



ALAMEDA COUNTY BHCS  
ROUND THREE  
INNOVATION GRANT PROGRAM



**CJM Associates (CJMA)**  
an Innovative Project Partner  
of the Carl B. Metoyer Center for Family Counseling (CFC)

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Reaching In:  
Reducing Isolation Due to Mental Illness  
by Partnering With Family Members/Loved Ones



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## OUR STORY

We began knowing that even the most isolated adults have families and loved ones with whom they have attachments and relationships more enduring than with any professional care provider. Especially if there is isolation, those relationships have been frayed or broken and the families have been marginalized during the treatment process. As a result, family members themselves become traumatized, isolated, and discouraged. We help family members recognize and understand those experiences – frequently occurring across generations, grieve the loss that accompanies the presence of serious mental illness (SMI) in a family, and develop new tools to care for themselves and their isolated loved ones. Our goal is to form more supportive relationships that will create broad and enduring natural support networks that are the remedy for isolation.

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**Project Name:** Reaching In: Reducing Isolation Due to Mental Illness by Partnering With Family Members/Loved Ones

**Grantee Organization:** Carl B. Metoyer Center for Family Counseling

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## Learning Questions

### Learning Questions Addressed

The Reaching In project looked at three learning questions:

1. How does the use of trained peers or family members of consumers for home-based outreach to socially isolated adults and older adults with serious mental illness reduce their isolation through relationship building?
3. How do volunteer opportunities that are interest- and skill-level appropriate with significant peer or professional coaching decrease social isolation and improve self-esteem and quality of life for isolated adults and older adults with serious mental illness?
5. How does a telephone- or telephone- and internet-based program that provides social interaction and individual support reduce isolation among adults and older adults with serious mental illness and lead to greater in-person social interaction over time?

### How Project Addressed Learning Questions

*Address your selected Learning Question(s) based on your project findings and final project desired outcomes. Explain how your strategies address the learning question(s). Were any other ideas or interventions employed to help decrease consumer isolation? Please explain.*

**1. Can the use of trained peers or family members of consumers for home-based outreach to socially isolated adults and older adults with serious mental illness reduce their isolation through relationship building?** Yes. Families reported a sense of being supported and validated regarding having and caring for a family member/loved one with a serious mental illness. A sense of hopefulness was created by witnessing the health

of the peer counselor. For the group who had a peer family partner the participants also experienced the power of holding boundaries with the family member/loved one and performing self-care within the context of caring for the person with a serious mental illness. Family members/loved ones of the target population can create a better relationship that reduces isolation if they can achieve the personal growth characterized by better understanding their family history and narrative about mental illness, adequately attending to their own mental health and wellness, and coming to a place of mindful, compassionate determination to engage constructively with the target population. Well-trained and supervised (particularly regarding professional behavior and expectations) peer wellness counselors may be able to assist with this process by serving as a bridge between the family member/loved one and the target population, but risk having their own mental health issues triggered in the process and thereby interfering with their ability to be helpful and productive. Family Partner counselors appear to be a better choice since they are less likely to be triggered by mental illness symptoms and can additionally help by validating the experience of the family member/loved one in a way that creates a space of wellness, forgiveness, and understanding that supports the recovery of the target population. The Wellness Coach/Project Coordinator, who supervised Peer and Family Partner Counselors, shared these reflections: "I strongly believe that having a peer and family partner helped each of the participants. Although each participant had their individual journey and timeline in terms of helping their loved one, they were able to find support from their peer in very distinctive ways. Overall, participants were able to explore different ways of carrying out their action plans. Their action plans became a foundation for trying new things, not only within their family system, but also within the extended community and larger system."

**3. How do volunteer opportunities that are interest- and skill-level appropriate with significant peer or professional coaching decrease social isolation and improve self-esteem and quality of life for isolated adults and older adults with serious mental illness?** Appropriate volunteer activities, whether formally through organizations or informally through personal contacts, can decrease social isolation and improve self-esteem in the target population. They increase a sense of purpose and belongingness by giving people a sense that they have something to contribute. For example, our target population engaged in volunteer home repair activities for others, photography, art and poetry groups, and faith-based group activities. These are all recognized as being of value by society and also carry their own intrinsic sense of accomplishment – thus reinforcing the worth of the activity for the target population and others, leading to stronger and more enduring social connections. Keeping this in mind, engaging in volunteer activities proved to be the most challenging strategy for our participants. Many of the family members/loved ones from the workshops expressed fear around having their loved ones try new things. The types of barriers already mentioned that are faced by family members/loved ones (stress, level of education, limited income, and their own mental health challenges) were particularly salient regarding getting them or the target population engaged in organized, regular volunteer activities.

**5. How does a telephone- or telephone- and internet-based program that provides social interaction and individual support reduce isolation among adults and older**

**adults with serious mental illness and lead to greater in-person social interaction over time?** This strategy must be well-tailored to individual families, their needs and capabilities. Most people have some access to telephones and internet based communications. Some families and consumers use these to isolate – making them poor candidates for even greater use. Others fear these types of communications and therefore such strategies are not appropriate. For others, however, we saw them being used to create close connections (through frequent electronic communication) that helped organize and foster in-person meetings. Some examples were creating faith-based groups and support groups. In other cases, learning to use programs like Skype, iCalendars, electronic alerts, and texting helped our participants maintain regular and meaningful contact that encouraged continued in-person social interaction whenever possible.

## Program Design

### Goals of the Program

This project sought to reduce isolation among adults, aged 18 to 59, who were isolated because of a serious mental illness (the target population). The primary approach was to “reach in” to the target population using family members/loved ones, partnering with peer or family counselors, who had gone through a proscribed healing and training process designed to help them better understand their unique, individual situations, develop better stress management and communications skills, and ultimately form better relationships with the target population. This would allow the family members/loved ones to work with the target population to develop strategies that would help the target population reduce their isolation. The intent of this program is to move beyond the psycho-educational and referral to resources approaches offered to family members/loved ones by organizations such as NAMI, SAMHSA, and the Family Education and Resource Center in Alameda County – offering them time and opportunity, under the guidance of mental health professionals, to understand, process, and reform their narratives about themselves, their families, and mental illness while helping them develop new skills and coping strategies to deal with their own stress and work with the target population to develop effective strategies to reduce isolation.

The project began by focusing on family healing and initially engaged family/loved ones through a twelve week workshop series that explored their individual history with mental illness (using narrative based story telling and family/cultural genograms) and addressed issues such stress, (using mindfulness based stress reduction techniques), psychological and behavioral triggers, grieving, self-compassion and forgiveness that are related to having a family member/loved one with severe mental illness. The workshops, co-facilitated by a therapist and a community wellness mentor, recognized the key supportive role of families and helped develop respite strategies, including individual stress reduction tools, forming supportive communities, and getting access to needed services. The workshops served as training for family/loved ones and community wellness mentors to form a supportive alliance and develop new approaches to reducing the isolation of consumers in their lives. Isolation reduction strategies related to forming more supportive

and honest relationships, engaging in volunteer activities, and using electronic media to create more in-person social interaction opportunities were all explored.

## **Program Design and Essential Components**

The overall program design focused on recruiting, educating, and working with the family members/loved ones of isolated adults with a serious mental illness (the target population) to enable them to form better relationships with the target population and encourage the formation of broader, supportive social networks, encourage participation in meaningful volunteer activities, and make use of electronic communication to create opportunities for more in-person interactions.

### **1. Design Focus Groups**

The program began by organizing two focus groups of family members/loved ones of those with a serious mental illness who were isolated, along with some community stakeholders. A draft plan of the program was presented and discussed at the focus group sessions. Focus group comments were incorporated into a revised program design.

### **2. Outreach and Recruitment of Family Members/Loved Ones for Workshops**

Recruitment was conducted, via a recruitment coordinator, to find family members/loved ones to participate in the workshops. Recruitment was done via community contacts, distributing flyers at community centers, and by announcements and presentations made at NAMI and FERC meetings and via their communications networks. Project collaborators were also engaged, as was Alameda County Behavioral Health Services, and individuals who were advocates for families of those with serious mental illness. Potential participants were screened via in-person and phone interviews.

### **3. Workshops**

Three, 12-week weekly workshops were scheduled and held. The initial workshop session was 5 hours in length, included snacks and lunch, and held on a weekend to provide a more intensive initial experience and provide an opportunity for participants to get to know one another. Subsequent workshops were 2 hours in length, included snacks, and were held either on a weekend morning or weekday evening. Workshops were designed to provide history and context regarding the treatment of mental illness, psycho-education about mental illness and its effect on individuals and families, exploration of personal experiences and family history regarding mental illness, the development of mindfulness based stress reduction techniques, practice in interacting with and encouraging the target population, developing action plans to help the target population reduce isolation, and sharing of personal experiences, struggles, and insights.

### **4. Follow-Up Engagement**

Each workshop series was attended by either a consumer Peer Wellness Counselor (2) or a Family Partner (1) to enable them to get to know both the participants and the program, and develop a working relationship with the participants. Following the completion of the workshop series, participants were given a workbook of project materials, including action plan worksheets to track progress. The Peer Wellness Counselors/Family Partner were to keep in phone, email, and personal contact with the participants on a weekly or bi-weekly



basis, encourage networking between group participants if appropriate and desired, get to know the target population if appropriate and desired, and hold group reunions with the workshop facilitators as deemed appropriate to encourage continued participation and share experiences and strategies.

## 5. Evaluation

Three survey-type instruments were administered at the beginning of the workshop series, and again at the end. Those instruments measured hopefulness, anxiety, and self-compassion. In addition, qualitative notes were made of important insights during the workshops, and contact and progress records were kept during the follow-up engagement periods.

### How Program Impacted Population Served

The participants all found the workshops very helpful regarding achieving a better understanding of how dealing with mental illness has affected their families, often over generations. Both constructing the family genograms and discussing these over weeks were uniformly thought to be beneficial. The mindful breathing exercises were also reported to be very helpful in reducing stress and many participants reported continuing to use this technique long after the workshops concluded. Participants constructed action plans to address isolation in their SMI loved one. They practiced discussing the action plans with their SMI loved one through role play exercises that utilized various tools they had learned throughout the workshops. As a result, participants reported long-term positive changes in their interactions with their SMI loved ones as a result of these exercises. The strategies concerning forgiveness and developing self-compassion were also found to be quite helpful for workshop participants based on their feedback that they developed an awareness of the importance of developing self-compassion as a necessary condition for their ability to have compassion for their SMI loved one and the challenge that person faced in maintaining wellness and recovery.

Overall, the workshop participants reported that they had learned to think differently about their loved ones with an SMI and therefore were able to interact more effectively with them. The level of positive response regarding the workshop follow-up period varied greatly depending on the ability and willingness of the workshop participants to push their action plans forward. It also varied depending on whether the cohort had a peer counselor assisting them or a family partner. The two cohorts with a peer counselor had, overall, a less favorable or productive experience than the cohort with a family partner where the response was quite positive and the participants are continuing to support each other past the end of the study period. In other words, that cohort began their own community building. Overall, the participants said they wanted the workshops to go on for a longer period of time – six months was the consensus time period. Their observation was that no where else were they given time or assistance in expressing and processing their feelings – and then given tools to help deal with their feelings.

## Program Strategies

Following the drafting of an original project plan and curriculum, two community focus groups were convened to review it. The focus groups (about 10 people each, recruited by a recruitment coordinator) were made up family members and community stakeholders, including some service providers. Adjustments to the curriculum were made based on input from the focus groups. This process took approximately three months.

A recruiting process of 2 – 3 months was required for each workshop cohort (approximately 8 – 10 people). Intensive outreach needed to be conducted with stakeholders such as NAMI and FERC, including advertising in their communications vehicles and in-person presentations at their meetings. In addition, outreach to the general community was conducted via flyers and in-person contacts. Once potential candidates came forward, screening was conducted by the project facilitator to determine their readiness to participate in the workshops.

Once organized, the workshops were presented over a 12-week period. The first workshop lasted 5 hours and included snacks, drinks and lunch. The subsequent workshops were two hours each and included snacks and drinks. The workshops varied somewhat in their cadence and content, depending on the needs of the participants. Following the first session when participants were just getting to know one another, the workshops all included significant time for individual check-ins and processing about what had been learned so far and how it applied to the circumstances of individual lives. All workshops included discussion and practice of mindfulness stress reduction techniques.

The general progression of the workshop series was as follows:

Week 1: Naming of issues and experiences; Brief history of how mental illness has been addressed in this country over time; Social and community issues regarding mental illness, including stigma and discrimination; Complex traumas experienced by family members/loved ones caring for someone with a serious mental illness; Isolation & secrets; Stories of hope and recovery. Following lunch the concept of an intergenerational story about mental illness within the family was introduced and work began on constructing individual family genograms tracing mental illness, substance abuse, and related traumas across several generations for each participant. Finally, the overall structure and goals of the program were reviewed.

Weeks 2 & 3: Continuing work on the individual family genograms, combined with information and discussion about understanding our individual history regarding mental illness, the intergenerational transmission of trauma, and how to better understand relationship patterns.

Weeks 4 & 5: The idea that part of coping with a family member/loved one's development of a mental illness involves going through a grieving process was introduced. The 5 stage process of grieving was reviewed in detail, along with why it is important to allow time for



grieving – perhaps not just once, but periodically as new difficulties or traumas arise – before being able to effectively address the issues raised by mental illness.

Weeks 6 & 7: Education and practice about identifying triggers of stress was presented, along with how to identify dysfunctional responses to stress in one’s own life. An exercise and model for developing alternate, more functional responses to stress was presented and role played.

Weeks 8 & 9: The notion of self-compassion was introduced along with why it is important to develop this capacity when dealing with a chronic illness, such as mental illness. The idea that another important capacity needed in this context is compassion for others – but that in order to develop that capacity we first need to have compassion for ourselves, was also introduced and discussed. Finally, the concept of forgiveness as a process rather than an end state – of oneself and of others – was explained and discussed with relationship to personal experiences of the participants.

Weeks 10 & 11: The concept of isolation, how it arises and why it is important to combat it, was presented and discussed. Developing practical strategies to combat isolation was begun through putting together work plans that identified goals and strategies for better engaging with the target population and working with them to develop a wider range of outside activities and a broader social support network.

Week 12: The workshop series was reviewed and plans were discussed about the next phase. Appreciations and comments were presented about the process so far.

#### Follow-up Strategy Implementation Period

Following the conclusion of each workshop series, a six month follow up period began during which time the Peer Wellness Mentor or Family Partner kept in contact on a weekly or bi-weekly basis to track progress on their isolation reduction strategies and provide assistance (such as developing a relationship with the person who has a serious mental illness) and guidance for implementing and adjusting the strategies. Participants were encouraged to keep in contact with one another through electronic means and in-person meetings, to provide support and encouragement. At about the three month mark, each group reconvened with the project facilitators to review progress and share experiences. In the final month of the project a three group meeting was held for all workshop participants to share experiences and reflections and increase the breadth of their supportive networks.

## **Target Subpopulation**

### **Identification and description of subpopulation**

Our target subpopulation was two pronged, where we addressed the consumer and the family member/loved one concurrently. Both have mental health issues, needs and strengths that are closely intertwined. Our strategy involved working with the (less isolated) family member/loved one to help them “reach in” to the isolated SMI consumer in an effort to develop relationships and strategies that would lead to the consumer being less

isolated. The consumer target population, then, must have a family member/loved one willing and able to participate in the workshop series, and develop and implement strategies to reduce the isolation of the consumer.

The family members/loved ones who participated in the workshops generally had mild to moderate depression. Some also had characterological symptoms and a few appeared to have some schizoaffective symptomology. The consumers who had a serious mental illness (and who were the target population for the workshop participants) formed a heterogeneous group of Bipolar I, Delusional, Major Depression, Schizophrenia - Paranoid Type, and Schizoaffective Disorders.

The isolated adult (18 to 59) subpopulation for whom this appears most effective is younger adults at the beginning of their struggles with mental illness, who do not yet have long institutionalization or incarceration histories and who are at the beginning of a trajectory towards serious isolation.

Although we were not able to test our model on a wide range of cultures, ethnicities, and languages – we do not feel either this recommendation or approach in general is dependent or significantly influenced by any of those factors. Who delivers the training and assistance and the specific ways in which is delivered, however, are likely to be heavily influenced by whether there is a cultural/ethnic/linguistic match between the provider and recipients. Given the stress, burnout, and lack of confidence in service providers that we encountered among family members/loved ones of the SMI target population – the ability of the Workshop facilitator and the Peer Wellness Mentor or Family Partner to establish a bond (based on trust and confidence) with the family members/loved ones will be a key ingredient of success.

Regarding the family members/loved ones, there was a general need to better understand what mental illness is and how it has been and is addressed (or not) in our society – and most had a strong desire to acquire such understandings. There was also a need to better understand their own family histories regarding mental illness and they were highly motivated to do so. Both groups needed to feel a reduction in mental health stigma in their extended families and society. Both also needed and wanted a closer connection with each other. Those with a serious mental illness often needed to have better management of their symptoms and a healthier, less dysfunctional enmeshment with their family members/loved ones. They desired the opportunity to succeed or fail in their wellness through their own agency, and we see this as a strength. Overall, one of the biggest strengths that everyone had was a continued desire to connect with one another and a reluctance to give up.

The Wellness Coach/Project Coordinator, who supervised Peer and Family Partner Counselors, shared these reflections: “Across all groups, we found that families did not feel supported within the system. They often found themselves feeling frustrated, angry, scared, and confused. Equally worrisome was that many did not know what exactly their loved-one was diagnosed with, what that diagnosis meant, and what medications they were prescribed. On the other hand, it was impactful to see how much dedication, love, and

willingness some participants had; against all internal and external stressors. Many of their own lives had been consumed due to the full time job of fighting the system. Many participants came to realize that despite their good intentions, some of them were causing more harm than good for their loved-one.”

### **Description of BHCS stakeholders**

Reaching In partnered with two BHCS contracted providers, the Carl B. Metoyer Center for Family Counseling that served as our fiscal agent and Bay Area Community Services (BACS) that provided meeting space, community contacts, and community information. Although BACS was originally intended to serve as the primary source for family members/loved ones to participate in the project, after a great deal of effort and searching over approximately six months, no family members/loved ones were referred to the Reaching In Project from BACS. The Family Education and Resource Center (FERC), and to a lesser extent the National Alliance on Mental Illness, East Bay (several chapters) initially provided some advice about the project plan and later were the primary source of participants after the Reaching In project staff itself. BHCS stakeholders also participated by providing feedback through the two focus groups held at the beginning of the project and the field testing meeting held at the end of the project. Family members participated through attending the workshops and working with the Peer or Family Partner Mentors throughout the project. As with the BHCS stakeholders, family members participated in the initial focus groups that reviewed the project plan and in the field testing meetings at the end of the project. Clients/consumers were involved through their association with the family members/loved ones who attended the workshops. They also participated in giving feedback through the field testing which was done in conjunction with PEERS and was conducted as a joint presentation of the Reaching In and Special Messages projects.

### **Cultural responsiveness of strategies**

Reaching In asked participants to tell their own story, created the space for their own voices, and gave them tools to refine and – from their own perspective – create a healthier story over time for themselves and their loved ones with SMI. By its very nature, such an approach is culturally responsive and therefore honors the cultural/ethnic/linguistic components of individual and family lives.

### **Effectiveness of Strategies**

“Tracking Thoughts,” an evidence based, cognitive behavioral therapy (CBT) tool was used as a strategy to help family members/loved ones think and react differently to stressful events brought on by the severely mentally ill (SMI) loved one. Mindful breathing was another useful tool used as a strategy to help people stop and think, remain calm, and act with intention when engaging with the SMI loved one. The genograms focusing on mental health issues in families allowed the family member/loved ones to process their narrative and launch them on a journey of creating a more organized and integrated narrative, thereby reducing isolation and improving the relationship with the SMI loved one. Participants also benefited from exploring the five stages of grief (a well documented process) in a way that

specifically addressed the topics of forgiveness and self-compassion – a series of activities that allowed them to move past some internal psychological barriers to more effectively engaging with the SMI loved one. The development of Action Plans helped participants organize and track their efforts at reducing isolation. Reaching In also promoted a sense of community. We encouraged participants to expand their support system and encouraged families to reach in to other families within their groups – and to reach out to other groups, as well as other families in the community who may be having similar experiences.

One of the primary indicators of success are statements from the workshop participants themselves, along with their continued attendance at the workshops (after some initial attrition) and participation in the project over time. Virtually all participants remained in contact with the project for its entire duration and many expressed a desire to continue beyond that point. Notes were taken during the workshops and consultation meetings were held with staff afterwards, with special meetings held periodically throughout the project to monitor progress and discuss new ideas and approaches. Three quantitative survey instruments were used, taking measurements at the beginning and the end of the workshop series: 1. Hope Trait Scale, showing a 6% decrease in feelings of hopelessness. 2. Beck Anxiety Inventory, showing 10% decrease in feelings and physical symptoms of anxiety. 3. Self-Compassion scale, showing a 2 % increase in statements indicating self-compassion and a 3% decline in statements indicating a lack of self-compassion. Most participants reported improved relationships with their family members, including those with serious mental illness – especially regarding their ability to understand one another’s experiences and communicate clearly about goals and expectations. One of the most hopeful developments was the formation of on-going supportive relationships and with one cohort, a support group. Reports from external sources, those who knew the participants outside of this project, also indicated an increasing in wellness, ability to talk about experiences and feelings, and engagement with others. Finally, there were a number of examples of the isolated loved one with SMI increasing their engagement in social activities and using electronic media to stay in contact and connect with others.

## Program Replication

We feel that this program would best be replicated in conjunction with, and as a follow-up to, services provided through NAMI East Bay (such as the Family-to-Family workshops) and the FERC – offered to carefully screened family members/loved ones who are prepared to fully engage with an intensive process designed to reduce their stress and isolation, leading to an improved quality of life for themselves and the person in their life with a serious mental illness. There are several important factors to be considered for a successful replication:

- ✓ The workshops should be facilitated by a licensed clinical mental health worker.
- ✓ Those running Reaching In workshops and engagement efforts should have paid positions – running these programs is not an appropriate volunteer activity. Consequently, a reimbursement stream must be identified such as MediCal, private insurance, or private pay.

- ✓ Family Partner and Peer Wellness Counselors need to be adequately trained and supervised (including training and success about how to not have their own mental health symptoms triggered by the work) – and preferably have prior experience working as behavioral health supports.
- ✓ Family Partner Counselors are generally a better match for working with family members/loved ones than Peer Wellness Counselors.
- ✓ Weekly workshop meetings should probably be held over a six month time period with the first 12 sessions devoted to the curriculum developed for this project and the remainder of the sessions devoted to working on implementing and critiquing Reaching In work plans and strategies, building and solidifying a supportive network, and review and elaboration of materials already presented based on the real-life experiences of the group members during this time.
- ✓ Potential workshop participants should be screened and assessed regarding their readiness to participate in this type of workshop. Most importantly, participants should not be struggling with their own un- or under-treated mental health problems as the point of the groups is to engage and benefit their family members/loved ones.
- ✓ Workshop participants must commit to attending all the workshop sessions on a regular basis as this model does not work on a drop-in or intermittent attendance format.
- ✓ While the groups formed during workshops should be supportive, these are not support groups and potential participants must understand and agree to this format. Family/loved one participants must be prepared and able to actively engage in a number of activities, including psycho-education about mental illness, exploration of and engagement with family and personal histories regarding mental illness, substance abuse, and trauma, and developing and acting on strategies to better engage the isolated family member/loved with serious mental illness.

*Identify staffing requirements (per workshop series):*

- *Job title;*
- *Role/ responsibilities with Full Time Employment (FTE);*
- *Required qualifications, certification and / or licensure*

Job Title	Roles and Responsibilities	Qualifications
Lead Facilitator	<ul style="list-style-type: none"> <li>• Refine and revise workshop curriculum, as needed.</li> <li>• Supervise the recruitment coordinator and work with project resource organizations to ensure proper recruitment.</li> <li>• Screening of workshop participants.</li> <li>• Facilitate workshops.</li> </ul>	Licensed mental health professional with experience working with families and community mental

	<ul style="list-style-type: none"> <li>• Collect data from workshops.</li> <li>• Fulfill any evaluation and reporting requirements.</li> <li>• Supervise all project staff.</li> <li>• FTE, approximately .1 per workshop cohort.</li> </ul>	health services.
Assistant Facilitator	<ul style="list-style-type: none"> <li>• Assist lead facilitator with program design, implementation, evaluation, and reporting.</li> <li>• Assist with facilitation of workshops.</li> <li>• Education, coaching, and support of Family Partner Mentors. Recruitment and retention of project participants.</li> <li>• FTE, approximately .1 per workshop cohort.</li> </ul>	Mental health professional intern with interest in working with families and community mental health services.
Family Partner Mentor	<ul style="list-style-type: none"> <li>• Attend and participate in workshops.</li> <li>• Form productive working relationships with family members/loved ones and target consumers to devise and implement isolation reduction strategies.</li> <li>• Keep notes on implementation of isolation reduction strategies.</li> <li>• Provide input into project design and development.</li> <li>• FTE, approximately .15 per workshop cohort.</li> </ul>	Experience as a family member/loved one of someone with a serious mental illness. Training and experience as a behavioral health care peer mentor.
Administrative Assistant/Participant Recruitment & Retention Coordinator	<ul style="list-style-type: none"> <li>• Assist project staff with administrative needs.</li> <li>• Arrange for meeting rooms, food and drinks, and materials for workshops.</li> <li>• Liaison with community partners, stakeholders, and others to identify and recruit potential participants.</li> <li>• Regularly contact participants to encourage and/or confirm attendance at workshops.</li> <li>• FTE, approximately .05 per workshop cohort.</li> </ul>	

*Identify the collaborators necessary to the success of the program.*

The ideal collaborators would be:

- ✓ Mental Health Association of Alameda County.
- ✓ Family Education Resource Center.
- ✓ National Alliance on Mental Illness, Alameda County.
- ✓ Alameda County Behavioral Health Care System.



*Recommendations for resource, facilities, and infrastructure requirements needed for support:*

*Technology and equipment needs*

- ✓ Laptop computer with PowerPoint.
- ✓ Digital projector.
- ✓ Projection screen.
- ✓ Internet access for video clips.
- ✓ Flip chart paper and stand.
- ✓ Markers.
- ✓ Snacks.
- ✓ Coffee, tea, water.
- ✓ Poster Board.
- ✓ Art supplies (e.g., scissors, rulers, glue, drawing materials, poster board, etc.).

*Systems and services needs (e.g., billing, interpreter, etc.)*

- ✓ Billing/Accounting.
- ✓ Insurance.
- ✓ Communications.
- ✓ Facilities – meeting rooms/venues.
- ✓ Evaluation.

## Budget requirements

### Reaching In Workshop Series

#### Series Description

Each workshop series serves 8 - 10 participants and consists of 24 weekly meetings, the first of which is 5 hours and the following 23 are 2 hours each for a total time of 51 hours.

#### Personnel Costs

Item	Description	Hourly rate	Total hours	Cost for 2 Workshop Series
Lead Facilitator	51 hrs. in workshops; 25 hrs. pre & post workshop; 6 hrs. curriculum design and refinement.	\$150.00	82	\$12,300.00
Assistant Facilitator	51 hrs. in workshops; 25 hrs. pre & post workshop.	\$50.00	76	\$3,800.00
Family Partner Mentor	51 hrs. in workshops; 14 hrs. pre & post workshop; 48 hrs. working with participants outside of workshops	\$20.00	113	\$2,260.00
Administrative Assistant - Participant Recruitment/Retention Coordinator	48 hrs. Scheduling, shopping, errands, food and room arrangements, workshop set-up and breakdown, etc. Identify potential participant pool, develop contact information, recruit participants, maintain regular contact with participants (including weekly reminders prior to each workshop), and troubleshoot any attendance problems.	\$30.00	48	\$1,440.00
Total personnel Cost				\$19,800.00

#### Non-personnel Costs

Item	Description	Cost per participant	Total number of participants	Cost for 2 Workshop Series
Food	Lunch for opening workshop (\$15 for 10 people); snacks and drinks for all workshops (2 snacks for opening workshop) (\$5 per person per snack; 10 people per workshop).	\$135.00	10	\$1,350.00
Program supplies	Materials for workshops, genogram construction, mindfulness toolbox, etc.	\$60.00	10	\$600.00

IT, recording, etc.	Technology needs for workshops such as projectors, screens, software, etc.	N/A	N/A	\$1,000.00
Total non-personnel costs				\$2,950.00

*One - time costs (e.g., implementation and training)*

Since the program is already developed, it only needs to be adopted and implemented – but there are no special costs for that. Training is best accomplished by having an inexperienced facilitator partner with an experienced facilitator in order to learn the program and experience how it works.

*Other resources required for infrastructure support*

- ✓ Meeting room sufficient to hold 12 to 15 people comfortably and accessible to participants.
- ✓ Group tables for constructing genograms.
- ✓ Evaluation services.

# REACHING IN:

Reducing Isolation Due to Mental  
Illness by Partnering With  
Family Members/Loved Ones

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# REACHING IN:

## Session 1

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Partnering With Family Members/  
Loved Ones & Peer Mentors



*“There is no agony like bearing an  
untold story inside YOU.”*

*-- Maya Angelou*

# Naming of Issues/Experiences

- ◆ What does our society say about people with serious mental illness?
- ◆ What it is like to have a family member/loved one with a serious mental illness?
- ◆ What does society say about the family members/loved ones of someone with a serious mental illness?
- ◆ What would you like society to say, but does not now say, about people with serious mental illness and/or their family members/loved ones.

# History of How We Have Treated Those With Serious Mental Illnesses

- ◆ Some examples of how mental illness has been addressed over time and across cultures.
- ◆ Changing attitudes towards, and ways of dealing with, mental illness in this country (1800 – present)?
- ◆ Some very different models (e.g. Geel).



# Addressing Mental Illness in the 19<sup>th</sup> Century

- ◆ Mental illness has always existed.
- ◆ Beginning in the 19<sup>th</sup> century, awareness of mental illness grew.
- ◆ With urbanization, industrialization, and an increasingly complicated social environment, fewer and fewer places remained for people with mental illness to live.

# Mental Illness in the 19<sup>th</sup> Century

- ◆ Increasingly, the burden of caring for the mentally ill fell on local and state governments.
- ◆ Mentally ill persons who were not in asylums often ended up in other institutions: poor houses, the welfare system, or prisons.
- ◆ The original asylum model eventually became unworkable because:
  - ✧ The cost of such care was very high;
  - ✧ There were never anywhere near enough places for those who needed care; and
  - ✧ Many types of mental illness proved not to be curable, or even very treatable.



# Second Half of 19<sup>th</sup> Century Saw Several Struggles

- ◆ Separate institutions for the chronic and the acute;
- ◆ Hospital care for some with community neglect for most (then as now, most individuals were not hospitalized unless they were a danger to themselves or others);
- ◆ Large, centralized county institutions versus smaller, decentralized county institutions;
- ◆ Institution only care versus institution plus transitional and community care; and
- ◆ Rapidly increasing numbers of aged mentally ill entering mental health institutional care rather than poor houses.



# Early 20<sup>th</sup> Century

- ◆ Around 1900 most states moved to a system of state responsibility for the mentally ill.
- ◆ The need for custodial care for the elderly and chronically mentally ill continued to conflict with the therapeutic ideals of mental hospitals.
- ◆ Those admitted stayed longer (years as opposed to months in the 19<sup>th</sup> century) and were much more likely to die in the institution.

# Mid 20<sup>th</sup> Century

- ◆ The transition of mental hospitals from places of hope and cure to places of maintenance and death led to a decline in both public and professional opinion about their worth.
- ◆ Following World War II, care for the mentally ill began to shift from the asylum to the community.
- ◆ During and because of World War II many more people were screened for mental disorders:
  - ✧ More and more serious psychiatric disorders were identified than had previously been recognized.
  - ✧ Early treatment in non-institutional settings produced positive results.



# What Went Wrong

- ◆ Large institutions were shut down while supportive services ensuring access to basic needs such as food, shelter, income, social networks, and recreation were generally not provided.
- ◆ Fiscal constraints and political attitudes were such that an adequate amount of community based services have never been provided.
- ◆ Strong links between community centers and mental hospitals were not created.
- ◆ The field shifted from an emphasis on psychodynamic approaches to biologically based (i.e., medication centered) approaches – thus deemphasizing care and quality of life as a goal.

# What Went Wrong

- ◆ A significant federal reform, passed in 1980, was repealed the following year under the Reagan administration.
- ◆ The federal government withdrew direct support for community mental health services and replaced it with block grant money – giving primary control to the states.
- ◆ Community mental health services have increased fees, reduced staffing and services.
- ◆ Waiting lists developed for services.
- ◆ Service quality decreased.



# What Went Wrong

- ◆ People with more severe problems began to use community mental health services

*Because of --*

- ◆ Increased deinstitutionalization and decreased funding for other services.

*Leading to –*

- ◆ Fragmentation of services and inequalities between service areas since some were impacted by these trends more than others.

# Citations

- ◆ Grob, G.N. (1994). *The Mad Among Us: A History of the Care of America's Mentally Ill*. New York: The Free Press.
- ◆ Smucker, B. (2007). *Promise, Progress, and Pain: A Case Study of America's community Mental health Movement from 1960 to 1980*.  
[http://mentalhealthhistory.org/Promise\\_Progress\\_Pain.pdf](http://mentalhealthhistory.org/Promise_Progress_Pain.pdf)

# Social & Community Issues

- ◆ Generally, the public is familiar with common physical health problems, risk factors, and preventative strategies.
- ◆ Despite a high prevalence of mental health problems affecting 10 to 20 percent of the population, much of the general public is not knowledgeable about mental illness.



# Key Factors Causing Stigma and Discrimination

- ◆ Ignorance: Lack of accurate knowledge about mental health issues.
- ◆ Prejudice: Negative attitudes and emotions towards people with mental health problems.
- ◆ Discrimination: Rejecting or disadvantaging behaviors towards people with mental health problems.

*All three areas must be addressed to improve the social climate for those with serious mental health problems*

# What Is Stigma?

- ◆ Shame.
- ◆ Bias.
- ◆ Prejudice.
- ◆ Marginalization and Isolation.

# Complex Traumas of Family/Loved Ones and the Seriously Mentally Ill

- ◆ On-going fear of loss and harm.
- ◆ No clear answers from professionals or society about how to address the illness.
- ◆ Increasing isolation from others, especially family and friends.
- ◆ Unpredictability of symptoms or the trajectory of the illness.
- ◆ *Other on-going traumas you have experienced: \_\_\_\_\_?*



# Isolation & Secrets

- ◆ Family secrets around mental illness.
- ◆ Community shame from having mental illness in the family.
- ◆ Withdrawal from others because of lack of understanding, compassion, or easy solutions.
- ◆ False belief the mental illness is a moral failing or character flaw.

# Story of Hope and Recovery

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<http://www.mentalhealth.gov/talk/recovery/index.htm>

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# Experiences of Family Members

- ◆ Trauma.
- ◆ Coping and defense.
- ◆ Role of non-mentally ill family members.
- ◆ Fears and expectations.



# Family System

- ◆ Mental illness, like any chronic disease, is a family affair.
- ◆ How are family systems organized around the presence of mental illness?
- ◆ How has your family system been organized around dealing with mental illness?



# What Informs The Story?

- ◆ Involuntary Commitment & Treatment.
- ◆ Substance abuse.
- ◆ Incarceration.
- ◆ Poor quality of life.
- ◆ Fear of premature death.
- ◆ Responsibility for causing the mental illness and its consequences.

# The Impact of Culture

- ◆ What is culture?
- ◆ How do different cultures deal with mental illness?
- ◆ What is the impact of having to deal with mental illness in different languages?
- ◆ Does the marginalization of some cultures affect how mental illness is addressed within them?

# What Is Your Story?

- ◆ What stories have you borne and not told?
- ◆ What trauma have you experienced?
- ◆ What success have you achieved?
- ◆ What are your hopes and expectations?



# Intergenerational Story/Impact

- ◆ Many types of serious mental illness tend to run in families – seem to be passed on both through genetics and social learning.
- ◆ Beliefs about mental illness and how to deal with it (or deny it) tend to be part of an intergenerationally transmitted family story.
- ◆ Family secrets about mental illness tend to be kept across generations.

*Likely Result: Isolation and denial about an issue that is not likely to go away.*

LUNCH

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# Genograms

- ◆ What a genogram is – how it helps us tell our story.
- ◆ Who to include.
- ◆ What to include (types of issues).
- ◆ How we will make them (process & logistics).



# Isolation Reduction & Re-Engagement Strategies

- ◆ What can you do to support your loved ones re-engagement?
- ◆ Action Plan.
- ◆ Strength-based communication.
- ◆ Six-month follow up.



# REACHING IN:

## Sessions 2 & 3

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Mindfulness Stress Reduction

Breathing and Relaxation  
Exercises

# Genograms Continued



# Potential Topics

- ◆ Understanding Our History.
- ◆ The Intergenerational Transmission of Trauma.
- ◆ Understanding Relationship Patterns.



REACHING IN:

Sessions 4 & 5

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Mindfulness Stress Reduction

Breathing and Relaxation  
Exercises

Grieving

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# An Individual Process

- ◆ Medical Definition of *Grief*:

deep and poignant distress caused by or as if by bereavement –

- ◆ *also* a cause of such suffering *Loss*:

- ✧ failure to keep or to continue to have something;

- ✧ the experience of having something taken from you or destroyed.



# DABDA: Five Stages of Grief

- ◆ Denial.
- ◆ Anger.
- ◆ Bargaining.
- ◆ Depression.
- ◆ Acceptance.

Kübler-Ross, E. (1969). *On Death and Dying*. New York: Simon & Schuster

# Stage 1: Denial and Isolation

The first reaction to learning of terminal illness or death of a cherished loved one is to deny the reality of the situation. It is a normal reaction to rationalize overwhelming emotions. It is a defense mechanism that buffers the immediate shock. We block out the words and hide from the facts. This is a temporary response that carries us through the first wave of pain.

# Stage 2: Anger

As the masking effects of denial and isolation begin to wear, reality and its pain re-emerge. We are not ready. The intense emotion is deflected from our vulnerable core, redirected and expressed instead as anger. The anger may be aimed at inanimate objects, complete strangers, friends or family. Anger may be directed at our ill, mentally ill, dying or deceased loved one. Rationally, we know the person is not to be blamed. Emotionally, however, we may resent the person for causing us pain or for leaving us. We feel guilty for being angry, and this makes us more angry.



# Stage 3: Bargaining

- ◆ The normal reaction to feelings of helplessness and vulnerability is often a need to regain control—
- ◆ If only we had sought medical attention sooner...
- ◆ If only we got a second opinion from another doctor...
- ◆ If only we had tried to be a better person toward them...
- ◆ Secretly, we may make a deal with God or our higher power in an attempt to postpone the inevitable. This is a weaker line of defense to protect us from the painful reality.



# Stage 4: Depression

Two types of depression are associated with mourning:

1. Reaction to practical implications relating to the loss. Sadness and regret predominate this type of depression. We worry about the costs and burial. We worry that, in our grief, we have spent less time with others that depend on us. This phase may be eased by simple clarification and reassurance. We may need a bit of helpful cooperation and a few kind words.
2. This type of depression is more subtle and, in a sense, perhaps more private. It is our quiet preparation to separate and to bid our loved one farewell. Sometimes all we really need is a hug.

# Stage 5: Acceptance

*This is not a period of happiness and must be distinguished from depression.*

- ◆ Reaching this stage of mourning is a gift not afforded to everyone. Death or the illness may be sudden and unexpected or we may never see beyond our anger or denial. It is not necessarily a mark of bravery to resist the inevitable and to deny ourselves the opportunity to make our peace. This phase is marked by withdrawal and calm.
- ◆ Coping with loss is ultimately a deeply personal and singular experience — nobody can help you go through it more easily or understand all the emotions that you're going through. *But* others can be there for you and help comfort you through this process. The best thing you can do is to allow yourself to feel the grief as it comes over you. Resisting it only will prolong the natural process of healing.



# Triggers of Stress Example

Found out son lied to board & care manager about his schedule:

- ◆ **Body Response:**
  - ✧ Heart pounding.
  - ✧ Muscles tense.
- ◆ **Feeling Response:**
  - ✧ Anger.
  - ✧ Disbelief.
  - ✧ Betrayal.
  - ✧ Helplessness.
  - ✧ Embarrassment.
  - ✧ Fear.
  - ✧ Exhaustion.

# Triggers of Stress Example

## ◆ Automatic Thoughts:

- ✧ “He’s gonna get kicked out of the house.”
- ✧ “I bet he did this on purpose.”
- ✧ “I’ve got to fix this.”

## ◆ Alternate Thoughts:

- ✧ I feel grateful he has some support (from his house manager who helps structure his morning) in this situation.
- ✧ I have a good relationship with the house manager.



# Triggers of Stress Example

## ◆ Action Plan:

- ✧ I'm gonna rest now and take care of this in the morning.
- ✧ Next time I'll call the house manager.

# REACHING IN:

## Sessions 6 & 7

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Mindfulness Stress Reduction

Breathing and Relaxation  
Exercises



# Alternate Responses to Stress

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Planning and Practicing New  
Solutions to Old Problems



# REACHING IN:

## Sessions 8 & 9

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Self Compassion

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Helping Others Heal Begins With  
Allowing Ourselves to Heal

# *What is Self-Compassion?*

- ◆ Definition of self-compassion.
- ◆ The three elements of self-compassion.
- ◆ What self-compassion is not.
- ◆ Self-compassion versus self-esteem.



# Definition of Self-Compassion

- ◆ Having for yourself the compassion you feel towards others who are suffering.
- ◆ Not judging or criticizing yourself when you are having a hard time or something is difficult.
- ◆ Taking a moment to acknowledge that things are hard for you – and that's okay – when you feel you are failing at something.
- ◆ Most importantly, having compassion for yourself means that you honor and accept your humanness.

# The Three Elements of Self-Compassion

- ◆ Self-kindness: Being warm and understanding toward ourselves when we suffer, fail, or feel inadequate.
- ◆ Common humanity: Realizing that *all* people suffer and make mistakes rather than something that happens to you alone.
- ◆ Mindfulness: Taking a balanced approach to our negative emotions so that feelings are neither suppressed nor exaggerated.

# *Self-Compassion Exercise*

- ◆ How do you typically react to yourself?
- ◆ How do you typically react to life difficulties?



Compassion For Others?

Forgiveness

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# *Preparing to Forgive*

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[http://greatergood.berkeley.edu/article/item/what\\_is\\_forgiveness#](http://greatergood.berkeley.edu/article/item/what_is_forgiveness#)



# Preparing to Forgive

- ◆ Acknowledge the harm done.
- ◆ Experience the feelings: Grieve.
- ◆ Share the experience – Establish a human connection (*Do Not Isolate*).

# Steps to Forgiveness

- ◆ How do you feel?
- ◆ Commit to feeling better.
- ◆ May or may not lead to reconciling with the person being forgiven.
- ◆ Maintain perspective.
- ◆ Practice stress reduction, mindfulness.

# Steps to Forgiveness

- ◆ Give up on unreasonable expectations.
- ◆ Creatively explore new ways of achieving your goals.
- ◆ Live your life well.
- ◆ With self compassion – remember your forgiveness.



# Mindfulness Stress Reduction

Breathing and Relaxation  
Exercises

# REACHING IN:

## Sessions 10 & 11

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Mindfulness Stress Reduction

Breathing and Relaxation  
Exercises



# Isolation

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Developing New Reaching In  
Strategies

# Task For Week 11

*Develop an action plan for the family member/loved one.*

# Plan for Family Member/Loved One

- ◆ What are the housing needs? How can they be improved to reduce isolation?
- ◆ What are they transportation needs and options? Are they adequate to enact each isolation reduction strategy?
- ◆ What are the medication and medication management needs?



# Plan for Family Member/Loved One

- ◆ What are the income needs (including gainful employment where appropriate)?
- ◆ Can technology be used to reduce isolation?
- ◆ Can volunteer opportunities be used to reduce isolation?
- ◆ How can family members/loved ones be more connected?

# Plan for Caregivers

- ◆ What is the family respite plan (whether it's creating 'free time' or breaks OR broadening the circle of adults who can support the consumer)? How can the number of caregivers be increased? Does everyone involved have a role that is well defined and understood by all?
- ◆ What is the family transition plan for when a caregiver is no longer able to contribute support?

# Plan for Caregivers

- ◆ What can the caregiver do to reduce their isolation?
- ◆ What can the caregiver do to educate the public and reduce stigma?



# REACHING IN:

## Session 12

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Partnering With Family Members/  
Loved Ones & Peer Mentors

# Mindfulness Stress Reduction

*Breathing and Relaxation Exercises*

# Wrapping Up and Moving Forward

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*Strategies for the Next Six Months*



# Action Plan: 3 Learning Questions

◆ ?

◆ ?

◆ ?

# Appreciative Inquiry

- ◆ What positive moments or insights out of the last 12 weeks that will help you to stay focused and sustain your change?
- ◆ Share your story.
- ◆ What is your dream, vision, or hope for the future?
- ◆ How will you make it happen?

# Lend a Hand To Reach In To Help Isolated Consumers

We're looking for family members/loved ones of isolated consumers *and* consumer peers on the road to wellness



\* Location: \_\_\_\_\_

\* Date: \_\_\_\_\_

\* Time: \_\_\_\_\_

- Join Our Focus Group
- Earn \$40

We are developing strategies to engage families/loved ones of isolated consumers – Working with them to 'reach in' to help the isolated consumer 'reach out.' We need your expertise, experience & feedback as we design our curriculum.



OR

\* Location: \_\_\_\_\_

\* Date: \_\_\_\_\_

\* Time: \_\_\_\_\_

\*

Name  
Phone Number

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# Reaching In

## Do You Have a Family Member/Loved One Who is Isolated Due to a Serious Mental Illness?

*Explore your story; Form a supportive community; Develop and try new ideas to reduce your loved one's isolation.*

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*The Reaching In Project is designed to reduce isolation among adults with a serious mental illness, aged 18 – 59. The Project focuses on family healing. It initially engages family members/loved ones through a twelve week workshop series that explores their history with mental illness (using narrative based story telling and the stories of participant family's history and background). The workshop curriculum addresses issues such as stress, confusion and frustration (using mindfulness based stress reduction techniques) that can result from having a family member/loved one with severe mental illness. The workshops serve as training for family/loved ones and community wellness mentors who form a supportive alliance and continue to work together for 6 months to develop new approaches to reducing the isolation of family members/loved ones in their lives.*

### Join Our Project:

- 12 week workshop series
- 6 month follow-up to support engagement strategies
- Develop engagement strategies
- Build community with other family members
- Stipend for attending workshops



### Workshop Schedule

**Where:** Address \_\_\_\_\_

**When:** Workshop 1: Day of Week \_\_\_\_; Date \_\_\_\_; Time of Day \_\_\_\_ (5 hours)

Workshops 2 - 12: Day of Week \_\_\_\_; Date \_\_\_\_ to Date \_\_\_\_; Time of Day (2 hours)

Monthly follow-up meetings: From Date \_\_\_\_ to Date \_\_\_\_

*For Further Information Call:*

**Name**

**Phone Number**



## **Reaching In Project**

### **Engaging With a Strategy Instructions for Participants**

**Step 1** - Describe Your Strategy: Have your strategy already planned and thought through (Hint: Use the "Formulating Strategies to Reduce Isolation" worksheet).

**Step 2** - Describe the Resistances: What hasn't worked in the past, What you think might go wrong or awry in the conversation:

*NOTE: If met with resistance, it's time to remember to remember, take a breadth, think of an alternate response (for example, use your "track your thought" worksheet), practice the alternate response.*

**Step 3** - Set a boundary for yourself: Carefully choose the circumstances of the engagement (time, emotional state, etc.), formulate an exit strategy to disengage (knowing that you will re-engage later).

**Step 4** - Discuss With Your Loved One Their Needs and Feelings: Using your "Strength Based Communication Styles" handout, have a little discussion about how your family member/loved one might be feeling and what he or she might need.

**Step 5** - Look For Agreement: Look for overlap between what you think your family member/loved one needs or wants and what you would like to see them do. This may take some work to find commonality.

**Step 6** - Select a Strategy: Try to come to some agreement on a strategy or concrete next steps - even if it is a partial strategy or a few steps in a longer journey.

*For Example: You want him to be involved in community events with other people while he wants to stay at your house. Each of you wants him to have a place to be where he feels comfortable. Agree that for each hour he spends at your house, he also spends 15 minutes in a social setting that he feels relatively safe in, talking with other people.*

**Step 7** - Agree on an Action Plan: List out specific actions that will be taken within a definite period of time.

**Step 8** - Follow Up: Keep in regular contact with Peer Counselor and other supports to assess progress, brainstorm additional strategies and solutions, and obtain emotional support



## **Reaching In Project: Workshop Follow-Up Instructions for Mentors**

### **Participants**

1. Participants must clearly identify the family member/loved one who is isolated and who has a serious mental illness.
2. That family member/loved one must be between the ages of 18 and 59.
3. Diagnosis of serious mental illness:
  - a. The diagnosis of the family member/loved one should be known and written down.
  - b. If the diagnosis is not known, the reasons why it is not known should be written down and some possible diagnoses should be suggested. If at all possible, getting the family member/loved one assessed and diagnosed should be a part of the Reaching In strategy.
4. In accordance with the instructions and activities during the workshops, each participant should have written strategies formulated that are designed to reduce isolation. While any type of strategy that might be useful can be tried, at the very least, the three questions below must be addressed:
  - a. How can family members/loved ones help reduce isolation?
  - b. Can volunteer opportunities be used to reduce isolation?
  - c. Can technology (including smartphones and the internet) be used to reduce isolation – being mindful of the fact that technology often seems to create more isolation?

### **Peer Wellness Mentors**

1. Ensure that each participant has completed steps 1 – 4 under Participant Instructions, preferably by the end of the workshop series, but at the very latest within 2 weeks of the workshop series ending.
2. Ensure that each participant has their strategies written down on a worksheet and that you have a copy of each worksheet.
3. Develop a regular time and manner of checking in with each participant as they implement their initial strategy, assess and modify it, and develop new, additional strategies over time. Contact should occur every week, or at the very least every other week. Phone, Skype, email, or text contact may be used, but at least once per month an individual, in-person meeting must be held with each participant.

4. Keep a log listing each participant contact or attempted contact, using the participant contact spreadsheet. If participants fail to keep an agreed upon contact and you are unable to make contact within a week of that failure, inform the Project Coordinator.
5. Participant contacts should include:
  - a. A brief check-in about how things are going generally.
  - b. A reminder about which strategy or strategies are currently being worked on *and*, based on the previous contact, where the participant is in the process of identifying, implementing, or evaluating the success of each strategy.
  - c. A discussion with the participant about how the next steps (as identified during the previous contact) went during the intervening time:
    - i. If successful, discuss and document *what* worked and *why* it worked.
    - ii. If not successful, *what* barriers arose and *why*.
    - iii. Regardless of whether progress was made, always identify and document what will be done next: Taking further steps in the plan; Working to remove barriers to progress; or Identifying a new strategy to try.
6. Document the substance of the contact by writing a detailed note – preferably immediately after the contact, but no later than 24 hours after it is concluded. The notes need to reflect conversations with participants about what Reaching-In strategies they are planning on trying, their plans for trying them, their experience in implementing them, and the results. There should also be some reflection on the part of the participants about their thoughts and feelings about trying the strategies. Questions should also be asked about tools and supports we discussed during the workshops, whether the participants are using them, and the participants' evaluations about whether and how these tools may be helping them cope with stress and challenges in their lives around reaching in to their loved ones.

#### *Overall Note About Check-Ins*

These check-ins should not just be about what and how the participants are doing in general. While these may be helpful inquiries to engage the participants, the check-ins are supposed to be working sessions that focus on developing “reaching in” ideas, formulating implementation strategies, evaluating the results, then developing more strategies and going through the same process over again. At the end of the six month follow-ups there should be a series of strategies that have been tried and that are reflected in the notes being made.

*It is critical that follow-up contacts are primarily about helping the participants identify, implement, and evaluate a series of strategies.*

## **Reaching In Project**

### **Formulating Strategies to Reduce Isolation**

**Please consider the following as you develop an *Action Plan* geared to reduce isolation for your loved one:**

1. Can your collaboration with the peer counselor help reduce your loved one's isolation through relationship building?
2. How can volunteer opportunities decrease social isolation and improve self-esteem and quality of life for your loved one?
3. How can a telephone- or telephone- and internet based-program, that provides social interaction and individual support, reduce isolation and increase social interaction for your loved one?

#### **STEP 1: Identify Things your family member/loved one may want**

*Write down some things your family member/loved one might want that would help reduce isolation:*

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*Role play a conversation with your family member/loved one that uses Strength Based Communications – Communications that are characterized by:*

- Listening.
- Understanding.
- Acceptance.
- Validation.
- Honesty.
- Hopefulness.



*Example of something your family member/loved one might want:*

Welcoming Places To Go That Have Meaningful Activities – These are characterized by:

- Safety.
- Comfortable, including access to food, warmth, and the company of others.
- Opportunities to socialize.
- Recreational opportunities.
- Meaningful activities may or may not include gainful employment, but do need to be activities that interest the person.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**STEP 2: Identify Significant Need-Related Strengths and Barriers**

*In formulating a strategy for reducing isolation, consider how some of the needs below might be addressed in order to make the strategy successful:*

- What are the **safety** needs? Is lack of safety (physical or psychological) a barrier to reducing isolation? What can be done to address this barrier?
- What are the **agency** needs – the need to have **control** over one’s life, exercise choice, and have a say over what one does? Is lack of agency or control a barrier to reducing isolation? What can be done to address this barrier?
- What are the **housing** needs? How can they be improved to reduce isolation?
- What are they **transportation** needs and options? Are they adequate to enact each isolation reduction strategy?
- What are the **medication** and medication management needs? Does medication need to be obtained or managed better before isolation (or isolation causing behaviors such as uncontrolled emotional outbursts) can be reduced?
- What are the **income** needs (including gainful employment where appropriate)? Is a lack of income or resources causing isolation and if so, how can this be addressed?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**STEP 3: Plan for Caregivers**

*A successful isolation reduction strategy must address the needs of caregivers as well as the isolated family member/loved one. When developing a strategy, consider:*

- What is the family respite plan (whether it's creating 'free time' or breaks for an individual OR broadening the circle of adults who can support the family member/loved one)? How can the number of caregivers be increased? Does everyone involved have a role that is well defined and understood by all?
- What is the family transition plan for when a caregiver is no longer able to contribute support?
- What can the caregiver do to reduce their own isolation?
- What can the caregiver do to educate others and reduce stigma?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Thought Record

<b>Situation/Stressful Event:</b>			
<b>Feelings/Mood:</b>	<b>Body Response:</b>	<b>Automatic Thought:</b>	<b>Alternate Response:</b>
<b>Action Plan:</b>			



## Clinics with Sliding Scales

<b>Clinic</b>	<b>Phone Number</b>
ACCESS	(888) 892-7997
The Wright Institute	(510) 548-9716
CBT Clinic	(510) 923-2241
Women's Therapy Center	(510) 524-8288
Psychotherapy Institute in Berkeley	(510) 548-2250
Center for Creative Growth	(510) 527-2100
Blue Oak Counseling Center	(510) 649-9818
Psychological Services Center	(510) 628-9065

Wednesday (5:30-7:00pm)	
<p>Ms. Marianne Gunther-Murphy 5435 College Ave Suite 107 Oakland, California 94618 (510) 931-7264</p>	<p>Depression or anxiety "This group offers more immediate support and skill building for those dealing with depression, anxiety, loss, transition, relationship difficulty. Price: \$100-\$150 a session Also provides a sliding scale</p>
<p>Howie Harper Multiservice Center (510) 834-8771 Psychological Services Center (510) 628-9065</p>	<p>Drop-in program for men and women with dual diagnosis Individual, couples, and family therapy.</p>
<p>Bucklew Programs (415) 457-6964 www.bucklew.org</p>	<p>Bucklew Programs is a non-profit agency providing a variety of community-based services to adults with a serious mental illness. Depending on the county, services include 24-hour long-term group homes (Residential Support Services), supported housing, assisted independent living, affordable housing, and employment training, placement and support.</p>
<p>HealthRight 360 Walden House and Haight Ashbury Free clinics Administrative Offices 1735 Mission Street San Francisco, CA 94103 (415) 762-3711</p>	<p>"HealthRight 360 offers a continuum of mental health services and integrated treatment for clients with co-occurring substance use disorder and mental health problems.</p>
<p>*WestBridge 1361 Elm Street, Suite 207 Manchester, NH 03101 Main Phone: 866-843-1338 Main Fax: 603-634-4447</p>	<p>"WestBridge treats individuals who experience co-occurring mental health symptoms and substance use disorders." Residential (Inpatient) Treatment- Florida &amp; New Hampshire (Men only) Outpatient Treatment- Florida &amp; New Hampshire Treatment Specialties for Dual Disorders: Thought Disorders (including Schizophrenia, Schizoaffective Disorder) Mood Disorders (including Bipolar Disorder, Major Depression) Anxiety Disorders Post-Traumatic Stress Disorders</p>
<p>*Pasadena Villa (Florida and Tennessee) (877) 845-5235 &amp; (407) 246-0887 Fax: 407-329-3300 Email: <a href="mailto:info@pasadenavilla.com">info@pasadenavilla.com</a></p>	<p>Pasadena Villa Psychiatric Residential Treatment Centers treats adults, 18 and older, with clinical diagnoses that include: Schizophrenia, Anxiety Disorders, Bipolar with Psychosis, Autism Spectrum Disorders, Bipolar Disorder, Schizoaffective Disorder, Asperger's Syndrome, Co-occurring Substance Abuse or Addiction. Adult residential therapy for mental illness, with an emphasis on social integration.</p>

Updated: April 2015

Daisy Porres  
"Reaching In Project" Coordinator

Wednesday (5:30-7:00pm)	
<p>Ms. Marianne Gunther-Murphy 5435 College Ave Suite 107 Oakland, California 94618 (510) 931-7264</p>	<p>Depression or anxiety "This group offers more immediate support and skill building for those dealing with depression, anxiety, loss, transition, relationship difficulty. Price: \$100-\$150 a session Also provides a sliding scale</p>
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Updated: April 2015

Daisy Porres  
"Reaching In Project" Coordinator

First Name \_\_\_\_\_

## The Trait Hope Scale

*Directions:* Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

- 1. = Definitely False
- 2. = Mostly False
- 3. = Somewhat False
- 4. = Slightly False
- 5. = Slightly True
- 6. = Somewhat True
- 7. = Mostly True
- 8. = Definitely True

- \_\_\_ 1. I can think of many ways to get out of a jam.
- \_\_\_ 2. I energetically pursue my goals.
- \_\_\_ 3. I feel tired most of the time.
- \_\_\_ 4. There are lots of ways around any problem.
- \_\_\_ 5. I am easily downed in an argument.
- \_\_\_ 6. I can think of many ways to get the things in life that are important to me.
- \_\_\_ 7. I worry about my health.
- \_\_\_ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- \_\_\_ 9. My past experiences have prepared me well for my future.
- \_\_\_ 10. I've been pretty successful in life.
- \_\_\_ 11. I usually find myself worrying about something.
- \_\_\_ 12. I meet the goals that I set for myself.



First Name \_\_\_\_\_

### Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly – But it didn't bother me much.	Moderately – It wasn't pleasant at times.	Severely – It bothered me a lot.
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3

First Name \_\_\_\_\_

## How I Typically Act Towards Myself In Difficult Times

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

**Almost  
never**  
**1**

**2**

**3**

**4**

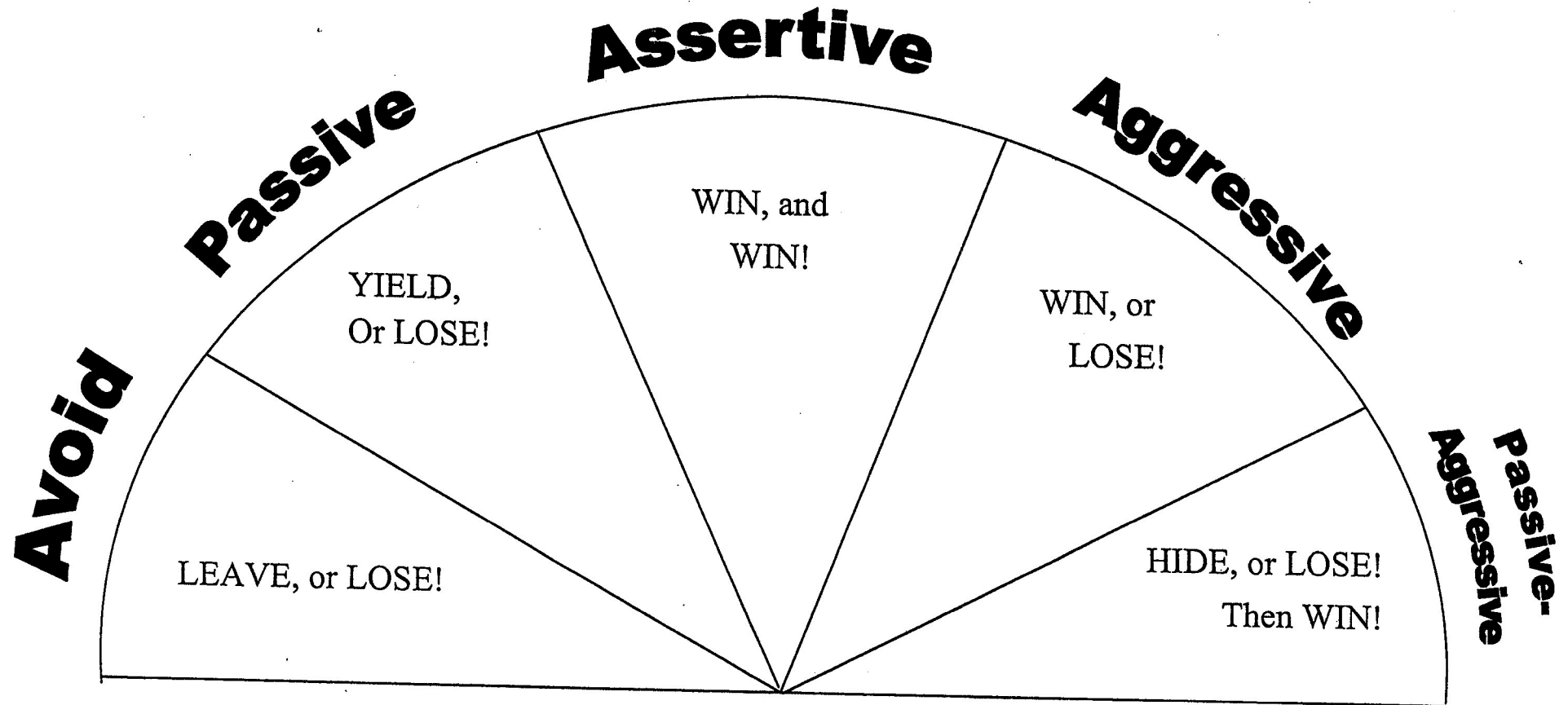
**Almost  
always**  
**5**

- \_\_\_\_\_ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
- \_\_\_\_\_ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- \_\_\_\_\_ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
- \_\_\_\_\_ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
- \_\_\_\_\_ 5. I try to be loving towards myself when I'm feeling emotional pain.
- \_\_\_\_\_ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- \_\_\_\_\_ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- \_\_\_\_\_ 8. When times are really difficult, I tend to be tough on myself.
- \_\_\_\_\_ 9. When something upsets me I try to keep my emotions in balance.
- \_\_\_\_\_ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- \_\_\_\_\_ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

First Name \_\_\_\_\_

- \_\_\_\_\_ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- \_\_\_\_\_ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- \_\_\_\_\_ 14. When something painful happens I try to take a balanced view of the situation.
- \_\_\_\_\_ 15. I try to see my failings as part of the human condition.
- \_\_\_\_\_ 16. When I see aspects of myself that I don't like, I get down on myself.
- \_\_\_\_\_ 17. When I fail at something important to me I try to keep things in perspective.
- \_\_\_\_\_ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- \_\_\_\_\_ 19. I'm kind to myself when I'm experiencing suffering.
- \_\_\_\_\_ 20. When something upsets me I get carried away with my feelings.
- \_\_\_\_\_ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- \_\_\_\_\_ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- \_\_\_\_\_ 23. I'm tolerant of my own flaws and inadequacies.
- \_\_\_\_\_ 24. When something painful happens I tend to blow the incident out of proportion.
- \_\_\_\_\_ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- \_\_\_\_\_ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

# Conflict Styles







# Challenging the “Shoulds”

- Entitlement

**Inflammatory** -- I want it, so I *should* be able to have it!

*Calming* -- It would have been nice. I can live without it. It's not all-or-nothing. I can get some of what I want now, maybe more later.

- Control

**Inflammatory** -- I *should* be able to make her do what I want!

*Calming* -- I can't control her. I can make requests. I have to earn her cooperation.

- Blame

**Inflammatory** -- She caused this problem, so she *should* have to fix it!

*Calming* -- What part of this problem am I responsible for?

- Mind-reading

**Inflammatory** -- I *shouldn't* have to tell him--he *should* just know what I want!

*Calming* -- He can't read my mind, anymore than I can read his. We can talk about what we expect from each other.

- Guarantees for Life

**Inflammatory** -- I *should* be able to live without sickness, disappointment, unnecessary stress, or set-backs!

*Calming* -- There will always be some pain or frustration. I'll still find enough support and happiness.

- Fairness

**Inflammatory** -- I *shouldn't* have to do more than my fair share!

*Calming* -- Life isn't always fair. Sometimes I have to do more; sometimes others will have to do more. I can still negotiate to do less, or request help from someone else.



MISSION: Our mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.

VISION: We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

VALUES: Access, Consumer & Family Empowerment, Best Practices, Health & Wellness, Culturally Responsive, Socially Inclusive.

## **Alameda County Behavioral Health Care Services**

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