SERIOUS MENTAL ILLNESS IN RURAL POPULATIONS

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LEARNING OBJECTIVES

- Describe two factors which constitute a classification of serious mental illness.
- Describe three elevated risk factors in rural populations/communities, to inform a comprehensive assessment and treatment approach for persons with serious mental illness in order to increase outcomes related to access and engagement.
- Describe two differences between the rehabilitation/recovery model and the pathology-deficits model.
- Describe three components of the CBT Model for SMI.

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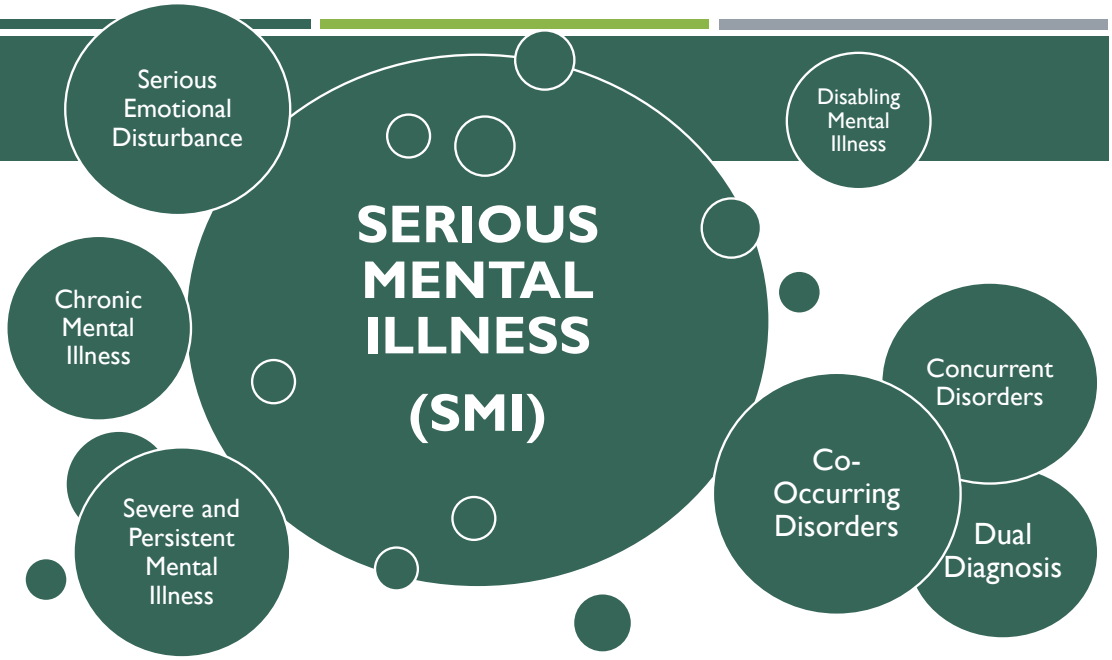

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TERMINOLOGY

- Severe Mental Illness
- Chronic Mental Illness
- Persistent Mental Illness / Severe and Persistent Mental Illness
  - "Chronic" and "Persistent" dropped in federal language[1]
  - Not all are severe or chronic & to reinforce the notion of recovery
- Disabling Mental Illness
  - For legal purposes: eligibility for disability or supplemental social security benefits
- "Dual Diagnosis" / Concurrent Disorders / **Co-Occurring Disorders**
  - Most often in reference to MH condition + substance use disorder

- Chronic Mental Illness > Severe and Persistent Mental Illness > **Serious Mental Illness**

1 (SAMHSA, 2016)

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TIMELINE & DEFINITION

- First formal movement to study SMI was NIMH conference in 1990
- First defined in 1993 as certain diagnoses which are:
  - Relatively persistent (e.g., lasting at least a year);
  - Result in comparatively severe impairment in major areas of functioning
    - Such as cognitive capabilities; disruption of normal developmental processes (especially in late adolescence); vocational capacity; and social relationships[1]
- **SAMSHA in 2013[2]:**
  - **Age 18+, diagnosable DSM disorder, currently or in the past year**
  - **Resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities (relationships, ADLs, self-care, employment, recreation)**

1(Federal Register, 1993) 2(SAMHSA, 2013) 3(APA, 2009)

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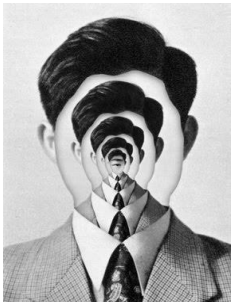
- APA:[1]
  - SMI is the term used in federal statutory and regulation language
  - "Developmental disabilities and (formerly labeled) Axis II diagnoses generally do not meet the criterion alone, but sometimes co-occur with another diagnosis that does meet it."
- SAMHSA:[2]
  - All mental illnesses have the potential to produce impairment, interfere with QOL, or qualify as "serious" based on the federal definition
- Dementia and Mental Disorders due to GMC are also excluded from SMI definition[2]
- Inclusion may vary by state, e.g., some definitions will include Borderline PD, OCD, or eating disorders[2]



1 (APA, 2009), 2(SAMHSA, 2016), 3 (Glynn & Jansen, 2016)

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- **The DSM diagnoses commonly associated with SMI include:**
  - **Schizophrenia[1,3]**
  - **Schizoaffective Disorder[1,3]**
  - **Bipolar Disorder[1,3]**
  - **Severe depression with or without psychotic features[1,3]**
  - **Delusional Disorder[3]**

- Commonly co-occur:
  - Trauma-related disorders (e.g., Posttraumatic Stress Disorder)
    - In rural populations: Generational trauma
  - Personality disorders
  - Obsessive Compulsive Disorder
  - Substance Use Disorders
  - Depression, even in non-affective disorders such as Schizophrenia, is common

1 (APA, 2009), 2(SAMHSA, 2016), 3 (Glynn & Jansen, 2016)

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- Children & Adolescents

- Serious Emotional Disturbance (SED)
  - "Diagnosable mental, behavioral, or emotional disorder in children or youth experienced in the past year that resulted in functional impairment that substantially interfered with or limited the youth's role or functioning in family, school, or community activities"[1]
    - Found in educational settings/IEPs: Term used to refer to disorders affecting academic learning and achievement

- Mental, Emotional, and Behavioral Disorders[2] (MEB)
  - Also noted as a preferred term for disorders causing significant impairment in children
  - Supported by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)

- More information: https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf

1 (SAMHSA, 2020), 2(O'Connell, Boat, & Warner, 2009)

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WHY IS SMI/SED COMPETENCE RELEVANT TO PRACTICE IN THE MIDWEST?

- SAMHSA – Early Serious Mental Illness Treatment Locator
- https://www.samhsa.gov/esmi-treatment-locator
- Living Well with Serious Mental Illness | SAMHSA

- Earlier an individual receives treatment, greater likelihood of better quality of life outcomes

- Note: Practice Guidelines actively being reviewed and updated

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- Building Workforce Capacity to Treat Adults with SMI
  - 2008 to 2013
  - Doctoral psychologists – 83258 to 83142
  - But per capita availability decreased because general population increased
  - Approximately 6 of 10 psychologists serve an SMI client in a given month
    - Average of 10 SMI clients per month by those who do
  - Example of disparity: 60% of persons diagnosed with Schizophrenia have Medicaid Coverage
    - 32% of psychologists participate in Medicaid
  - Policy changes attempting to address the issue
    - In Missouri, the Medicaid Health Home provision used to support CMHC health homes
    - Expansion of telehealth

(Offson, 2016)

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CURRENT IMPACT & FORECASTING

- 6.5% of Americans age 18 to 26 receiving disability benefits because of SMI [1,2]
- 3.5% civilian population in U.S. has a mental health related disability [2]
- At any one time approximately 20% of Americans have a diagnosable mental disorder interfering with functioning in employment, school, or daily life [3]
- 27% to 60% of persons diagnosed with SMI have a co-occurring substance abuse diagnosis[4]
- SAMHSA updated data (2017)
  - https://www.samhsa.gov/data/report/2017-how-update-samhsa-smi-and-sed-estimates

1 (GAO, 2008) 2 (Jans, et al., 2004) 3 (US Dept. of Health and Human Services, 1999) 4 (Glynn & Jansen, 2016)

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- Common overlap with co-occurring serious medical illness
- Different studies will list figures in the billions referencing "cost"
  - Defined in various ways, including lost income, cost of treatment, etc.
  - Example: Annual Expenditures for Adults with Mental and Medical Health Condition
    - Without MH Condition
      - Average: $1,913
      - High BP, Diabetes, Heart Condition ($3,481 to $4,697)
    - With MH Condition
      - Average: $3,545
      - High BP, Diabetes, Heart Condition ($5,492 to $6,919)

(MEPS, 2003)

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- Patients diagnosed with a mental health disorder and who received treatment had their overall medical costs reduced by 17% [1,2,3]
- Compared to:
  - 12.3% increase in medical costs for those with no treatment for their mental disorder[1]
  - In addition to
    - Increased suicide completion
    - Increased likelihood of legal involvement
    - Increased likelihood of homelessness

1 (Chiles, Lambert, & Hatch, 2002;) 2 (Linehan, et al., 2006) 3 (Pallak, Cummings, Dorken, & Henke, 1995)

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- **Aging Population**

- In previous 10 years, number of older adults over 65 years old increased by 33%[1]
  - Expected to double by 2060
- By 2030, all baby boomers (born 1946-1965) will be older than age 65[1]
  - One in every five residents will be over 65 years old.
  - The number of older adults will exceed the number of children
  - 4.8% will have a Serious Mental Illness
- According to APA[2]
  - An estimated 5,790 more geropsychologists will be needed in the U.S. to meet the needs of individuals 65+
- Individuals ages 85 and older have the highest rates of suicide[3]
- Older Adults Living with Serious Mental Illness The State of the Behavioral Health Workforce (samhsa.gov)

1 (SAMHSA, 2018) 2 (APA, 2021) 3 (CDC, 2022)

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- **Loss due to Mental Illness / Suicide**

- 1 life lost every 40 seconds globally, 1 life lost every 11 minutes in United States
- Second leading cause of death in 10-14 and ages 25-34 and 3rd leading cause in 15-29 year olds
- 10% of 9-12th graders report making an attempt
- More than 50% of persons who died by suicide did not have a known mental health condition
- For each loss due to mental illness, there are an estimated
  - 4 hospitalizations due to attempts
  - 8 emergency department visits related to suicide
  - 27 self-reported attempts
  - 275 people seriously considered suicide

(CDC, 2022)

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- Once suicide costs an estimated $1,329,553
  - > 97% of this cost was due to lost productivity
  - Remaining 3 percent were costs associated with medical treatment.
- Total cost of suicides and suicide attempts (2015) = $93.5 billion annually
  - *Note: Rates increased 33% between 2000 and 2018, then declined 5% between 2018 and 2020*
  - *Cost in United States more recently estimated as* $70 billion annually

- "Every $1.00 spent on psychotherapeutic interventions and interventions that strengthened linkages among different care providers saved $2.50 in the cost of suicides."

- Bipolar Disorder (depending on the source, 2014 to current):
  - Up to 60% will attempt suicide
  - 10 to 25% die by suicide (1 in 5)

Suicide Prevention Research Center (sprc.org); 2015, United States data

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- Serious mental illness is associated with an annual loss in earnings totaling $193.2 billion in the U.S. each year
  - Approximately half of cost of depression attributable to reduced productivity of workers
  - Includes direct (health care costs, disability payments, provision of EAP and support services) and indirect costs (impact on caregivers, family, communities) of mental illness
- There is hope
  - 94% of adults surveyed in the US believe suicide can be prevented Suicide statistics | AFSP

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- Persons with SMI estimated to die 25 years earlier than those without these diagnoses[1]
  - Higher rates of suicide, injuries from violence, exposure to trauma
  - Limited access to healthcare
  - Increased rates of cardiovascular illness and related deaths
    - Smoking
    - Obesity
- *…Rural communities at a higher risk for medical conditions such as obesity, diabetes, heart disease, high blood pressure*[2]
- *…Higher likelihood of health disparities in rural communities*

1(Glynn & Jansen, 2016), 2 (Crosby et al., 2005)

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Smoking cessation

- Up to 80-90% in SMI population
- SMI and concurrent substance abuse consume 44% of cigarettes sold
- Success factors:
  - Advice from physician
  - Pharmacotherapy
  - Counseling
  - Supportive environment
- Barriers: Socialization, may deliver relief from side effects of certain medications by decreasing blood levels, effect of stimulant helps with some cognitive limitations

Weight management

- Side effects of medications
- Weight gain related to development of insulin resistance, arthritis, musculoskeletal disorders, metabolic syndrome
- Research suggests greatest success associated when introduced with medication initiation
- Barriers: Available diet in residential treatment, finances

1(Glynn & Jansen, 2016)

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ATTENTION TO DIVERSITY: RURAL COMMUNITIES

- More than 1 in 5 persons in the U.S. live in a rural area[1]
  - 60% of rural Americans live in MH professional shortage area[2]
- No consistent operational definition
- Common features & considerations[3]
  - Remoteness/Isolation
  - Agriculture
  - Poverty
  - Religion
  - Behavioral norms: Smoking, underage substance abuse, sedentary
  - Stigma: Fear and discrimination

1(U.S. Census Bureau, 2010) 2 (U.S. Health and Human Services, 2012) 3(Smalley & Warren, 2012)

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- Females at a higher risk for abuse[1]
- Higher risk for medical conditions (obesity, diabetes, heart disease, high BP)[2]
- PCPs don't always have the specialized training for comprehensive treatment of SMIs
- Rural vs. Frontier
  - Various definitions
    - 0-20 persons/mile; travel distance (90miles) and travel time (90minutes) to market center
    - More recently- a statistical measurement of functional isolation

1 (Boyd & Mackey, 2000) 2 (Crosby et al., 2005)

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- Rural (vs. Urban Treatment Admissions for Substance Use Treatment)[1]
  - Younger
  - Less diverse
  - Primary use of alcohol, non heroin opiates, and stimulants
    - Urban: primary abuse of heroin or cocaine
  - More likely to be referred by CJS, Less likely to be self-referred
  - Almost twice as likely to engage in daily use (ages 12 and older)
  - No significant difference regarding co-occurring MH disorders
  - More likely to have full time employment
    - Urban: more likely to be homeless

1 (SAMHSA, 2012)

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- Negative outcomes associated with SMI populations often amplified in rural areas

- Five leading causes of death in rural communities (January, 2017)[1]
  - Heart disease, cancer, unintentional injury, chronic lower respiratory disease [CLRD], and stroke
  - Mortality decreasing at a lower rate than urban populations
    - More potentially preventable deaths (those in persons <80 years in excess of what would be expected)
  - Contributing factors: Older age, lower income, more illnesses, limited physical activity, social circumstances and behaviors
  - Tobacco use increases chance of heart disease, chronic lower respiratory disease, and stroke

1 (Garcia et al., 2017)

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- Nationally cigarette use is higher among adults in rural versus urban counties
- Self-reported obesity was higher in rural than urban areas; increased with greater rurality
- Rural counties have a higher rate of un-insured persons, shortages in providers, lack specialty care options, longer distance to travel in emergencies, lack of screening services for early identification
- Unintentional injuries include trauma in vehicle accidents to substance overdose (opioids)
- Funding is often allocated on basis of population, leaving rural areas underfunded despite higher risk

- Common values: Determination, hard work

1 (Garcia et al., 2017)

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- How equipped do clinicians feel in rural areas?

- MH Providers in Rural Appalachians
  - 83% regularly treat substance abuse concerns
    - Only 66% felt competent to treat individuals with SA concerns
  - 90% domestic violence issues
  - 80% regularly work with individuals with disabilities
  - 52% work with LGBT+ populations
  - 41% work with older adults

(Hastings & Cohn, 2013)

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A FEW DIVERSITY RESEARCH UPDATES…

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FARMING/AGRICULTURE

- Stressors: Rain/drought, crop productivity, isolation,[1] livestock issues (theft, trauma), land ownership, price changes, natural disasters[2]
- Suicide rate: 36 per 100k compared to 27 per 100k on average in other professions [2]
- Symptom yield may be similar (depression, anxiety) – understanding culture, community, cause is critical [1,2]
- Active Coping, African American Farmers [3]
  - Minimal literature focusing on health of older farmers with historically marginalized identity(ies)
  - Positive perspectives on work and farm future, and attachment to the land
- Mobile App:
  - Testing suggested needs for more frequent reminders, higher quality audio recordings, and shorter modules[4]
  - Other research found preferences for specific themes, colors, relatedness factors
- Protective factors, Resiliency
  - Increasing social support and sense of belonging[5]

1 (Padhy et al, 2020) 2 (Parrish, 2016) 3 (Maciuba et al, 2013) 4 (Gunn et al, 2022) 5 (McLaren & Challis, 2009)

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PARENTS & CHILDREN

- Rural mothers with mental health symptoms[1]
  - Expressed strong desire for connection
  - Connectedness to self and others, broader meaning and purpose can expedite recovery for rural women
  - Prior trauma and rejection created development of trust barriers, preventing some mothers from seeking connection
  - *SIDE NOTE ON GROUP THERAPY IN 2023*
- Impact of rurality on anxiety in school age children[2]
  - Can have significant negative impact on anxiety and its management, *but* school-based interventions can minimize effect on academic outcomes
  - Importance of embedding when possible and relationship with school
- Sociodemographic risk factors and child temperament[3]
  - High negative affectivity driven by a. rural status and b. income-to-needs risk
  - Rurality predicted negative affectivity over and above

1 (Hine et al, 2018) 2 (Harvey & Clark, 2020) 3 (Gouge et al, 2020)

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What factors should be considered in your rural or frontier clinic / services for them to be inclusive and welcoming to all?

DISCUSSION QUESTION

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CURRENT GLOBAL STATE OF AFFAIRS

- COVID-19 pandemic
- Civil rights, human rights, and inclusion related issues
- Adults with SMI and children with SED/MEB
  - Preparation for a disaster may be harder
  - Symptoms may worsen
  - May need specific support during response and recovery phases of a disaster
- SAMHSA: Disaster Behavioral Health Information Series (DBHIS)
  - Resources related to SMI and SED in the context of disasters
  - https://www.samhsa.gov/dbhis-collections/smi

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- **Side note on isolation and loneliness**
  - Isolation - characteristic of some rural and frontier areas
  - Isolation/Loneliness - Risk factor associated with suicidal ideation
  - Isolation/Loneliness – Increases observed during COVID-19 pandemic
  - 2019 Study of 20,000 individuals
    - 47% reported feeling alone
    - **13% reported feeling they had not one person in their life that knows them well**
      - At least 1 in 10 !

(Cigna, 2019)

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- Problems with:
  - Availability
  - Accessibility
  - Acceptability
- Overlapping characteristics of rural settings and SMI populations contribute to
  - Entering treatment late
  - Entering with more advanced symptoms
    - Thus often requiring more intensive and more expensive forms of treatment
  - Smaller social support networks
  - A negative perception of treatment providers / healthcare system
  - In other words, missing many of the insulating and protective factors associated with recovery

SMI/SED Populations are Underserved. Rural Populations are Underserved.

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- APA argues 1/3 to ½ of persons with SMI reach recovery potential to return to an improved level of functioning, BUT may not be able to do so because of other barriers[1]
  - Client's own perception of functional deficits
  - Too few psychologists with a combination of clinical, administrative, and advocacy skills[2]
  - Policies
  - Third-party reimbursement issues
  - Lack of established comprehensive systems with necessary components
  - Student loan debt
  - Lack of staff or appropriately trained staff
  - Public belief SMI is not associated with recovery; Stigma
  - May make working with SMI in rural regions less attractive
  - Risk of rehabilitation efforts becoming "community based custodial care" or cycle of chronicity
  - ***But not after today !!***

1 (APA, 2009) 2 (Reddy et al., 2010)

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THINGS ARE IMPROVING

- Research continues to provide support for recovery-based models which not only manage the symptoms but improve quality of life
- In short-term treatment, the percentage of individuals improved[1]:
  - 60% for schizophrenia, 80% for bipolar disorder, and 65% for major depression
- One-year relapse rates were significantly different as compared to placebo groups[1]:
  - Schizophrenia (25% v. 80%), bipolar disorder (34% v. 81%), and major depression (18% v. 65%)

1 (Davidson, Harding, & Spaniol, 2005; 2006)

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- There is a growing emphasis from professional organizations on "recovery" rather than just maintenance of remission
  - Research and literature within the last 10-15 years
  - APA Resolution on Recovery (2009)[2]
  - 2010 APA Convention
  - Arthur Evans Jr, PhD testifies on Capitol Hill, March 26, 2014.[3]
- Reports document less than half of persons with SMI seeking some form of treatment[1]
  - Even fewer seen by a mental health professional
  - Research suggests the treatment the SMI population historically received was rarely evidence based practices known to produce positive outcomes
    - Thus lessening the likelihood of return and increasing cynicism
    - CASE EXAMPLE: Misdiagnosis, Needs not met, Perception of incompetence
- There is a need to train mental health providers ***now.***

1 (US Dept. of Health and Human Services, 2007) 2 (APA, 2009) 3 (Evans, 2014)

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- APA argues the core competencies associated with proficient treatment of persons with SMI are unique and distinct[1]
  - Particularly in the case of persons who developed SMI symptoms early (e.g., adolescence) and have been vulnerable for much of their life
- For instance, modification to develop a comprehensive approach may be indicated
  - E.g., Social skills training for social phobia (i.e., role-play and HW) may be used for psychosis, but modified with features such as focus on appropriate self-disclosure, personal hygiene and subtle social cues
    - More generic interventions must be tailored to be distinct[1]

1 (APA, 2009)

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THE RECOVERY & REHABILITATION MODEL

- SMI historically thought of as untreatable in psychotherapy[1]
- SMI historically acknowledged as a biological disorder (esp. Schizophrenia and Bipolar Disorder) requiring only medication and institutional care[2]
- Increased public awareness: The New York Times commented on recent research (2015)[3]
  - Talk therapy is an effective treatment component for schizophrenia spectrum disorders
  - Based upon Kane et al. (2015) study in American Journal of Psychiatry[4]
    - NAVIGATE, a comprehensive, multidisciplinary, team-based treatment approach
    - 1) help with social needs, 2) education for family members, 3)talk therapy to learn treatment tools
- Move away from the pathology deficits approach…

1(Wright et al., 2009) 2(APA, 2009) 3(Carey, 2015) 4(Kane et al., 2016)

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Pathology-Deficits Approach / Medical Model	Recovery-Rehabilitation Model
Problem focused	Strength based
Past failures	Focus on success
Do for the individual	Collaborate with individual
Provider recommends	Integrated team
Dependence	Gradual independence

Fix this broken part

Keep the best parts and customize

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- **Recovery / Rehabilitation Model**
- President's New Freedom Commission on Mental Health (2003), ***recovery*** is[1]:
  - "…the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms… Science has shown that having hope plays an integral role in an individual's recovery" (p 5).
- *Objective:* Improvement in symptoms [2]
- *Subjective:* Changing attitudes to reflect hope, self-efficacy, empowerment[2]
- **Recovery**:
  - A framework for the intended outcome
- **Rehabilitation**:
  - The supports provided in the process
  - Referred to as PSRs – Psychosocial Rehabilitation Interventions

1 (President's New Freedom Commission on Mental Health, 2003) 2 (APA, 2009)

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- Barriers the provider and consumer must overcome: [1]
  - Stigma the individual with SMI has incorporated into their own beliefs
  - Previous negative treatment experiences
  - Lack of prior opportunities for self-determination
  - Negative side effects of no employment or unrealized goals
  - The highest reason for treatment not being sought or dropping out was wanting to solve the problem on their own[2]
- To make this change, delivery should focus on:
  - Consumer/Family driven services (i.e., holistic)
  - Increasing ability to cope with life challenges (build resilience not just reduce symptoms)
- The model aligns with changing landscape of healthcare[3]
  - Emphasis on providers measuring and documenting change
  - More and more, we are educating the public on Mental Health First Aid, suicide, and comfort talking about mental health

1 (Glynn & Jansen, 2016) 2 (Kessler, 2001) 3 (Evans, 2014)

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WHY ARE THE FIRST SESSIONS CRITICAL?

- Modal # of behavioral health visits is frequently ONE (Why?)
- AND *both* clients and treatment providers rate quality of relationship as the curative factor when they experience improvement
  - Person Brain Model Hint: Theories don't change people, **people change people**
- No pressure. Be patient.
  - An opportunity for a corrective experience may be eventual
  - What is immediately critical is facilitating a *positive treatment experience*
  - For most people to heal / get better / improve, they will need enough trust built to come back.

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HOW DO WE ACHIEVE ENGAGEMENT AT THE OUTSET?

- Two things to fall back on:

1. Apply basic neuroscience as it relates to relationships
2. Implement best practice engagement actions

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NEUROSCIENCE & RELATIONSHIPS

- The Person Brain Model (Brief Overview)
  - Relate well and react less
  - Blends brain and relational science, trauma-informed approach
- Four Elements of Flourishing
  - Understand basic functions and needs
  - **Safe – Significant – Respected – Related**
  - Relatedness and inclusion
  - A focus on connection can create hope, which stimulates courage

(Baker & White-McMahon, 2017)

- Our brain is wired for survival
  - AND is wired for the potential to change
    - Neuroplasticity – brain can change throughout the lifespan
    - Epigenetics – brain is sculpted by the environment

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- Culture
  - Respect is filtered through culture
    - Be intentional about understanding individual cultural experiences
- Triune Brain (adapted from Paul McLean)
  - **Survival**
    - Recognize threat/danger and keep us alive
      - **Emotional**
        - Memories and experiences ("Spice", Intensity)
          - **Logical**
            - Thinking, decision making, attention

(Baker & White-McMahon, 2017)

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- Journey to Neurotransactional Repair

  Hope → Motivation → Transformation → Resilience

- Facilitate sequence with Neurodynamic Interventions
  - Normalizing, flourishing, belonging, attachments, reimbursements…

- Dopamine
  - Levels influence whether we feel shame or success
  - Stimulates mood, motivation, attention
  - Helps us see rewards and take action toward them…
    - **Creates potential for hope**

- "Therapeutic helpers craft experiences that reshape the brain"

(Baker & White-McMahon, 2017)

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COMPONENTS OF RECOVERY MODEL

- **Assessment**[1,3]
  - Diagnosis, functional behavior, and the biopsychosocial interaction
  - Strengths-based assessment
  - Identification of cognitive deficits and executive functioning
- **Engagement**[1,2,3]
  - Education, Role Induction, Rapport, Consumer Collaboration, Establishing Supports
- **PSR Interventions**
  - Evidence Based, Promising Best Practices, Supporting Services[3]
  - Integrative: Psychological, psychosocial, and psychopharmacological methods[1]
- **Goals Emphasizing**[2]
  - Adherence to interventions/objectives, maintenance of progress, and prevention of relapse
  - **Recovery:** reducing symptoms, improving functional skills/capabilities, and improving QOL

1(APA, 2009) 2(Wright et al., 2009) 3(Glynn & Jansen, 2016)

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- In rural settings,
  - Important to be a generalist, with skills developed in both psychological assessment and delivery of intervention[1]
  - Common problems in the interaction of psychological and biological factors, resulting in:
    - Poor stress tolerance, poor emotional regulation, severe cognitive deficits, agitation or impulsivity, extreme anxiety, depression, and/or social withdrawal
  - Cognitive impairment is one of the major components of the disorder, per developing research[1,2]
- CONSULTATION EXAMPLE – Why facilitate both therapy and assessment?
- To be particularly relevant in treating this distinct population, establishment of psychological assessment skills is highly recommended[1]
  - Specialized testing skills are suggested:
    - Neuropsychological testing, observational assessment, functional behavioral analysis
    - Strengths based assessment skills[2]

1 (APA, 2009) 2 (Glynn & Jansen, 2016)

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- Perhaps more important is the ability to establish a working relationship[1] to facilitate engagement[2]
  - Relationship building with consumers, family, and community partners
  - An amplified need in rural communities
- The model is new
- Early career psychologists (ECPs) will commonly be adopting the role of educator for consumers, their families, and *practicing healthcare providers*
  - Consider, a graduate from even just 5 years ago likely did not have a course in SMI
- Program development in rural communities will be an essential skill for the current generation of ECPs

1 (Wright et al., 2009) 2(Glynn & Jensen, 2016)

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ASSESSMENT

- Diagnostic interview and social history are necessary ***but insufficient***

- Include Strengths-Based Assessment[1]
  - Capabilities, accomplishments, potential

  - What is something you are proud of?
  - What are some dreams for the future?
  - What matters the most to you?
  - When you started high school what did you want?

  - CASE EXAMPLE: The joy of vacuuming and color TV

1 (Glynn & Jansen, 2016)

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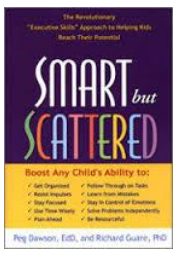
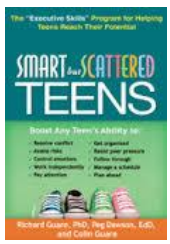
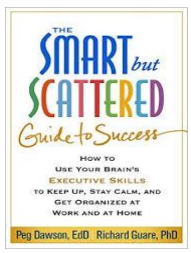
- Assess co-occurring medical needs
  - Tobacco use, weight management
  - Consent to communicate with physician, dietician, etc.

- Assess cognitive impairment and executive functioning
  - Emerging research and publications on executive functioning skill development
  - "Smart but Scattered" book series
    - Child, Teen, Adult
    - Each book includes an assessment of areas for growth and **strengths** plus corresponding EF chapters







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ENGAGING PEOPLE AS PARTNERS

- Person Centered Planning[1]
  - Assessment of cultural factors
  - Awareness of possible reasons people are reluctant to engage
    - Past negative experiences
    - Stigma
    - Don't believe they need treatment
    - Severity
    - Social barriers: poverty, homelessness, physical health, social skills
  - Avoid leading discussion with ideas about adherence (*but* provide details on possible duration for positive change)
  - Ask who they would like involved in the treatment process
  - Shared decision making
    - Promotes empowerment, and creates consumer responsibility and accountability

1 (Glynn & Jansen, 2016)

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PSR INTERVENTIONS

Evidence Based Practices[1]

- **Family based services**
- **CBT**
- **Skills training**
- **Concurrent disorders interventions**
- **Psychosocial interventions for weight mgmt.**
- Assertive community treatment
- Supported employment
- Token economy

Promising practices[2]

- Medication management for adherence
- Cognitive remediation
- Psychosocial treatments for recent onset schizophrenia
- Peer support/Peer delivered services

1(Glynn & Jansen, 2016) 2(Dixon et al., 2009)

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- EBPS[1]
- Family Based Services[1]
  - Family psychoeducation
  - Anxiety and mood symptoms commonly manifest in the family members of persons with SMI[2]
- CBT
- Skills Training
  - Application of behavior therapy not focusing on symptom reduction but on improving functioning
  - Behavior shaping
- Interventions for Concurrent Disorders
  - Motivational Interviewing
  - Treatment more effective when treatment for both disorders offered by one educated provider
  - Research notes limits using MI for SMI beyond substance use intervention

1(Glynn & Jansen, 2016) 2(Weiss et al., 2009)

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- PROMISING PRACTICES[1]
  - Integrated approach, includes cognitive enhancement approaches
- Cognitive Remediation
  - Behavioral shaping targeting neuropsychological functions (attention, concentration, planning, memory)
- Medication/Illness Management
  - Strategies to increase adherence, including education, stress management, support involvement
- Early Psychosis Interventions
  - Common onset is 15 to 26 (for all SMI); suicide risk higher
  - Multimodal – includes many of the aforementioned interventions
  - Delays in assessment and treatment often interfere with intervening in the critical period

1(Glynn & Jansen, 2016)

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ACTIVITY: RESOURCE EXPLORATION

Rural Hub

- www.ruralhealthinfo.org

SMI Advisor

- https://smiadviser.org/

(SAMHSA) Disaster Behavioral Health Information Series (DBHIS)

- https://www.samhsa.gov/dbhis-collections/smi

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CBT-MODEL FOR SMI TREATMENT

- Wright et al. (2009) strongly emphasize in the CBT Model that CBT is actually but one feature of a comprehensive approach[1]
- For instance there is a lack of evidence supporting CBT as a stand-alone treatment for schizophrenia or bipolar disorder[1]
  - Even if the patient refuses medication, one CBT-oriented goal is to promote acceptance of pharmacotherapy
- Meta-analysis supporting CBT + pharmacotherapy as more effective than either alone in treatment of depression[2]

1 (Wright et al., 2009) 2 (Friedman, 2006)

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WHY THE CBT MODEL FOR SMI?

- CBT does not only have to be about adjusting thoughts and behaviors
- More broadly, integrative CBT can be thought of as a means of increasing patient activation in their own lives
- In other words,
  - Clarifying familiar routines associated with less than optimal outcomes,
  - while taking the patient out of "reactivity" and seemingly automatic habit,
  - in conjunction with facilitating hope associated with recovery rather than maintenance,
  - can offer an opportunity for success a patient with SMI may not have thought possible
- Plus, the components of the CBT model align fairly well with APA/SAMHSA recommendations for Recovery and Rehabilitation in the treatment of SMI

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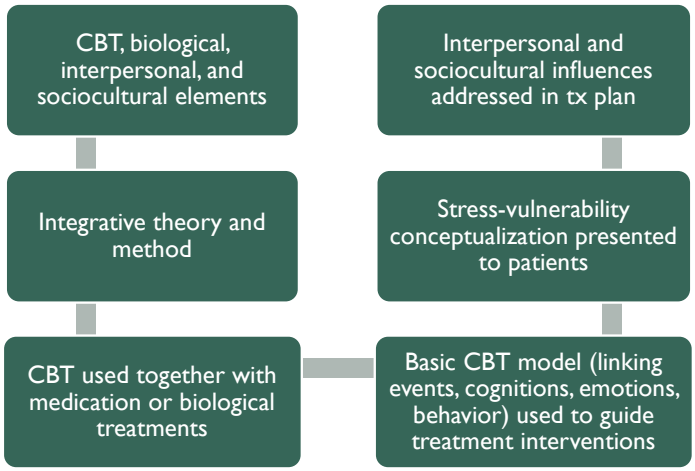
CBT MODEL: COMPREHENSIVE APPROACH



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Three Common CBT methods (in conjunction with assessment)[1]

- Optimize the therapeutic relationship **(Assess, Engage)**
  - Interest in treatment may range from wariness to aversion
  - Slowly paced, nonthreatening questioning
  - Ranging from collaborative (as suggested by all CBT formats)[1] to a variation of "befriending"[2] (such as in thought disorders or treatment-resistant depression)
  - "Promoting a good working relationship is the rate-limiting step for treatment progress"[1]
- Normalize and destigmatize **(Engage)**
  - Help patient
    - Develop healthy attributions (i.e., meanings attached to the illness)
    - Minimize self-criticism
    - Adopt a problem solving attitude
    - Accept stress-vulnerability conceptualization
    - View the therapist as an ally
- Provide psychoeducation **(PSR)**

1 (Wright et al., 2009) 2 (Kingdon and Turkington, 2005)

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Additional CBT Methods **(PSR)**

- Modify Automatic Thoughts
- Implement Behavioral Strategies
  - Consider blending Motivational Interviewing
  - Both as interventions and relapse prevention planning
- Modify Core Beliefs
  - During assessment, determine if patient is a candidate for schema change interventions to modify maladaptive beliefs
    - Schemas about trust in schizophrenia; Schemas about self-image in bipolar disorder
- Address Problems with Concentration or Thought Disorder
  - Modify treatment methods; Monitor impact of impaired thoughts
  - Employ Executive Functioning Interventions (See: "Smart but Scattered" books)
- Enhance Adherence
- Treat Co-morbid Substance Abuse
- Establish Relapse Prevention Skills

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- Actions in the Initial Sessions

- **Engaging and Assessing**
  - Be patient
  - Development of a therapeutic relationship may be a primary goal in and of itself,
    - E.g., first step toward challenging the belief others are dangerous
  - Barriers
    - Inherent barriers associated with symptom clusters
    - Personal circumstances: negative treatment experiences, symptoms viewed as positive or enjoyable
    - Sociocultural: past discrimination
    - Service issues: negative treatment experiences, financial constraints, medical needs compete with MH needs, effects of medication/medication beliefs (side effects, incorrect dosage, medication seen as only solution)

(Wright et al., 2009)

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- **Normalizing**
  - Improves collaboration and reduces stigma
  - Commonly cited that 20% of persons will experience MI, 90% are estimated to recover
- **VIDEO CLIP 4**
- **Educating**
  - Match intellectual level
  - Emphasize collaborative learning rather than lecture
    - Encourage questions, use handouts, ask for feedback or summaries
    - Assign reading
  - Consider use of "therapy notebook"

(Wright et al., 2009)

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CBT MODEL: CASE CONCEPTUALIZATION

- Biopsychosocial Model; Comprehensive **(Goals)**
  - Case Formulation Worksheet: https://www.appi.org//File%20Library/Products/APP_62321_Appendices-CBT_Wright.pdf
- Building a Timeline
  - Use Socratic questioning
    - Can you remember when you last felt really well?
    - What was happening at that time?
- Assess vulnerability
  - Do you know anything about your birth? Complications/illnesses? (Organic)
  - Did you suffer major losses during childhood? Episodes of bad treatment during childhood? (DEP/TR)
  - Have you always been the type of person fascinated by the occult/magic? (SCH)
  - Have you always been negativistic/perfectionistic type of person? (DEP)
- Identify Schemas

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TREATMENT APPROACHES

- Schizophrenia Spectrum Disorders
  - Hallucinations, delusions, perceptual disturbances
- Bipolar Disorder
  - Manic symptoms
- Persistent and/or Severe Depression
- Co-Occurring Substance Abuse

- Overlooked Associated Features

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SCHIZOPHRENIA SPECTRUM DISORDERS

- The impetus toward recovery stimulated research within the last ten years to "remodel" the treatment approach for schizophrenia
  - Some are listed in the APA CAPP Task Force on Serious Mental Illness/Severe Emotional Disturbance 2011 – 2012 Report[1]
- Meta-analyses support integration of cognitive remediation and psychosocial rehabilitation to create stronger overall effect[2]
  - A key feature is the use in conjunction
- Dilemmas[3]
  - Associated symptoms suggest goal and agenda setting themselves as an intervention to document and measure
    - If misperceived (i.e., in thought disorders or manic states), the relationship may suffer
  - CASE EXAMPLE – "…medications can decrease symptoms in 75% of individuals diagnosed with schizophrenia and reduce the risk of relapse from 70% to 30-40%..."[4]
  - Attempts to modify schemas for patients who are delusional are counterproductive

1(APA, 2012) 2 (McGurk, 2010) 3(Wright et al., 2009) 4(Falloon et al., 1998)

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DELUSIONS

- Emphasis on relationship
  - Expect beliefs to be resistant to change initially; Gradual; Often shorter initial sessions
  - Help patient see therapist views them as person rather than illness
- Assessment
  - Important to examine the historical details in period preceding first episode
  - Onset of beliefs, any possible stressful events,
    - Triggers may be reminders rather than events, or accumulation of minor stressors
  - Search for stress-vulnerability explanation
    - Determine how thoughts were linked to triggers and how together they became beliefs
  - Consider strength of beliefs (PSYRATS) and insight (Beck Cognitive Insight Scale)
- Plausible Education and Normalization
  - Paranoia in response to stress; heightened vigilance can be a normal adaptive response to feeling threatened
  - VIDEO 5: Tracing the Origins; VIDEO 16: Investigating a Delusion

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- Modifying Delusions
  - Examining evidence and impact on functioning
  - This often includes involving family members or trusted peers to help the patient collect and challenge evidence in vivo
- Interventions
  - Evidence for / Evidence against cards
  - Perspective taking exercises
  - ABC Technique
  - Thought Records (Simplified – Three columns rather than more complex strategies)
    - Event, Automatic Thought, Realistic Thought
- Schema Modification
  - Be sensitive; Consider a focus on reducing overgeneralization

CASE EXAMPLE: Imbalance of investigation and empathy; Complaint to administrators

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- Grandeur
  - Unrealistic goals – (movie star, football player, etc.)
  - Use gradual guided discovery rather than immediately eliminating hope with reality testing
  - Work toward goals could be motivating, then adjust perception at a later stage
    - "If you are going to be a film star, what are the first hygiene steps you might take?"
- **Resistant Delusions (VIDEO 7) "Agreeing to Differ"**
  - Redefine Expectations – Focus on shifting behavior patterns assoc. with managing stress
  - Inference Chaining – Identify a troubling belief and ask questions to determine what it infers
    - Opens up a new dialogue…When did you first feel this way? Cause you trouble?

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HALLUCINATIONS

- Engaging
  - Collaborative Empiricism – therapist and patient explore the voice hearing together like scientists testing hypotheses; Avoids confrontation
  - Lines of questioning (p. 129)
  - If rapport is established, consider homework which helps gather information
- Normalize
  - You are not alone; One person in approx. 50 (2-3%)
  - If asked directly and you haven't hallucinated – consider an honest response
    - Perhaps you have awoken thinking the phone was ringing – experienced a common hypnogogic hallucination
- Introduce CBT model
  - Explain the tracking process of triggering events, associated thoughts and emotions
- Generate a "Problem List"
  - Patient records issues they wish to work on and collaboratively select targets

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- Interventions
  - After relationship is formed and patient desires to learn more
  - Work on developing rational / functional explanations
    - Socratic questioning, examining evidence, checking out beliefs with trusted others
    - Resistance: Provide pamphlet, "Did you read anything that gave ideas for different possibilities?"
      - Be creative: Where can we find out what the devil has said to people in the past?
  - Voice Diary
    - What was I doing? How strong? How did I feel?
    - Examine links between triggers and patterns between emotions to suggest coping strategies
  - Audio record the voices to challenge fear others hear them
  - Coping strategies
    - Distraction, Focusing, Schematic/Metacognitive
    - Coping cards
  - Graded exposure
    - For co-occurring intrusive recollection, associated with trauma/stress

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NEGATIVE SYMPTOMS

- Alogia - lack of thoughts
  - Focus on improving communication
- Attention deficit – inability to focus/concentrate
  - Focus on distracting influence of voices or ruminations
- Anhedona – absence of feeling
  - Avoidance due to numbing? Consider trauma informed care
- Amotivation – limited level of activity
  - Re-evaluate attainability of goals; Adjust expectations
  - Remember from MI – Avoid Argumentation and Roll with Resistance en route to Supporting Self-Efficacy
  - Find the balance between validation and enabling

- Don't underestimate the potential one has to adapt to an injury or disease
- Paradoxical – suggest patient take time off or back off on expectations; set goals to take back control

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- Share the strategy with caregivers / family
- Assist them letting the patient take the lead ; their efforts may be perceived as pressure
- Broken leg analogy
  - Rest and immobilize the broken bone, without doing so, it fails to heal properly
  - After it heals, gradually complete physical therapy to use the leg again, putting minimal pressure on it
  - If a broken leg isn't allowed to heal, a person might not be able to walk with it
  - If a broken mind isn't allowed to heal, a person may be limited in ability to think with it

1. Review barriers to progress (i.e., what is the cause of social withdrawal?)
2. Identify motivating interests
   a. Consider period of rest/readjustment
3. Establish small goals as steps toward road to recovery
   a. Graded tasks; Classic cognitive behavioral interventions + TMC + MI

- VIDEO17: Treating Negative Symptoms (Time Pending)

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IMPAIRED COGNITIVE FUNCTIONING

- Historically limited psychological intervention for disorganized thoughts or dialogue
- Pseudophilosophical thinking – search for meaning or avoidance?
- Wooliness of thought – vague and imprecise
  - Speak in brief concise statements
- Talking past the point – introduce "press the buzzer" intervention
- Concrete thinking – ask for feedback, use visuals (whiteboard, etc.)
- Tangential thoughts – use whiteboard to zig-zag points compared to intended goal
  - Challenge patient to identify intended message, slow down, and explain how points relate
- Loose associations – identify targets, gently bring back focus
- Thought blocking (gaps, stoppages) – identify thoughts immediately before the block
  - Often it is anxious or unpleasant, then shift focus to coping methods

- VIDEO 15: Helping with Thought Disorder

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- **More Serious Symptoms**
- Knight's Move Thinking – sudden jump between concepts
  - Usually possible to ask why/how the jump occurred rather than disengage
- Derailment – more gradual
  - Ask to stop and complete the previous point
- Fusion
  - Identify the main themes and shape interview to focus on them
- Neologism – two unrelated sections of words
  - Attempt to discover why they were put together
- Word Salad
  - Involve caregivers, attempt to identify links between changes in severity of word salad as a means of detecting stressors

- A common theme in intervention is maintenance of reflection and the collaborative relationship
  - Can be a corrective experience itself, in that these symptoms oft prompt others to disengage

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DEPRESSION CHRONIC AND TX-RESISTANT

- Anti-suicide Plans
  - Identify reasons to live
  - Safety precautions
  - Identify adaptive cognitions and behaviors to fight despair
  - Identify coping strategies for possible triggers
- Building Hope
- Challenge Low Energy and Lack of Interest
  - Promote strengths
  - Motivational Interviewing
- Schema modification for low self-esteem (considerable time and effort, be patient)
  - From "I'm worthless" to "I've had some success and want more."
  - Frequent homework to put revised schemas into place (Acceptance interventions)
- CBT interventions for sleep to regulate circadian rhythms and sleep-wake cycle

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BIPOLAR DISORDER -MANIA

- Peak of mania – Hold off on teaching new skills
- Primary emphasis of this treatment approach is prevention of recurrent episodes through early recognition of symptoms
- Barrier – pleasant experiences with grandiose, euphoric manic symptoms
  - i.e., mania following depressive episode may be welcomed by the patient
  - Initiate problem solving strategies for periods of racing thoughts
- An initial step – working with the patient to conclude / commit to treating mania
  - Those who enjoy euphoria often despise the depressive episodes, so learning to control mania can be presented as a way to manage the illness as a whole

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- **Mania Prevention Plan**[1]
- Lifestyle management
  - Manage medications – discontinuing meds is most common precipitant
  - Manage sleep – preventive strategies, stimulus control
  - Manage stress – help cope with IP conflict
    - Socratic questioning versus suggesting what to say
    - Be patient teaching assertiveness skills
  - Activity, Symptom triggers, Substances (60-70% prevalence)
- Recognize Emerging Symptoms
  - Worksheets for recognition and monitoring (See next slide)[2]
- Plan Ahead
  - Avoid exacerbating stimuli, Plan for temptations, Talk treatment adherence, Stabilize sleep, Encourage calls for help
- Take Action to Control Symptoms (Catch – Control – Correct)[2]
  - Learn from each experience

1 (Basco & Rush, 2005) 2 (Basco, 2006)

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Table 8–4. Mild, moderate, and severe symptoms of mania

Mild	Moderate	Severe
Everything seems like a hassle; impatience or anxiety	More easily angered	Irritability
Happier than usual; positive outlook	Increased laughter and joking	Euphoric mood; on top of the world
More talkative; better sense of humor	In the mood to socialize and talk with others	Pressured or rapid speech
More thoughts; mentally sharp, quick; lose focus	Disorganized thinking; poor concentration	Racing thoughts
More self-confident than usual; less pessimistic	Feeling smart; not afraid to try; overly optimistic	Grandiosity—delusions of grandeur
Creative ideas, new interests; change sounds good	Plan to make changes; disorganized in actions; drinking or smoking more	Disorganized activity; starting more things than finishing them
Fidgety; nervous behaviors like nail biting	Restless; prefer movement over sedentary activities	Psychomotor agitation; cannot sit still
Not as effective at work; having trouble keeping mind on tasks	Not completing tasks; late for work; annoying others	Cannot complete usual work or home activities
Uncomfortable with other people	Suspicious	Paranoia
More sexually interested	Sexual dreams; seeking out or noticing sexual stimulation	Increased sex drive; seek out sexual activity; more promiscuous
Notice sounds and annoying people; lose train of thought	Noises seem louder, colors seem brighter, mind wanders easily; need quieter environment to focus thoughts	Distractibility—have to work hard to focus thoughts or cannot focus thoughts at all

Source. Reprinted from Basco MR: *The Bipolar Workbook: Tools for Controlling Your Mood Swings.* New York, Guilford Press, 2006, p. 60. Used with permission.

Category	When manic	When depressed	When feeling OK
Mood			
Attitude toward self; self-confidence			
Outlook on the future; thoughts about suicide			
Usual activities			
Social activity			
Ability to function			
Sleep habits			
Appetite/eating habits			
Concentration and decision-making ability			
Energy level			
Creativity			
Speech patterns			

Figure 8–1. Symptom summary worksheet.

Source. Adapted from Basco MR: *The Bipolar Workbook: Tools for Controlling Your Mood Swings.* New York, Guilford Press, 2006, p. 63. Used with permission.

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CO-OCCURRING SUBSTANCE ABUSE

- Mental health and substance use – leading cause of combined disability and death in women
  - Second highest in men
  - Predicted to be in top five leading causes of mortality and disability by 2020 [1]
- The most common co-morbid issue with SMI [2]
  - Estimated 50% of persons with SMI will have a co-occurring substance abuse issue during their life
    - Schizophrenia=4x as likely; Bipolar Disorder=5x as likely
    - 22.3% versus 7.7% (adults without serious psychological disorders)
- Empirical correlates
  - Substance use treatments for non-SMI populations must be modified[2]
  - Support for a shift from the acute care model to a longitudinal recovery management model

1(DeLeon et al, 2011) 2 (APA, 2009)

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- Additional resources
  - "Treating Patients with Bipolar Disorder and Substance Dependence: Lessons Learned" (Weiss, 2004)
  - *Co-Occurring Disorders* by Charles Atkins, MD (2014)
    - Example treatment plans with specific goals and how outcome/progress is measured
    - Broken down by various combinations of substance and mental health disorders

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CO-OCCURRING TRAUMA DISORDER

- Beyond the scope of the current presentation
- Trauma-Informed interventions (e.g., TF-CBT, ACT)

- Consider Attachment, Regulation, and Competency (ARC) protocol
  - Framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress
  - Treatment planning for the child and caregiver (who may also be responding to the world as influenced by complex trauma symptoms)
  - http://www.traumacenter.org/research/ascot.php
  - Blaustein and Kinnibaugh (2010): *Treating Traumatic Stress in Children and Adolescents*

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ACTIVITY: RESOURCE EXPLORATION REVISITED

Rural Hub

- www.ruralhealthinfo.org

SMI Advisor

- https://smiadviser.org/

(SAMHSA) Disaster Behavioral Health Information Series (DBHIS)

- https://www.samhsa.gov/dbhis-collections/smi

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RURAL RECAP: INCREASING ACCESS

- 7 year study on SMI population patient satisfaction in rural community with CMHC + general practitioner treatment[1]
  - Use of case management, relationship building, continuity of care
  - Improvement noted in psychotic and affective symptoms
  - Patients were overall satisfied with local services, but most satisfied with GPs
  - GP is a key entry point for intervening with this population

- Partnering with medical and community providers is ***an essential entry point*** for successful implementation of comprehensive SMI programs

1 (Ruud et al., 2016)

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BEST PRACTICES

- Preparedness & Proactivity
  - Pre-established consent, confidentiality, information sharing policies
- Generalist
  - Psychological assessment, psychotherapy variants, familiarity with community and population-specific resources
- Assertive, Yet Patient
  - Maintenance of referral relationships & advocacy, but patient when establishing rapport with patients
- Recovery / Rehabilitation Philosophy
  - The empirical trend is toward recovery for persons with SMI, not simply maintenance
- Insulating Factors
  - Self-Care Plan (Pre-established boundaries, Peer consultants, Regular self-evaluation); Familiarity with new policies, treatments, community resources, ethical requirements

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- Early emphasis on the relationship[1]
  - Balancing features such as hope (i.e., depression), safety (e.g., thought disorders), and education
- Social and community interventions should complement biological and psychological interventions to reintegrate the person into a supportive social environment. [2]
- Involvement of family or support network[3]
- Medication adherence and psychosocial issues should be on the agenda for every session[1]
- Even if a provider's clinical repertoire is strong, competencies in policy, administrative, organizational, and community-based skills are essential [2]
- Wellness checks are now recommended at every session
  - Meeting basic needs during pandemic, assessment of new stressors / increased distress / changes in risk, etc.

1 (Wright et al.., 2009) 2 (APA, 2009) 3 (Glynn & Jansen, 2016)

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- **Additional skillsets:**
- Know the landscape
  - Ability to thoroughly discuss: accessing healthcare/coverage, disability applications, specific community resources, changes in reimbursement models
- Grant writing skills
  - In 2014 Congress awarded $25 million for early intervention MH programs[1]
- Program development skills
  - Trend toward comprehensive and/or collaborative treatment services
- Active membership and participation in professional organizations
  - Attendance at conferences, pursuing additional certifications, etc. are also options for reducing isolation and loneliness
- Stay current re: Best Practice Guidelines
  - For example: APA Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization (2019)

1 (Carey, 2015)

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- Ability to develop a treatment plan which incorporates:
  - Specific, measurable treatment plan goals
  - Estimated completion dates
  - Documentation of progress over time per measurement
  - Documentation of collaboration with others involved in care
  - Actions to take when identified needs are beyond the scope of your service/practice

  - Components of the model:
    - How will you document collaborative planning and "measure" rapport?
    - How are strengths being identified and reinforced?
    - How are tobacco and weight issues being managed?
    - How are cognitive issues being managed?
    - How are family and support services documented?

      - There are many details to track - Prepare a plan in advance!

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- Digital Mental Health Revolution

  - 2017: 77% of Americans owned a smart phone
  - More than 10,000 mental health apps available
  - Area of innovation
  - Utilization of monitoring for psychiatric rehabilitation

  - Real world utility?
    - Identifying early warning signs for relapse
    - Enabling those with mental illness to return to work

  - And of course…telehealth!

(Tal & Torous, 2017)

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OPPORTUNITIES IN RURAL PRACTICE[1]

- Ability to be a generalist
- Integrated care
  - Collaboration becomes a "necessary luxury"
- Financial incentives
- Congruence with beliefs and values
- Freedom and flexibility
- More salient feeling of making a difference
- Closer relationships with colleagues, possibly with the community

  - Protective: Rural practitioners' level of social support makes burnout less likely (rural Kansas)[2]

1 (Hastings & Cohn, 2013) 2 (Kee et al., 2002)

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STAYING ACTIVE & RESOURCES

- U.S. Department of Health & Human Services: Federal Office of Rural Health Policy
  - New policies, funding opportunities, trainings/webinars
  - The Announcements from the Federal Office of Rural Health Policy are distributed weekly.

- National Association for Rural Mental Health: www.narmh.org
  - Journal of Rural Mental Health

- Rural Health Information Hub
  - www.ruralhealthinfo.org

- APA Divisions 12 and 18; State Psychological Association

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- APA Task Force on SMI and SED
- http://www.apa.org/practice/leadership/serious-mental-illness/default.aspx
  - So many excellent free resources

- SMI Curriculum developed in 2011 to 2012
  - Pilot tested in 2012 to 2013 and subsequently published
  - 15 modules
  - http://www.apa.org/pi/mfp/psychology/recovery-to-practice/index.aspx
  - For links to the free curriculum documents (408pg. text & PowerPoints):
  - http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx

  - Proficiency in Psychology: Assessment and Treatment of SMI (2009)
  - http://www.apa.org/practice/resources/smi-proficiency.pdf
  - "…primarily concerned with assisting individuals experiencing SMI throughout the life span to regain functional capacity and live satisfying lives in the community, regardless of their age."

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- SAMHSA
  - ESMI Treatment Locator
    - https://www.samhsa.gov/esmi-treatment-locator
  - Disaster Behavioral Health Information Series (DBHIS)
    - https://www.samhsa.gov/dbhis-collections/smi
  - Extensive list of resources by searching "SMI" or "SED" in search tool

- SAMHSA & APA
  - SMI Advisor
    - https://smiadviser.org/

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QUESTIONS?

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Recovery:
"A process of *change* through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
(SAMHSA)

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