers to how medical personnel prioritize who they help first. While they seek to help all when many

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57 Neil Brown and Patricia L. Miles, *Brown Miles, Inc.*, Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
are in need, it makes sense to rank patients in terms of the immediacy and severity of their needs.

People tend to escalate to the severe levels of crisis easily. Crises involve uncomfortable events and feelings. The escalation is natural and should be anticipated. When crises are discussed during calmer moments, people are better able to sort them into categories. This activity is helpful because it prompts the kind of reflection that makes it possible to differentiate between levels of crisis. It’s more accurate and useful than behaving as though every uncomfortable event is a severe crisis.

5. **Build in concrete ways to determine whether or not the situation is improving in case “you can’t see the forest for the trees.”**

Some of the behaviors and events that comprise a crisis are extremely dangerous and unpleasant. It can be easy to panic, even when you don’t want to. But when a person cuts herself, for example, that particular behavior rarely stops all at once. Instead, cuts become gradually smaller, less lethal and require less medical intervention. Unless observers are paying close attention, they risk jettisoning a successful intervention because they see only another cut.

Similarly, when a person has difficulty managing his temper, that problem doesn’t just immediately disappear. Angry outbursts become less intense, less frequent, shorter, less destructive and less dangerous. It is again possible that these gradual improvements may be missed unless concrete benchmarks are defined and monitored.

6. **Don’t change the agreed upon priority outcomes during the crisis.**

People don’t make their best decisions in crisis. This includes both your employees and the people you serve so supervisors have to maintain a reasonable perspective. If the plan is for people to live in, work in or learn in a certain place, that should remain the outcome defined in the plan until things calm down. Then, when the crisis has lessened sufficiently or passed, it’s time to revisit the plan and make sure the big outcomes still make sense. If they don’t, the plan should be changed; if not, it should be continued, amended or adjusted as indicated.

This is not to say that big changes will not occur as the result of a crisis. Children and vulnerable adults must be protected and dangerous behavior must be addressed. Children may be moved to a safer setting. People may need to enter a rehabilitation or treatment setting. Others may be detained. These actions are or are related to legal mandates that apply to human service professionals. It is still important, especially in Family and Person Centered

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58 Common wisdom
59 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
Practice to keep in place a goal or outcome that’s important to those in crisis until things settle down.

7. **After the crisis, evaluate how well or poorly the crisis plan worked and adjust it as indicated.**

The first crisis plan developed is rarely the final one. This is because initial crisis plans are developed (hopefully) very early in the intervention process and typically early in the relationship by your staff and the people you serve. Your employees will hopefully build the type of trust and rapport with people that will make it more likely that they will hear about and recognize potential crises and help people develop appropriate responses.

Encourage employees to help families and consumers design the best possible initial plans for where and how things are currently and revisit them over time. Crisis plans should be evaluated and changed as information comes to light and each time they are implemented.

8. **Make sure that family members, friends and others (including your staff) aren’t inadvertently fueling the crisis.**

Supervisors have to maintain a clinically neutral attitude when they consult with staff about crisis planning. That neutrality allows them to see what everybody involved is doing in the actual crisis. Although it seems illogical to some, there are people who appear to live in crisis. There are situations in which people accidentally reward, facilitate or otherwise fuel crisis events. Supervisors should point the possibility of these influences out to staff. They may also need to steer staff away from accidentally adding to the crisis with their own behavior.

9. **Find teachable moments while maintaining physical safety.**

When crises begin to escalate, there are often opportunities to intervene in ways that will reduce or even prevent the crisis from developing further. There are also, unfortunately, opportunities to escalate it further or even get injured. It’s obviously important to help staff draw a clear and safe line between prevention and escalation.

The main thing for staff to remember is that people have their own ways of escalating and de-escalating. They have their own tempo as well. That’s one of the reasons crisis responses have to be individualized and strength-based. It is clinically inappropriate to assume anything about how each individual – child or adult – will enter into and exit a crisis.

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60 Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present
10. Remember: “*What is food to one, is bitter poison to others.*”\(^{61}\)
Back to that point: crisis plans have to be individualized and strength-based to be effective. One person is best supported by being surrounded by relatives while another does best when protected from that surrounding. Still another – most, maybe – wants some family members around and not others, some of the time and not others.

Some people are redeemed by prayer while others meditate, talk to grandma or listen to music. This is not said to be disrespectful. Supervisors don’t have to teach staff what should be important to or what could provide comfort to consumers and families. They instead guide them to find out, research and learn what’s comforting and valued. Staff are then better able to help people design effective crisis plans.

11. Rehearse the crisis plan in a dry run, if possible. People are more likely to implement what they have already practiced.\(^{62}\)
Anyone who has ever participated in a fire drill has seen a rehearsal of a crisis plan. It's important for supervisors to note why fire drills are held. The people who lead them or arrange for them are following Murphy’s Law (above) in a practical way. The practical part is the assumption that in a fire, people may be prone to panic. With that in mind, the rehearsals are intended to make it more likely that everyone will know what to do instead of panicking. In crisis planning, the more likely families, consumers and the people around them are to panic, the greater the focus on rehearsal.

The following scenarios are examples of reactive and proactive crisis plans. Bobby’s Story is an example of crisis planning in Family Centered Practice. Stacy’s Story, which follows, is an example of crisis planning in Person Centered Practice.

In both scenarios, crises are presented in the sequence that reflects the most likely crises first. It is equally correct to sequence them in order of most or least serious, etc.

Crisis Planning in Family and Person Centered Practice:
Examples for Supervisors

**Bobby’s Story: A Crisis Planning Example for Supervisors and Staff**
Bobby, age 15, has stolen his dad’s much prized van several times as well as the cars of several neighbors. When he was arrested the first time, he was found to have both beer and marijuana on his person. Bobby seems (to most observers) to be using the pot and the beer to bribe other kids to hang out with him although he has gotten high and drunk several times.


\(^{62}\) Ann May, Raleigh, NC.
Bobby hears threatening voices. He uses sharp objects (meat forks, knives, etc.) to ward off the voices. He also occasionally takes a stab at his younger brother and sister which has led his father, Ray, to restrain him, resulting in injuries to them both. Bobby has been evaluated by several doctors. The first one said that he has ADHD. The second said he had a conduct disorder and the third one thought he was oppositional and defiant. Each doctor tried a different medicine but none of them worked.

Charlene, Bobby’s mom, keeps sharp objects locked in the trunk of her car to keep the family safe. Bobby loves his mom, Charlene, and his Aunt Jessie, Charlene’s sister. Bobby is extremely eager to be a legal driver. He practices with virtual driving games and can already recite part of the DMV manual by heart. He and his Dad both follow racing, especially NASCAR and the Indy 500. When he can, Bobby dives into his favorite TV shows and movies. His current favorite movies are The Phantom Menace and the rest of the Star Wars series, and his all time favorites are the Star Trek movies.
<table>
<thead>
<tr>
<th>Incident</th>
<th>Reactive Crisis Plan</th>
<th>Proactive Crisis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bobby stabs someone</td>
<td>• Call 911 if urgent&lt;br&gt;• Apply first aid or get medical attention</td>
<td>• Develop a list of possible psychiatrists.</td>
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<tr>
<td></td>
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<td>• Bobby will interview the doctors who seem promising and choose his personal physician.</td>
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<td>• Recruit a carpenter, get materials, and build a lock box in the kitchen to store sharps.</td>
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<tr>
<td>Bobby refuses to take</td>
<td>• Report to his doctor, P.O., CPS and the court</td>
<td>• Recruit a clean &amp; sober mentor, who is managing his mental illness well.</td>
</tr>
<tr>
<td>his meds</td>
<td></td>
<td>• Bobby will use a medical journal to record his feelings, what he takes and any side effects.</td>
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<td></td>
<td>• Every Sunday, Bobby will set up and fill pill-of-the-day containers that hold a week’s supply of medication.</td>
</tr>
<tr>
<td>Bobby hits his little</td>
<td>• Parents de-escalate him&lt;br&gt;• Parents manage him physically if needed (TCI)³⁶&lt;br&gt;• Get him medical care as needed</td>
<td>• Bobby will study the Petty family to see how cause &amp; effect played out for them across 3 generations of racing.</td>
</tr>
<tr>
<td>brother</td>
<td></td>
<td>• Bobby will learn how cause &amp; effect “drives” the motor vehicle code &amp; weeds out unsafe drivers.</td>
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<td></td>
<td></td>
<td>• Bobby will go virtual driving and report on how cause and effect makes or breaks drivers, and how that relates to racing.</td>
</tr>
<tr>
<td>Bobby steals the van</td>
<td>• Ray and Jessie will look for him&lt;br&gt;• Charlene stays by the phone&lt;br&gt;• Call police if necessary</td>
<td>• Buy “The Club” for Ray’s van.</td>
</tr>
</tbody>
</table>

³⁶ The Family Life Development Center, Cornell University, Ithaca, New York
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<thead>
<tr>
<th>Incident</th>
<th>Reactive Crisis Plan</th>
<th>Proactive Crisis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bobby gets drunk or high</td>
<td>• Parents manage him physically if needed (TCI)</td>
<td>• Bobby will supply samples for urine analysis.</td>
</tr>
<tr>
<td></td>
<td>• Get him medical care as needed</td>
<td>• A supportive mentor who has a similar illness and who lives a clean and sober life.</td>
</tr>
<tr>
<td>Bobby gets arrested</td>
<td>• Call Aunt Jessie</td>
<td>• Now that Bobby has been successfully treated and is not psychotic or delusional, he will review <em>Star Trek</em> movies and identify decisions made by the characters, predict the likely outcomes and decide if each decision is good or bad.</td>
</tr>
<tr>
<td></td>
<td>• She informs the family</td>
<td>• Bobby will study discipline themes in <em>Phantom Menace</em> and the other Star Wars films, and write a report to submit to his P.O. and parents.</td>
</tr>
<tr>
<td></td>
<td>• They contact an attorney</td>
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</table>
Stacy’s Story: A Crisis Planning Example for Supervisors and Staff
Stacy, age 24, was referred to protective services by the police after the local hospital reported repeated ER trips for injuries allegedly incurred when she “slipped and fell.” The person who likely injured her is Paul, her 39 year-old boyfriend and the father of her youngest child, age 1 (her older child, age 2 ½, has a different father.) Paul has repeatedly threatened to take both children and never let her see them again. He forced her to quit a job program and her church, keeps her car keys in his pocket and sneaks up on her apartment to do “surprise inspections” of what she is doing. Paul has no real home, staying sometimes with Stacy and sometimes elsewhere, at locations not known to Stacy.

Stacy is a former cheerleader and pep squad member. She volunteered in a nursing home during high school and was much loved and appreciated by the residents. Also in high school, Stacy almost completed a beauty school program. She was a Young Life member at her church and helped out with the music ministry. Stacy’s favorite music is by Destiny’s Child, The Black Eyed Peas and R. Kelly.
<table>
<thead>
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<th>Incident</th>
<th>Reactive Crisis Plan</th>
<th>Proactive Crisis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul threatens to harm or kill Stacy</td>
<td>• Stacy will have a cell phone hidden in her apartment (set to never ring or vibrate – outgoing calls only) so she can call for help as soon and as safely as she can</td>
<td>• Stacy will think about the people in the nursing home and how they deserved to be treated and think about the lyrics to Where is the Love?(^{64}).</td>
</tr>
<tr>
<td>Paul beats up Stacy</td>
<td>• Call 911</td>
<td>• A retired police officer who volunteers at the Domestic Violence Shelter will teach Stacy the basics of self defense.</td>
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<td></td>
<td></td>
<td>• Stacy will attend a support group for victims (with fabricated documentation for getting away from Paul).</td>
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<td></td>
<td>• Stacy will read about the women in the Bible and jot down an ongoing list of their qualities she admires and share it with her support group.</td>
</tr>
<tr>
<td>Paul intimidates Stacy into sex</td>
<td>• Stacy will keep emergency birth control in every room of the apartment (Stacy will not call for help in this type of situation because it only happens when Paul is very drunk or high and she is afraid of serious harm before help will reach her).</td>
<td>• Stacy will attend therapy and explore Destiny’s Child songs like Survivor(^{65}) and Independent Women(^{66}) to decide who she wants to be.</td>
</tr>
<tr>
<td>Paul takes all of Stacy’s money</td>
<td>• Stacy has three twenty dollar bills well hidden in the apartment, in three</td>
<td>• Stacy will complete beauty school while Paul thinks she’s at a required work activity to maintain Medicaid.</td>
</tr>
</tbody>
</table>

\(^{64}\) Where is the Love? Song performed by The Black Eyed Peas – Album: Elephunk, 2004.

\(^{65}\) Survivor, Song performed by Destiny’s Child – Album: Survivor, 2001.

\(^{66}\) Survivor, Song performed by Destiny’s Child – Album: Survivor, 2001.
| Paul takes one or both of the children | • Stacy will call 911 with her cell phone as she leaves the apartment and uses her emergency money to get a ride to the police station. | • Stacy and her worker will meet with the law enforcement and court officers, explain her situation and give them photos of Paul and the children (this will be done secretly). |
| different places (flex fund escape money). and Food Stamp eligibility. |
This crisis plan format is presented as an example of the categories of information often found in crisis plans. Supervisors are advised to adapt it to fit their communities and their practice. This generic version will not work as well as one that is tailored to reflect local realities and priorities.

Crisis Plan Format

Name: ______________________________

People who can help in a crisis (names, relationships and phone numbers):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Major Outcomes:
 Immediate: ______________________________________________________

________________________________________________________________________

________________________________________________________________________

Short Term: ______________________________________________________

________________________________________________________________________

Risks/Triggers:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Medical/Disability Issues:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Significant Strengths, Interests and Relationships:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
<table>
<thead>
<tr>
<th>Family’s/Consumer’s Definition of Crises</th>
<th>Unmet Needs, if any</th>
<th>Underline the strength/s on which the reactive plan is based, if applicable and on all proactive plans</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Reactive Plans</strong> <em>(what will be done, who will do it &amp; how it will be done)</em></td>
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<td></td>
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<td><strong>Proactive Plans</strong> <em>(what will be done, who will do it &amp; how it will be done)</em></td>
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Evaluating a Crisis Plan: Issues for Supervisors

Consider a crisis and the resulting crisis plan that was designed for a consumer or family served by your organization and/or that was designed by one of your employees. As you answer the following questions, figure out how the employee could adjust the plan as indicated by how well it seems to fit the people and the crisis and how well or poorly it actually worked. Remember, your staff will need to critique this and other crisis plans the next – and every – time they are implemented...

- What aspects of the crisis plan worked?

- What aspects didn’t work, or didn’t work as well as was hoped?

- Were the immediate outcomes achieved?

- Were the short-term outcomes achieved?

- Were they the right outcomes, as things played out?
How well or poorly did the crisis plan include:

- Strengths
- Formal resource people
- Informal resource people

How well or poorly did the crisis plan meet unmet needs?

How practical was the plan, given the specific circumstances of the crisis?

How well or poorly did people fill their planned roles?

Was the right information available to the people who needed it? How readily?

Were the elements of the crisis plan in place quickly enough?
Family Crisis Plan for a Major Crisis like a Terrorist Attack or Weather Event

When families prepare for a major crisis, proactive crisis plans have a very different function than they have in ongoing crisis planning. These crisis plans can’t prevent serious crises but they can reduce their impact and help people survive them. They guide people to prepare for major crises in sensible, practical ways. If the anticipated crisis occurs, family members’ reactions are based on the preparation work done in proactive planning. Proactive planning puts in place the pieces people will need to react to the crisis.

Feel free to use this format as a starting point in crisis planning for your family. It is not complete so your input is important. No one plan can possibly fit each situation and each family. Think these issues and suggestions through with your family, especially in the light of what risks you all face.

Learn and act on what can be done to protect people and property: board up windows, store outdoor items safely, etc.

Keep a store of needed items in each designated place to go (first and back up ) and at each property at risk

Decide under what conditions protective plans will be implemented and who will implement them.
Family Name:

Crisis: A terrorist attack or major weather event

List the people in the family (kin and nonblood kin) and/or who reside in the home and their ages:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

List the pets in the home, the types of pets and their names: 67

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Identify each vulnerable family member (infants, elderly, people with disabilities, etc.) and describe their issues

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Outcomes:

- Family members will be safe and well
- Family members (kin and nonblood kin) will be together as much as possible
- If not, family members will know where each other are
- If possible, the family’s property will be preserved
- Other: ______________________________________________________________
- Other: ______________________________________________________________

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67 Jody Layton, M.S., Certified Trauma and Loss Specialist, New Jersey.
### Before the Crisis

#### Proactive/Preparation Plans

<table>
<thead>
<tr>
<th>Needs</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A way to find each other</td>
<td>- Recent photos of everybody held by several people in several places</td>
</tr>
</tbody>
</table>
| A way to communicate with each other immediately        | - A phone tree with key numbers  
- Cell phones (charged)  
- At least one land line phone  
- Change for pay phones  
- Prepaid phone cards  
- Phone and address directories (hard copy)            |
| A designated place to go                                | - We will all try to get to  
- Keys  
- Maps with alternate routes to the designated place   |
| The safest places to be in the designated place         | - Consult people who have experienced the type of crisis and solicit their input  
- Consult law enforcement and other potentially helpful resource people |
| Learn and act on what can be done to protect people and property: board up windows, store outdoor items safely, etc. | - Keep a store of needed items in each designated place to go (first and back up) and at each property at risk  
- Decide under what conditions protective plans will be implemented and who will implement them. |
| A “central switchboard” person to whom people will communicate their whereabouts and probable arrival time at the designated place | - Choose whoever is most likely to be at the designated meeting place when the crisis occurs |
| A back up designated place to go if the first one becomes unusable or unsafe | - We will all try to get to  
- Keys  
- Maps with alternate routes to the designated place  
- A phone plan for notifying family members that the back up designated place is now their preferred destination |
| The safest places to be in the backup designated place to go | - Consult people who have experienced the type of crisis and solicit their input  
- Consult law enforcement and other potentially helpful resource people |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a buddy system for family members who need assistance and for pets</td>
<td>- Ex: Jane picks up Grandpa, Joe gets the baby at day care, Barb brings the cats, etc.</td>
</tr>
</tbody>
</table>
| Money | - Change and cash stashed in designated place  
- Change and cash stashed in cars  
- Change and cash envelopes for each family member so a small amount of money will be available to everybody |
| Valuables and most important possessions \(^{68}\) | - Before anything happens, family members each list their 3-5 most important things to keep  
- Family members store their most important things preventably and as safely as possible (bank vaults, with relatives, in areas unlikely to be affected by the crisis, etc.)  
- Family members will back up needed computer files and keep them in places unlikely to be affected by the crisis \(^{69}\)  
- Family members know what and where each other’s valuables are and plan who will grab them and run when necessary  
- Family members take photos of each valuable possession and get estimates of its value when appropriate  
- Family members get insurance to replace important possessions |
| Transportation | - All cars will maintain at least ½ a tank of gas during the period in which the crisis is anticipated  
- Exact change for public transportation, if available  
- Schedules for public transportation, if available |

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\(^{68}\) Jody Layton, M.S., Certified Trauma and Loss Specialist, New Jersey  
\(^{69}\) Vicki Warren, MSW, LMSW, Community Solutions, Fort Worth, Texas
<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Water for 3 or more days</td>
<td>- Stock non perishables: canned goods (and manual opener), bottled water, nuts, dried fruit, bottled juice, etc.</td>
</tr>
</tbody>
</table>
| Cooking and eating supplies                 | - Grill, charcoal, wood, matches, camp stove  
- Utensils, paper plates and cups, paper towels, etc. |
| Cleaning and disinfectant supplies          | - Antibacterial detergent, soap or wipes  
- Rags  
- Bleach  
- Garbage bags |
| Medication for 3 or more days                | - Speak to physicians and request whatever extras are needed  
- Stock multivitamins and supplements |
| First aid kit                                | - Include antibiotic ointment, bandages in different sizes, over the counter drugs, etc. |
| Baby supplies                                | - Formula, baby food, diapers, wipes, baby aspirin, diaper rash ointment, etc. |
| Pet supplies\(^{70}\)                        | - Pet leashes, dishes and food/medicine for 3 or more days          |
| Utilities                                    | - Light sources not dependent on electricity, transistor radio, lots of batteries in different sizes (not rechargeable), back up cell phone battery and/or car charger\(^{71}\) |
| Sleeping supplies                            | - Blankets (wool or microfiber for cold places), sleeping bags, pillows\(^{72}\), etc.  
- Tarpulins, waterproof tents |
| Toileting supplies                           | - Bucket, toilet paper  
- Bleach, water\(^{73}\) |
| 3 days of basic clothing appropriate for local or anticipated weather | - Socks, underwear  
- Walking shoes  
- Tops and bottoms for layering (for warmth) or not (for heat) |
| Personal care supplies                       | - Soap, waterless antibacterial cleanser, tissues\(^{74}\), towels, tooth brushes and toothpaste, etc. |

\(^{70}\) Jody Layton, M.S., Certified Trauma and Loss Specialist  
\(^{71}\) Vicki Warren, MSW, LMSW, Community Solutions, Fort Worth, Texas  
\(^{72}\) Vicki Warren, MSW, LMSW, Community Solutions, Fort Worth, Texas  
\(^{73}\) Vicki Warren, MSW, LMSW, Community Solutions, Fort Worth, Texas  
\(^{74}\) Vicki Warren, MSW, LMSW, Community Solutions, Fort Worth, Texas
Helpful tools
- Duct tape, strapping tape, manual tools
- Plastic wrap, aluminum foil
- Scissors
- Paper, pens, pencils

Insurance
- Family members know where policies (homeowners, renters, liability, flood, equipment, jewelry, auto, other vehicles, business, etc.) are and plan for several people to grab them when needed.
- Duplicate documents stored in other places (i.e., not likely to be affected by the crisis), with family members, banks or elsewhere

Paperwork
- Wills, living wills, birth certificates, marriage and divorce documents, passports, social security cards, bank account numbers, credit card numbers, home ownership and mortgage records
- Investment records, pension information
- Copies of drivers licenses, license numbers, car titles and any others that are relevant

Other needs:

Other strategies:

During/after the crisis

<table>
<thead>
<tr>
<th>Reactions/Immediate Plans</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share breaking information rapidly</td>
<td>Utilize the phone tree and whatever news sources remain available</td>
</tr>
<tr>
<td>Get to the designated place</td>
<td>Share information and what means of transportation are available</td>
</tr>
<tr>
<td>Task</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Choose and implement transportation strategies based on what is available: cars, bikes, public transit, ride sharing, walking and in some situations, hitch hiking</td>
<td>Share information and what means of transportation are available</td>
</tr>
<tr>
<td>Implement buddy system</td>
<td>Keep “central switchboard” person informed</td>
</tr>
<tr>
<td>Report whereabouts and likely arrival time (at designated place) to “central switchboard” person</td>
<td>“Central switchboard” person will make sure that people who could help each other due to geographic proximity can do so</td>
</tr>
<tr>
<td>Inventory what is actually there at the designated place</td>
<td>Count or measure how much of everything there is in reference to the number of people who will need it</td>
</tr>
<tr>
<td>Conserve resources as needed</td>
<td>Use the best information you can get on what is happening so you know how much needs to be conserved</td>
</tr>
<tr>
<td>Family members in the crisis should notify distant family members (those who were not involved in the crisis) that they’re okay</td>
<td>Use phone tree or directions</td>
</tr>
</tbody>
</table>

75 Christine Wilson, Pittsburgh PA
Safety Planning in Family and Person Centered Practice: An In Depth Look for Supervisors

The most important priority for Family and Person Centered Practice is the same for all services and interventions: ensuring the safety of consumers and families. This is true for both congregate and home based services, short and long term supports and for adults, children and families. How to assess family and consumer safety and plan to maximize it and minimize risk is an important part of this section of the Curriculum.

Whatever type of work you and your staff do for families and consumers, at any point in the intervention you provide, your staff should be prepared to initiate immediate safety planning as the new, number one priority, when safety risks occur. If safety planning fails to adequately contain or minimize the risk, whatever next steps are indicated by state and local law must be pursued. This is the type of decision that must have supervisory input and oversight.

Safety plans are an important part of the record for every consumer and family. They should be separate from other documents in order to emphasize the need for them and to make it easier for supervisors to monitor and evaluate them. For every customer for whom there has been a history of unsafe action, a safety plan should be developed, documented and updated in concert with policy and practice in your organization. Similarly, when families or consumers are engaging in or affected by new, or possibly just unknown or unanticipated risks, a documented plan should be part of the record.

When families and consumers disagree with your staff on whether or not risk exists, how severe it is or whether or not safety planning is needed, the families’ or consumers’ refusal should be formally documented and signed by whomever your organization’s policy dictates.

If your organization has human resource experts, they should be consulted on issues like employee safety, documentation of refusals to plan and so on. This part of the Curriculum is intended to provide only general information. Supervisors should also get advice and input on safety from their colleagues and their managers. The specifics of how to ensure employee and consumer safety have to be resolved by each organization that provides services that are Person and Family Centered.

Assessing the Basic Safety of Consumers and Families: A Treatment Planning Priority

Teach your employees to remember, as they assess and respond to safety issues: they can’t take anything for granted. They can’t assume that others who are working with the
family, or who have had contact with the family or consumer in the past, have assessed safety. Once they begin working with a family, they are at least partly responsible for their safety or lack of safety.

For children’s and family services:
- Count the children
- Know their ages (from the file, referral, etc.) and match each child to his/her age
- Note observations on how the children look
- Compare your observations to other information and assess the degree of match for each child:
  - Size
  - Behavior
  - Development
  - Physical condition
  - Apparent/observable mood
  - Connection with reality
  - Breadth and depth of relationships with other family members
  - Degree to which each child seems relaxed
- Note how many adults are in the home
- Learn the adults’ names and how they are connected to the family
- Compare the above with the information in the record

Some communities now photograph children so workers can match up the children in the home with the photos in the record. Sometimes, this is done in the interest of maintaining a complete record. In some areas, however, this is done because a child has been killed and a substitute child (a neighbor, for example) has been used to keep the count the same and avoid detection of serious, life threatening abuse.

For adult services:
- Tell staff to find out who is in the home, full or part time, and learn what their roles and relationships with the consumer are.
- Make sure they compare their observations of the consumer to whatever information they have:
  - Age
  - Size
  - Observable mood
  - Awareness of place, time and date
  - Apparent health/medical status
  - Connection with reality
  - Connection to other people
- Encourage your staff to note what people are wearing and whether or not it was sensibly selected in terms of climate, environment, setting and expectations.
- Remind staff to engage with consumers in whatever setting they meet, learn what each of them value and engage with them in ways that reflect those values.
For office based services:
- Note the appearance of the individual. Is he/she well? As focused as possible?
- Look for signs that a person may have been hit, pushed or otherwise physically harmed.
- Notice if the person is dressed safely for the weather and reasonably for his/her environment.
- Ask people if they are safe and well or troubled by issues related to illness, disability or abuse.
- When individuals are parents or otherwise responsible for the care of children, keep an eye on the safety of each child. Report concerns and suspicions to the people responsible for assessing whether there is abuse or neglect.
- Be sensitive to signs of undiagnosed mental illness or drug and alcohol use and ask people who exhibit these signs to consider medical assessment and intervention.
- If service recipients seem ill or feverish, offer to get them medical care or advise them on how they may get it.

Important Safety Questions for Staff in Family and Person Centered Practice

- Is everybody involved safe?
- Are any protective services currently involved with the family or consumer?
- If not, should there be? Know the criteria for a mandated abuse/neglect report.
- Are there orders of the court, probation department, or parole board that need to be considered?
- Are there health, mental health or disability issues that need to be addressed immediately?
- Does anybody involved in the planning process pose a safety threat to others similarly involved? To innocent bystanders?
- Are people who need supervision getting enough?
Safety Planning in Family and Person Centered Practice: Questions for Supervisors to Consider*

* see also Assessment: Positive and Negative Evidence

**Step #1:** What, exactly, is the person doing that is unsafe? Be thorough in your description. Think about when the unsafe behaviors occur, who is around, the conditions under which they occur, etc.

It’s important to be as specific as possible in safety planning. Safety compromises almost always involve behavior, so that’s generally a good place to start (later steps involve the physical setting, who is at risk and so on)

Consider the multiple parts of the question above. When defining behavior, think about whether or not each behavior is part of a chain. Many behaviors are, so look at every aspect of the behavior including when it begins. It may not yet be unsafe but it may be the first clue that it will be, if or when the behavior escalates.

Look for indications that behavior may trend toward happening at certain times or under certain conditions. Does it occur when certain people – or certain types of people – are present? Is there a victim? Victims? Potential victims? Who is threatened? Who is not?

Does the presence of certain people make it less likely that the unsafe behavior/s will occur? What are the factors that decrease the chance that the behavior will occur? These questions focus on elements of the setting in which the unsafe behavior occurs, key information in intervention planning.

**Step #2:** How is the unsafe behavior functioning for the person? What does it probably get for the person? What does it help him/her avoid? Is it helping him/her get attention? Get over on somebody?

In the simplest possible terms, behavior either gets something for the person behaving or allows them to avoid something. The science of behavior is mostly about people so it is inexact, but there is a lot of evidence that getting and avoiding things is key in determining how behavior functions.

Unsafe behavior is no exception. This is sometimes difficult to understand. We think people will be motivated exclusively, or at least mostly, by positive things. Both historic and recent research indicate that people are sometimes motivated by negative things: negative attention, rejection, affirmation of feelings of inadequacy, etc.

People may act, sensibly, to avoid punishment but they may also be motivated by the need to avoid responsibility, commitment or even praise. People have been known to avoid chores, work and keeping promises.
Whether or not what people get and/or avoid with unsafe behavior makes sense to observers, it's critical to observe the relationship between those factors and what people do. That relationship is called the function of the behavior. A behavior may function to get sexual pleasure or a feeling of control over emotions or circumstances. A behavior may function to avoid feelings of rejection by rejecting someone first. It may function as a way to avoid responsibility and rules.

Safety plans work better if the people designing them understand how the risky behavior/s function. Planners can then determine if there are safe ways the person can get what he/she gets and avoid what he/she avoids in positive, healthy, legal ways.

Step #3: What about the physical settings in which the individual lives, behaves, etc.? How does each setting support safe behavior? Unsafe behavior? What supervision is available? What can be done to the actual environment to force safe behavior?

Unsafe behavior occurs in a setting. The setting, which is an important factor in safety planning, is where the behavior occurs. It can also include who is there, what time it is, whether it's public or private and numerous other factors.

In safety planning, it’s sometimes critical to know who can see whom, or what, from where. Other times, it’s important to know where dangerous things are and how well or poorly they have been stored or adapted for safety: electrical sockets and wiring, stairs, shared walls, the ability to monitor certain individuals (electronically or otherwise), the capacity for potential victims to access immediate assistance and the availability of toxic substances, to name only a few examples. Even where people sleep, eat, play or work can influence the development of effective safety plans.

Step #4: Generate alternative safe behaviors, to replace the individual’s unsafe choices, that are consistent with his/her age, strengths, culture, and choices.

Probably the most difficult thing to achieve in reference to unsafe behavior is to stop it without doing anything else. The safety plan is more likely to work if it stops a behavior by replacing it with one or more other behaviors. This approach allows safety planners to help the person or people who compromise safety or are contributing to the risk find several other things to do instead of the behavior in which they are presently engaging. In some safety plans, it may be strategic to arrange for the individual who actually engages in the safe replacement behavior to be rewarded. Of course, the person would also be punished for engaging in the unsafe behavior. Research over the course of decades indicates that rewards and punishments, used accurately and strategically, work best when used together.
Planners have to make sure that the newly learned alternative, or replacement, behavior/s are consistent with the age, gender, culture and values of the person/s for whom they are suggested. They also have to make sure the behaviors are safe. Whether or not they are effective in ameliorating the risky behavior must be carefully assessed and monitored on an ongoing basis.

Step #5: What reasons (aside from consequences, see #6) does the individual have to make safer choices, in the short term? Long term? (Focus on child-centered, family-centered or person-centered rationales, whichever applies.)

An important function of safety planning is to help whoever is creating a risk to see reasons why he/she should not. In safety plans, these are the big, more general rationales for behaving safely. They are most effective when they are personal; important to the person for/with whom they are generated.

In this step, planners are advised to stick to broad stroke reasons and then move on to specific consequences in Step #6.

Step #6: What are the consequences that the individual will experience for unsafe behavior? What are the consequences, as the person/people at the center of the plan might define them, for safe choices?

**Consequences of unsafe behavior:**
- arrest, detention, court action
- punishment
- loss of relationships
- loss of jobs, housing, possessions
- external control (curfew, electronic probation, etc.)
- negative reputation

**Consequences of safe behavior:**
- control of one’s day-to-day life
- liberty
- employment maintained and opportunities to advance preserved
- intact relationships
- positive reputation
- lifestyle maintained

The bullet points, above, are intended to help you get your staff to think about assigning specific consequences to unsafe behavior. The consequences should be locally accurate and realistic. If there is a 70% chance that an external consequence (detention, placement, etc.) will be applied, planners should state that. It’s important that this part of the planning process is as true as possible. When negative consequences for unsafe behavior are less than 100% likely, planners should address that. The plan can then reflect what will be done to collect evidence or to otherwise ensure appropriate punishment when external consequences are uncertain: extra monitoring, zero tolerance, electronic surveillance, random urinalysis, etc.
Step #7: What will be the indicators that establish that the individual is making progress? Not making progress? (State these in measurable terms.)

Safety plans have to be measurable. The most important thing to measure in a safety plan is the actual condition of the consumer, the family and the community. The sexual offender has either offended or not, as defined in Step #1, by engaging or not engaging in the entire chain of behavior involved. The suicidal person is alive or is not, has attempted suicide or hasn't, has threatened suicide or hasn't, etc.

It may be necessary to measure outcomes like these in more than one setting. Results in these settings and other indicators used to assess progress should be documented in each safety plan along with how each will be measured.

For some safety plans, it’s a good idea to have neutral third parties, including experts in whatever type of risk is involved, review safety plans and help monitor progress. For others, officers of the court or protective services workers will collect information, monitor the plan and evaluate progress on safety. Many safety plans are reviewed and monitored by judges, an important signal of the importance of these plans.

Step #8: What treatment will be given to the consumers/s? What is the plan to teach and practice safe choices for the person/people at the center of the plan? How will they master positive alternative behaviors? How will they be motivated?

Some behaviors that comprise safety risks respond to treatment. The type of treatment, its duration and exactly how it is implemented are issues safety planners have to consider.

Treatment works when it fits the people who receive it. Supervisors have to make sure that staff look closely at treatment programs to see if they are family or person centered. There is no room for assumptions in safety planning. Supervision 401: Systems of Care provides tools to help supervisors, staff, families and communities get clearer ideas about what treatment programs do and don’t deliver.

Safety planners will consider treatment options that are community based whenever that is possible. Creative thinking can make treatment options accessible even when they have not been in the past. The availability of affordable technology, for example, has been an important factor in making community based safety plans both effective and reliable.

Instruction and practice can be important tools in changing unsafe behavior. Some people who have triggered safety planning by their behavior can behave differently or better when they are taught what to do differently and how and when to do it.
Interventions in safety plans have to define the level of mastery necessary for planners and concerned others to conclude that the safety risk has been eliminated. With zero tolerance the most frequently stated measure for unsafe behavior, mastery is a clear issue. Can the person actually behave as planned – safely – under duress, without supervision, when tempted, etc.? Will that achievement endure over time? Across settings and relationships?

Motivation is a key issue in behavior change. Punishment is supposed to deter unsafe behavior. In Family and Person Centered Practice, a punishment is only considered a punishment if it actually deters the unsafe behavior that it follows. Clinically, that means that the punishment has to be understood or experienced by the person receiving it as caused by the unsafe behavior.

When appropriate, rewards may also be implemented to help consumers achieve behavior change. The definition of reward matches the standard for the definition of punishment: it has to work, i.e., it has to increase the occurrence of the safe alternative behavior. When concrete rewards are inappropriate, planners can use verbal praise. They can also point out the absence of punishment and the presence of liberty in the life of the consumer or family because risk has been eliminated.

Step #9: When, how, and how often will the individual be given “booster shots” to continue to make safe choices?

Change is difficult, not just for the people you and your staff serve, but for people in general. Think about and encourage your staff to think about changes you all have decided to achieve: changes in eating, gambling, sex, relationships, spending, lottery, exercise and so on. In all probability, you have personal experience and evidence on the difficulty of achieving real change.

This difficulty is addressed by lots of people in a variety of ways: the 12 Step Programs, support groups, Weight Watchers, exercise “buddies” and many more. These groups provide, among other things, the booster shots referred to above. Safety plans are more successful when the need for ongoing, accessible and on target support is available.

Step #10: Is there any technology that will make it easier to keep the people around the person safe? Who has it, what is it, how much does it cost, and where do you get it?

The availability of affordable technology has been very beneficial in safety planning. Consider the following: fire, smoke and gas detectors, motion sensors, door and window alarms, baby and sleep monitors, pagers, cell phones, PDAs, iPods, and many more. All of these have been used in safety plans. Door alarms let people know that a potentially unsafe person is roaming around at night. A cell phone can allow a person
to reach out to a resource person immediately and affordably. If an opportunity to read certain texts helps a person choose a safer path, a PDA can hold thousands of inspiring words. If music calms a person who might otherwise explode in anger, an iPod (or other MP3 Player or portable compact disc player, which are cheaper) makes it easy to provide. Email allows people to communicate with anyone, anywhere, whether it’s your grandpa, mom or best friend.

These and other technologies make safety plans “do-able” as opposed to having to rely on highly restrictive settings as the only way to contain or eliminate risk.

Safety Analysis and Planning in Family and Person Centered Practice: Examples for Supervisors

Supervisors have to make certain that staff know that their ability to provide helpful supports to people while they continue to live in their homes and in their neighborhoods is largely dependent on their ability to keep them and those around them safe. If public safety is compromised, the reaction of citizens, who expect innocent bystanders to be protected, will be both huge and warranted. Read Toby’s story and review the safety plan that follows. Remember that this is a practice scenario, not an actual plan. It is intended strictly for guidance and training. Paula’s story follows as does a hypothetical safety plan for her situation. This plan is similarly intended for guidance and training only.

Toby’s Story
Toby, 13, came to the attention of the court when he was charged with fondling an adult woman who was visiting his family. He waited until just before dawn, apparently climbed under the sofa bed she was sleeping on and touched her genitals.

Toby was arrested and detained when the family friend notified the police. His sister, who had reported similar actions from Toby without a response from their mom, felt so relieved – and affirmed – that she was actually pleased. Toby’s mom had completely ignored her daughter’s reports. She said “boys will be boys” in defense of what he was doing.

The ensuing investigation revealed that Toby’s 16-year old sister found him repeatedly entering the bathroom when she was showering, hiding in the shower to watch her use the toilet and sneaking into her room when she was changing clothes.

A search of Toby’s room revealed that a peephole from his room into his sister’s room was almost completed. Homemade tools were found that he was probably using to slip the lock she installed on her bedroom door.

Toby is a clever boy, good with his hands and highly verbal. He would like to learn to be good at sports so that he can hang around with the other guys. Toby doesn’t feel that
he is good enough at any sport to participate in organized athletic opportunities and thinks he will be laughed at if he tries to get involved.

Residential care is available for Toby. The mean age of the youth in the available facility is 16.3, although they will admit boys aged 12 – 19. Toby is 5’1” tall and weighs 107 pounds.

Thanks to Susan Furer, Psy.D., Sharon Lindsey, Ph.D., Joan Mechlin, MSN, CS, MA.

**Step #1:** What, exactly, is the person doing that is unsafe? Be thorough in your description. Think about when the unsafe behaviors occur, who is around, the conditions under which they occur, etc.

_Toby touched his mother’s friend illegally, very early in the morning when everyone else was asleep. The fact that he molested an adult female who was neither conscious nor aware showed that his act was premeditated and carefully planned. He is spying on his sister using virtually any excuse to see her unclothed._

**Step #2:** How is the unsafe behavior _functioning_? What does it probably get Toby? What does it help him avoid? Is it helping him get attention? Get over on somebody?

_He’s probably feeling some power and control and is likely sexually stimulated as well. He has access to female bodies (visual and touch) potentially without the usual stresses of “going out with” girls his own age. He’s also getting over on his mom and avoiding being accountable for his acting out._

**Step #3:** What about the physical settings in which Toby lives, behaves, etc.? How does each setting _support_ safe behavior? Unsafe behavior? What supervision is available? What does Toby need to choose safe actions?

_Toby’s room is next door to his sister’s, with a common wall, making the peephole viable. There hasn’t been much supervision largely because his mom is in denial in reference to his behavior and has not acted to protect her daughter. Instead, she is minimizing the seriousness of Toby’s behavior._

_If Toby’s room was across the hall rather than next door, the peeping could be eliminated. More supervision is essential as would the ability to lock the bathroom and his sister’s bedroom doors with locks that he cannot slip. This should trigger fire safety planning for Toby’s sister since a locked door may pose an additional safety risk._

**Step #4:** Generate alternative safe behaviors, to replace his unsafe choices, that are _consistent_ with his age, strengths, culture (supervisors should assign one, that reflects their consumers) and choices.
Toby can masturbate in his room or the bathroom, provided he is alone, without potential witnesses, and he is behind a locked door. Toby needs a forced, therapeutic intervention aimed at specifying what is and is not safe sexual behavior. Education about the cycle of sexually offensive behavior should be a part of this intervention.

Toby can become involved in sports and other age-appropriate activities, with help and, initially, supervision from a one-on-one male resource person.

**Step #5:** What reasons does Toby have to make safer choices, in the short term? Long term? (Focus on child-centered rationales)

**Short Term:** Toby can possibly avoid residential placement or detention. By remaining in the community, he can decrease the likelihood that he will be victimized. He'll also avoid the loss of his family, his freedom, and the trust of everyone who finds out why he's in treatment.

**Long Term:** Toby and his mom won't have to wonder if his juvenile record has really been expunged. He will also remain free.

**Step #6:** What are the consequences that Toby will experience for unsafe behavior? What are the consequences, as Toby might define them, for safe choices?

**Consequences of unsafe behavior:**
- Immediate arrest and detention
- Missing school and lower grades
- Stuck in a bad place with bad food
- Having a reputation as a loser and a pervert
- Girls might look down at him
- People at school would find out

**Consequences of safe behavior:**
- Privacy, not humiliation
- Remain at home and at school
- Second chance to have an okay future
- Keep the life he has now and face his future with hope

**Step #7:** What will be the indicators that establish that Toby is making progress? Not making progress? (State these in measurable terms.)

Toby’s sister will report (to support people outside of the family) no suspicious activities that take away her privacy or her subjective feeling of safety.

There will be no reports from school or anywhere else about unsafe sexual behavior.
Toby’s teachers will be asked on a regular basis to notice how well or poorly he maintains a reasonable distance from other students.

**Step #8:** What is the plan to teach and practice safe choices for Toby and his mom? How will they master positive alternative behaviors? How will they be motivated?

Toby will participate in both individual and group sexual offender-specific therapy that focuses on maintaining a reasonable distance from others. His treatment will be managed by an expert in the area.

He will be given a variety of situations and taught to choose safe behavior, and will be praised for doing so.

Toby’s mom will have a mentor – another mother who has been in a similar circumstance and has responded successfully to ensure the safety of all of her children.

Toby will also have a mentor to help him work on targeted issues, such as boundaries, touch, dating, and sexually respectful behavior.

**Step #9:** When, how, and how often will Toby be given “booster shots” to continue to make safe choices?

Toby’s Probation Officer will see him once a week and ensure that he knows that he will be placed in detention if he violates his probation by making unsafe choices.

**Step #10:** Is there any technology that will make it easier to keep the people around Toby safe? Who has it, what is it, how much does it cost, and where do you get it?

Locks that cannot be picked by Toby will be helpful, as previously mentioned. A door alarm will signal Toby’s nocturnal movements, allowing his mom and sister to respond protectively.

**Paula’s Story**

Paula, age 31, has just filed an application for temporary financial assistance and food stamps. She is currently four months pregnant and has not seen a doctor yet, although she has medicaid. Paula has been in and out of psychiatric settings since her adolescent years, as evidenced by both her record and the scars on her arms and legs, from self-inflicted cuts and two suicide attempts. She is staying with different friends and acquaintances and currently has no stable residence. Her nutrition is poor. She’s mainly eating chips, other snacks and fast food.
Paula admits to using alcohol daily. She denies drug use although she has been arrested and detained several times for possession of crack cocaine as well as once for public intoxication.

Paula likes country western music, especially by Martina McBride, Shania Twain and The Dixie Chicks. She has maintained stable employment for as long as 10 months, mostly as a waitress. Her favorite stories are Cinderella-like tales revolving around waitresses and other working women: *It Could Happen To You, As Good As It Gets, Frankie and Johnny and Maid In Manhattan*. Paula is proud that she has survived a very tough life and says she will get through it fine in the end, just like the Coal Miner's Daughter.

**Step #1:** What, exactly, is Paula doing that is unsafe? Be thorough in your description. Think about when the unsafe behaviors occur, who is around, the conditions under which they occur, etc.

*Paula is drinking while pregnant and may also be using street drugs. She has not made use of her medical benefits by seeking prenatal care. Paula’s housing is unstable and she is not eating healthy food or taking prenatal vitamins.*

**Step #2:** How is the unsafe behavior functioning? What does it probably get Paula? What does it help her avoid? Is it helping her get attention? Get over on somebody?

*Paula dislikes being held accountable by anyone, which is likely the reason she has avoided medical care. She is probably in denial about the pregnancy, at least to a degree, so she can continue drinking and possibly using drugs. She enjoys the effects of both substances. Getting high one way or another has been Paula’s daily activity for just over 10 years. She also faces a physical withdrawal that substance abuse helps her avoid.*

**Step #3:** What about the physical settings in which Paula lives, behaves, etc.? How does each setting support safe behavior? Unsafe behavior? What supervision is available? What does Paula need to choose safe actions?

*Because of her unstable housing, Paula has no consistent access to cooking facilities. She has little to no support for safe choices because Paula tends to hang out with people who also drink and do drugs. She will need a consistent place to live where there is support for a healthy pregnancy.*
Step #4: Generate alternative safe behaviors, to replace her unsafe choices that are consistent with her age, strengths, culture (supervisors should assign one that reflects their consumers) and choices.

Paula has to stop using drugs and alcohol. This will probably mean that she’ll need inpatient rehabilitation. She must follow through with medical supervision of her pregnancy, including nutrition and other monitoring. Paula will have to get a job, unless her doctor says otherwise. She could probably hold down a waitressing job, full or part time.

She could learn from her heroine, Loretta Lynn, or from Carol the waitress in As Good As It Gets, in an ongoing therapeutic relationship with a mentor, nurse practitioner or mental health provider.

Paula should probably participate in community resources for clean and sober living; possibly Alcoholics or Narcotics Anonymous. She should also find some new friends who don’t drink or use drugs who can support her to do likewise.

Step #5: What reasons does Paula have to make safer choices, in the short term? Long term? (Focus on person-centered rationales)

Short Term: Paula has been reported to child protective services for using alcohol while pregnant. After the investigation, she entered inpatient rehab rather than risk jail or lose her baby the moment it is born, so going along with the people at the rehab is the path of least resistance. After discharge, Paula is required to have supervised, random urinalyses throughout her pregnancy. She hates it and hates the social worker who has been selected to work with her. If she passes the urinalyses she can get away from her worker sooner. Her worker is less likely to drop by to see her if she passes the urinalyses which makes Paula happy.

Long Term: Paula will be much healthier if she stops using drugs and alcohol, physically, mentally and emotionally. Her child will have a much increased chance for a normal life and a decreased chance of disability.

Step #6: What are the consequences that Paula will experience for unsafe behavior? What are the consequences, as Paula might define them, for safe choices?

Consequences of unsafe behavior:
- Arrest and detention
- Loss of custody of her child
- Court orders that force her to live a certain way

Consequences of safe behavior:
- A healthy baby
- Less interference from courts and Child Protective Services
- A safe place to live
• Social workers and court staff will keep coming around whenever they want
• Because of the above, none of her usual friends will let her stay with them
• Shame

• To be a good mom
• Freedom from guilt
• A new start with friends who care about her

Step #7: What will be the indicators that establish that Paula is making progress?  Not making progress? (State these in measurable terms.)

Paula will pass random urinalyses.  There will be drop-by visits to the apartment the child protective services worker helped her get to see if there is evidence that she is actually there and that she is eating as recommended by her physician.  She is required to attend 12 Step meetings and submit signed notes that confirm her attendance.  Her doctor will report the progress of her pregnancy to her child protective services worker and to the court.

Step #8: What is the plan to teach and practice safe choices for Paula? How will she master positive alternative behaviors? How will she be motivated?

Paula will complete rehabilitation successfully and attend 12 Step meetings daily.  She will also attend therapy at least once a week and participate in a mothers to be class on health, nutrition, labor, delivery and infant care.  Paula will also have the support of a doula.

In therapy, Paula will talk about the seasons of her life using the metaphors from the song Landslide.

Step #9: When, how, and how often will Paula be given “booster shots” to continue to make safe choices?

For Paula, the random urinalyses and the drop-in visits from the social worker function as booster shots, as do her appointments with her health care team.

Assuming that Paula complies with this plan and delivers her child, she will be monitored by child protective services staff at least weekly and will still be required to submit to random urinalyses until the court says otherwise.

Step #10: Is there any technology that will make it easier to make sure that Paula and her child are safe?  Who has it, what is it, how much does it cost, and where do you get it?
Paula will use a portable CD player to listen to songs that encourage her (Landslide, lots of other country music that helps her stay focused like This One’s For The Girls) to be a good mom. She will watch her favorite, uplifting mother and waitress movies on her therapist’s or sponsor’s VCR/DVD player.

Safety Plan Format: A Safety Planning Exercise for Supervisors and Staff

**Step #1:** What, exactly, is the person doing that is unsafe? Be thorough in your description. Think about when the unsafe behaviors occur, who is around, the conditions under which they occur, etc.

**Step #2:** How is the unsafe behavior *functioning for the person*? What does it probably get for the person? What does it help him/her avoid? Is it helping him/her get attention? Get over on somebody?

**Step #3:** What about the physical settings in which the individual lives, behaves, etc.? How does each setting *support* safe behavior? Unsafe behavior? What supervision is available? What can be done to the actual environment to force safe behavior?
Step #4: Generate alternative safe behaviors, to replace the individual’s unsafe choices, that are consistent with his/her age, strengths, culture, and choices.

Step #5: What reasons (aside from consequences, see #6) does the individual have to make safer choices, in the short term? Long term? (Focus on child-centered, family-centered or person-centered rationales, whichever applies.)

Step #6: What are the consequences that the individual will experience for unsafe behavior? What are the consequences, as the person/people at the center of the plan might define them, for safe choices?

Step #7: What will be the indicators that establish that the individual is making progress? Not making progress? (State these in measurable terms.)
Step #8: What treatment will be given to the consumers/s? What is the plan to teach and practice safe choices for the person/people at the center of the plan? How will they master positive alternative behaviors? How will they be motivated?

Step #9: When, how, and how often will the individual be given “booster shots” to continue to make safe choices?

Step #10: Is there any technology that will make it easier to keep the people around the person safe? Who has it, what is it, how much does it cost, and where do you get it?
Transition Planning in Family and Person Centered Practice: An In Depth Look for Supervisors

The difficulty of achieving certain changes is one of the themes of this curriculum. It’s also a central theme in Family and Person Centered Practice. The values and principles that guide this practice reflect real appreciation for the enormous task of making fundamental changes in how we live, behave, raise our children and so on. That’s why compassion is so central to all aspects of the work supervisors oversee.

Supervisors teach staff how to develop crisis and safety plans and monitor how they are implemented and documented. They also teach and model how to plan for change. Not every family or consumer will need three separate plans. For some, workers will borrow from all three planning models. For others, they will select whichever one fits best. Supervisors should remind staff that transitions may also trigger crises and jeopardize safety.

Transitions can be large and small. More importantly, they seem big to the people who experience them and sometimes not to the people around them. Consider the level of effort required to change the way we eat or quit smoking. These are brave attempts that the people pursuing them deal with all day, every day. It may even be their central thought for many days. It’s not unusual for the people around them, however, to not notice anything at all about their struggle, their anxiety and their pain.

Other transitions are big for some groups of people and not at all for others. Parents start preparing for the summer school break early, while people who don’t have children or who don’t have school age children just slip into summer. People of different faiths focus on what is required around their faith’s holidays: fasting, prayer, good works, sacrifice and more. Others are often unaware that the people around them are managing significant changes in their day-to-day activities to accommodate their religious beliefs. In Family and Person Centered Practice, workers help families and consumers plan for transitions because they can be stressful. The most frequent transitions in human service involve people moving from one environment to another. Typically, consumers enter an environment other than their own homes to achieve changes they were unable to achieve at home. Transition planning is an important tool in helping people maintain and build on those changes when they return to their homes and their other preferred environments.

Providers of residential and in-patient psychiatric and rehabilitation services are advised to plan for safety, crisis and transitions early in the placement process.
Most (if not all) of the individuals who graduate from these service options will benefit from the design of transition plans to “ease” their way home. Supervisors may not be able to directly control these providers but it is part of their leadership function to push practice in that direction and to set higher standards for all service providers.

**Transitional Crisis Plans**

When providers who embrace Family and Person Centered Practice see change approaching, they develop transitional crisis plans to help consumers and families adjust to whatever aspects of their lives have been, or will be, altered.

Transitional Crisis Plans:
- Reflect a down to earth understanding of how difficult change is for all human beings.
- Account for differences in companionship, support, external motivation, structure, and other key aspects of change.
- Can reduce the amount of time that families/individuals spend in formal, therapeutic environments.

Staff can be taught to consider the following changes and factors related to them as they assess the need for transition planning:
- Changes in the degree of structure of the living, working or social environment.
- Changes in the amount of companionship available across settings.
- Changes in the type of companionship, from people who support positive choices to people who either don’t or who actively influence negative or dangerous choices.
- Changes in the amount of oversight and supervision available, especially from lots of supervision to less or no supervision.
- Changes in the amount of focus required to successfully navigate the day, the environment or current events in the environment.
- Changes in the amount of personal support available to successfully participate in the events of day-to-day life.
- Changes in the amount of external support and reinforcement for participation, above.
 Changes in access to culturally and spiritually relevant activities, especially from lots or some access to less or no access.
 Changes in the nature or amount of opportunities to learn and grow.
 Changes in wellness, especially from good health to illness or disability.
 Changed chances to have fun or to be distracted and entertained, especially from lots to do to less or little.

Transition Planning: Some Teaching Examples for Supervisors

Supervisors can use the following examples in staff meetings and trainings to get employees thinking about the nature of change and the need to plan for important transitions that may make consumers and families vulnerable.

➢ From the intensive support for sobriety in a drug and alcohol rehabilitation facility to the neighborhood where she scored crack and the people in the neighborhood with whom she smoked

➢ From the behavioral support at the residential treatment center that had an observant staff supervising a very small number of children to the family that has six other children with a single mom who works full time to support the family

➢ From the well-structured therapeutic foster home specializing in working with sexual offenders in which he is the only child, preventing access to potential child victims, to a mainstream Eighth Grade classroom in a school that includes children who are younger and smaller

➢ From the psychiatric setting where people react supportively to behavior that is normally considered illegal, to the local park, patrolled by both a private security guard and law enforcement

➢ From the neglectful home, where the eldest child (age 11) is the primary authority for at least 15 hours each day to the foster home with responsible adults as the primary authority, 24 hours/day

➢ From prison, or any other setting for incarceration, to the family home (with the children who have each been in numerous kinship, foster homes and other placements returned) and the expectation to be employed and fully responsible for the family right away.
From the comfortable job site she’s used to, to a new job, a new community and a completely unfamiliar set of rules and expectations.

From a mostly unstructured schedule and cash public assistance to the very first job with an 8:30 a.m. start time, five days a week, 50 weeks a year.

From the hospital with expert nursing care post-surgery to home with non-professional helpers only, all of whom are working or going to school in addition to their other ongoing activities.

From the children’s system of care, that tends to provide more responsive supports, to the adult system of care, that tends to offer fewer supports.  

From the comfortable job site she’s used to, to a new job, a new community and a completely unfamiliar set of rules and expectations.

All of these situations call for transition planning even though they are very different from each other. Supervisors should make sure that staff realize that some of the transitions above are positive but still produce stress and expose those who experience them to an increased risk for crisis. It can also be useful to ask that employees consider the transitions in their own lives and how they manage them with the assistance of their families, friends and colleagues to inform the transition plans they help consumers design and implement. These can be important learning experiences for everybody on your team.

Transition Planning in Family and Person Centered Practice: Examples for Supervisors

Remember Tammy? She lost custody of her daughters because of her addiction to drugs but fought her way back with the help of the recovering community, the prophet Daniel, music and the memory of her mom. (pages 120-121)

Tammy’s Transition: Kim and Karlie are coming home.
<table>
<thead>
<tr>
<th>Needs</th>
<th>Strength-Based Strategies</th>
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<tbody>
<tr>
<td>• Tammy needs to remain clean and sober</td>
<td>• Continue her work with her sponsor, her home group and the recovering community.</td>
</tr>
<tr>
<td>• Tammy, Kim and Karlie need to reconnect and re-establish their relationships.</td>
<td>• Tammy will rent a new apartment in a different neighborhood, away from her drug-using friends.</td>
</tr>
<tr>
<td>• The girls need to start off well in their new school.</td>
<td>• Tammy will continue with random urinalyses.</td>
</tr>
<tr>
<td>• Tammy needs to establish that she is in charge and the girls need to respect her authority.</td>
<td>• They will join a church together and participate in the music ministry, the youth group and volunteer work.</td>
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<td></td>
<td>• Tammy and her social worker will enroll the girls together and make sure their records are complete.</td>
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<tr>
<td></td>
<td>• Each girl will be connected with a student ambassador who will help them find their way around and introduce them to new friends.</td>
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<tr>
<td></td>
<td>• An in-home therapist will work with them several times a week for 12 weeks.</td>
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Crisis plan:
- If the girls think their mom is using again, they will tell their pastor, Tammy’s social worker or the in-home therapist.
- If they are removed again, Tammy will arrange for them to stay with a close friend from NA who has seven years clean and who has served as an emergency foster parent in the past.

*Remember Shawn? He’s gained new skills, improved his ability to express himself, mastered his temper and treats his mom and other adults respectfully with help from America’s Special Forces, sports, athletic heroes and a former marine vice principal. (pages 119-120)*

**Shawn’s Transition:** Going home from the correction/residential treatment center where he was placed by the court.
<table>
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<tr>
<th><strong>Needs</strong></th>
<th><strong>Strength-Based Strategies</strong></th>
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<tbody>
<tr>
<td>• Continued opportunities to verbalize his feelings without acting out against others</td>
<td>• Shawn will meet with the vice principal the day after he returns home, before he starts back to school. They will design an anger management plan for school.</td>
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<td>• Shawn will email his teachers and key staff at the residential treatment center to report decisions he is making. They will encourage him and report his success to his mom and probation officer by letter. (6 weeks duration)</td>
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<td>• To continue to refine and live by his new moral code</td>
<td>• Shawn can use the school workout facilities during his free period.</td>
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<td>• Shawn and his mom will work with a therapist to study his favorite sports figures, anger and the decisions they make</td>
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<tr>
<td>• To continue to triage his emotions and exercise to control them</td>
<td>• Shawn will watch his favorite movies with his mom and talk over the ethical lessons they see with a family therapist</td>
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<td></td>
<td>• Shawn will join the YMCA and work out when he needs to, outside of school hours</td>
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<tr>
<td>• Shawn’s mom will have someone to talk to about his progress</td>
<td>• Shawn’s mom will keep in touch with the therapist who worked with them at the residential treatment center. She will also have private talks with their current therapist and Shawn’s probation officer.</td>
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</table>

**Safety plan:**
- When Shawn feels like he might get out of control, he’ll walk outside and shoot baskets for 15 minutes.
- Shawn’s mom will let him go out without saying anything.
- If Shawn doesn’t go outside to cool off and his mom thinks he’s losing control, she will go to her room, close and lock the door and call Shawn’s probation officer or their therapist for advice. If she feels she’s in danger, she’ll call the police.
Transition Plan Format

Describe the transition: ________________________________________________________________

Possible transition issues: _____________________________________________________________

Life Domain/s: ________________________________ Outcome/s: ______________________________________

____________________________________________________________________________________ Measurement: ______________________________________

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