NAMI

The Nation's Voice on Mental Illness

Provider Education Program

Note: 2011 revision: Program is 5 weeks now!

2010
States offering
NAMI Provider Education Program

2010
NAMI New York State
Regions offering
Provider Education Program

"The Provider Course emphasizes the involvement of consumers and family members as faculty in provider-staff training. The teaching team consists of five people:

> *Two family members trained as Family-to-Family Education Program teachers;*
>
> *Two consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and*
>
> *A mental health professional who is also a family member or consumer.*

The course reflects a new knowledge base -- the "lived experiences" of people coping with a mental illness or caring for someone who lives with a mental illness. Including this deeply personal perspective creates an appreciable difference in the program's content. It adds a means of teaching the emotional aspects and practical consequences of these illnesses to the academic medical information in the course." (NAMI National)

The impact of this program can be significant when the resources are available (5 person panel) and the providers are receptive. It is typically offered in regions which have a long standing and respected Family to Family programs and are well integrated into the local mental health system. Although no trainings are planned for 2011, please notify paul@naminys.org if you have interest in your area and additional resources can be forwarded.

NAMI Education, Training, and Peer Support Center Team

Lynne Saunders, Director of Field Services (with an emphasis on family and Veterans programs)
Cynthia Evans. Director of Field Services (with an emphasis on consumer programs)

Lynne and Cynthia will focus on technical assistance and support to the field across all programs, including continuing education in program leadership and management.

Teri Brister, Director of Training (with an emphasis on family, child and adolescent programs)
Sarah O'Brien, Director of Training (with an emphasis on consumer programs)

Teri and Sarah will focus on training, program content and updates, and will be responsible for repurposing existing programs into virtual formats.

Candita Sabavala, Departmental Project Director

Candita will work with departmental directors and staff to provide project oversight and direct supervision of support staff to ensure all departmental deliverables are met.

Maura Bulger and Carmen Argueta will continue as our indispensable departmental Coordinators, responsible for support functions across programs, with Carmen taking on the additional role of Spanish Language Specialist. In their support role as departmental assistants, *Blakelee Sharpe* will be in charge of document management, and *Marshall Epstein* will manage the demanding task of order fulfillment for all programs.

Cumulative Program Data as of June 2010

NAMI Provider Education Program: First piloted in 1995; became a NAMI national program in 2000.

- States now in the program: 23, plus 4 affiliate sites
- Foreign countries in program: Ontario, Canada
- Total number of provider graduates: 10,000+
- Family-to-Family team teachers trained: 562
- Consumer team teachers trained: 580
- Provider team teachers trained: 364
- Total team teachers trained: 1506
- State Trainers: 56

NEW JANUARY 2011 Format for the course. 5 Week program in place of the prior 10 Week program

CLASS 1: ORIENTATION: Introductions; Key principles guiding the course; Group exercise in building mutual respect and protection; The personal and family experience in critical periods of mental illness (Our trauma stories)

CLASS 2: CLINICAL BASES: Basic principles of secondary prevention/intervention in Community Psychiatry; Clinical strategies for responding to psychological trauma; Secondary prevention stage models of family/consumer emotional adaptation to mental illness; Group exercise to determine consumer and family needs in critical periods of mental illness (Stage I)

CLASS 3: RESPONDING EFFECTIVELY TO CONSUMERS AND FAMILIES IN STAGE II: The cascade of secondary traumas when families cope alone; Understanding symptoms as stressors (group exercise); Other significant stressors complicating passage through Stage II (Adverse effects of psychotropic drugs; Stages of adherence to medication; Co-occurring brain and addictive disorders; The trauma of incarceration and attempted suicide.

CLASS 4: INSIDE MENTAL ILLNESS: Gaining empathy and understanding of what it is like to contend with the psychological impact of brain disorders; Understanding defensive coping strategies to protect against loss of identity and demoralization; Reiterating our appeal for trauma informed care; Up from obscurity: The whole family experience.

CLASS 5: WORKING TOWARD RECOVERY: Suggested confidentiality guidelines: Case Study: How to frame collaborative work with consumers and their family; Recovery as conscious choice and action; Certification/Celebration

RESOURCE LIST

GLOSSARY OF TERMS

BASIC REFERENCES

TABLE OF CONTENTS

I. Welcome: Background of the course and introductions

II. Key principles guiding the course
First principle: Our no-fault approach (followed by class discussion)
(Class Discussion 1)
Second principle: Using the bio-psycho-social model of treating individuals with serious brain disorders.
(Class Discussion 2)
Third Principle: The trauma base of our lived experience

III. Group exercise: Devising "covenants of protection" to create a mutually safe, compassionate learning community
(BREAK: 10 MINUTES)

IV. The personal and family experience in critical periods of mental illness: Our trauma stories
(Class Discussion 3)
V. Request for accommodation of our lecture format

CLASS 1 AGENDA: INTRODUCTIONS;
PRINCIPLES OF THE COURSE; CREATING COVENANTS OF PROTECTION;
OUR TRAUMA STORIES:

I. Introduction and agenda

II. Basic premises of secondary prevention in community psychiatry: Clinical strategies for responding to psychological trauma (Question Period)

III.. Applying secondary interventions to families struggling with mental illness (group exercise in normative trauma responses)
(BREAK: 10 MINUTES)

V. The impact of mental illness on the family: Normative states of emotional reactions among family members
(Class Discussion 1)
(BREAK: 5 MINUTES)

VI. The impact of mental illness on the consumer: Normative emotional responses in the "stages of recovery" to mental illness
(Class Discussion 2)

VII. Class exercise: What families and consumers need when going through critical periods of mental illness.

CLASS 2: AGENDA: CLINICAL BASES: PRINCIPLES OF SECONDARY
PREVENTION: STAGE MODELS OF FAMILY/ CONSUMER EMOTIONAL
ADAPTATION TO MENTAL ILLNESS; EFFECTIVE INTERVENTION STRATEGIES FOR STAGE I

I. Introduction and agenda

II. The cascade of secondary traumas which occur in Stage II when a family is left to cope with mental illness without support.
(Class Discussion 1)

III. Understanding symptoms as stressors in mental illness: Empathy exercise
(BREAK: 5 MINUTES)

IV. Other significant stressors complicating passage through Stage II
Adverse effects of psychotropic drugs
(Class Discussion 2)
Stages of adherence to medication
(Class Discussion 3)
Co-occurring brain and addictive disorders
(Class Discussion 4)
The trauma of incarceration and attempted suicide
(Discussion)
(BREAK: 5 MINUTES)

V. Finishing our stories

CLASS 3: AGENDA: RESPONDING EFFECTIVELY TO FAMILIES AND CONSUMERS IN STAGE II: LEARNING TO COPE/GOING THROUGH THE MILL/DECISION

I. Introduction and Agenda

II. How discrimination has blocked our understanding of living with a life-altering mental illness

III. Psychological trauma associated with any serious illness: Permanent loss of the magical belief that one is exempt from harm; permanent loss of a predictable, dependable future.
(Class Discussion 1).

IV. Defensive coping strategies used to preserve self-esteem in mental illness
(Class Discussion 2)

V. How to assist people with mental illness in their struggle for self-esteem
(Class reading and discussion)

VI. Reiterating our appeal for trauma informed care
(BREAK: 10 minutes)
VII. Up from obscurity: The "whole family" experience: First-person accounts of the lived
experiences of other close relatives of people with serious mental illness.
(Questions from the class for the panel members, followed by class discussion.)
Sibling, adult child, and spouse testimony: What are the most difficult aspects of each
of these family roles?

CLASS 4: AGENDA: INSIDE MENTAL ILLNESS: EXPLORING THE "PSYCHOLOGICAL DIMENSION" OF MENTAL ILLNESS / MEETING THE WHOLE FAMILY

I. Introduction and agenda

II. Resolving client rights of confidentiality in a collaborative model of care:
The useful distinction between "illness information" and "privileged information".
What families want to know.

III. Helping a client and family move forward to stage III
Case study: How to "frame the case"; how to "work through" the case.
(Class responses to the case workbook)

(BREAK: 10 MINUTES)

IV. The cornerstone of emotional recovery in Stage III: Conscious choice and action.
Breaking the silence: Confronting stigma and discrimination
Challenging the myth of lifetime incapacity in mental illness
Class Reading and Discussion: Helping families and consumers in Stage III.

V. Certification, thanks and celebration

NAMI PEER PROGRAMS: BASIC PRINCIPLES

NAMI Family-to-Family Education Program
NAMI Provider Education Program
NAMI Family Support Group Facilitator Skill Training Program
NAMI Peer-to-Peer Recovery Education Course
NAMI Connection Recovery Support Group
NAMI In Our Own Voice
NAMI Basics

♦ Serious and persistent mental illness is a traumatic event for families and consumers alike, and must be understood in terms of this fundamental clinical perspective.

♦ Families and consumers adjust to this traumatic experience over time in a predictable process of coming to terms with profound dislocation in their lives.

♦ In each stage of adaptation, their emotional responses reflect a natural reaction to this process of adjustment, but their needs will differ in each stage.

♦ Family/consumer strength, persistence and heroism in the face of this overwhelming human challenge must be recognized and validated.

♦ Recovery and the reconstruction of personal priorities must be the goal of treatment

♦ Because of their lived experience, family members and consumers make ideal teachers, and peer-directed education courses provide a dimension of emotional healing not available in any other setting.

♦ Peer-directed educational and support programs must be included as an integral part of mental health services and be paid for by mental health systems.

Evidence from our Spanish classes indicates that because these basic principles underlie the curriculum, the beneficial impact of Family-to-Family is transcultural.

NAMI PROVIDER EDUCATION PROGRAM: COURSE DESCRIPTION

Background

The NAMI Provider Education Program is based on The NAMI Family-to-Family Education Program. It has been extensively rewritten to apply specifically to the learning needs of line personnel at public agencies who work directly with individuals suffering from severe and persistent brain disorders. The project was designed and developed by NAMI-Vermont, under the direction of Joyce Burland, Ph.D., author and director of the NAMI Family-to-Family Education Program. An initial year was devoted to a needs assessment of agency staff at all 10 Community Mental Health Centers in Vermont to determine the level of staff interaction with families, their attitudes toward families, and their openness to working collaboratively with families on the treatment team. The course was designed to approach this direct care-giving group in a way that would be effective and productive for them.

Course Perspective

The NAMI Provider Education Program presents a penetrating subjective view of family and consumer experience in serious mental illness. We consider the devastating event of brain disorder to have a profoundly traumatic impact upon our lives. We believe that our adaptation over time involves learning how to manage a traumatic syndrome process, and to become strong in our demands for services which provide the best support for recovery. Even though we move through stages of emotional resolution from disbelief to acceptance, we can never put the trauma completely behind us. Given the episodic or chronic course of brain disorders, the possibility of relapse threatens always to bring a "reenactment" of the initial trauma. It is our dedicated purpose in this course to help providers realize the hardships that families and consumers endure, and to appreciate their heroism in finding a way to reconstruct lives which must be lived, through no fault of their own, "on the verge."

The Teaching Team

The teaching team of the Professional Provider Program is one of its most unique features. The team consists of 5 people: 2 family members who are trained NAMI Family-to-Family Education teachers; 2 consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families and are dedicated to the project of recovery; the fifth team member is a mental health professional, who is also a family member or consumer, functioning as the team coordinator. The teaching team attends an intensive 3 ½ day Training Workshop to prepare them for teaching the course, and then meet together on their own to rehearse the class lectures.

The Provider Course has been specifically designed to involve consumers in the challenging work of provider staff training. To our knowledge, few teaching programs employ consumers in this kind of sustained educational effort, where they are paid to participate on a teaching team presenting a rigorous 10-week course. Moreover, much of the course reflects a new knowledge base--namely, the actual lived experience gained through coping with a brain disorder, and through caring for those who struggle with this life

challenge. Including this deeply personal perspective creates an appreciable difference in content, adding emotional and practical understanding to the academic/medical information in the course.

Results States in the Program To Date

At each agency we request that the Community Treatment Division Director attend the course, along with the key managers responsible for supervising programs and treatment teams. In many cases, the Executive Director of the agency has attended the classes. Class participants are drawn from all facets of agency services: Day hospital care, case management, residential care, crisis services, club house programs, homeless outreach, therapy, dual diagnosis treatment, vocational rehabilitation and job counseling.

Since 1998, NAMI state organizations in Alabama, the District of Columbia, Connecticut, Florida, Indiana, Iowa, Kansas, Pennsylvania, Minnesota, Mississippi, Missouri, Montana, New Mexico, Oklahoma,South Carolina, Utah, Washington, Wisconsin and Ontario, Canada have trained teams to conduct the program. Based on responses from over 6,000 mental health providers in these states, the reaction to the course has been overwhelmingly positive. In written evaluations, staff members reported that this course was fresh, relevant, helpful, enlightening, and emotionally overwhelming. They stated that not only had their approach towards families changed, but that their understanding of the life dilemmas of consumers had expanded as well. Almost every participant described how their own clinical practices had changed in response to what they were learning in class, and how their empathy for the realities of "living with" mental illness had grown as the course progressed.

Utilizing the feedback from these sites, the program has been revised and edited to reflect staff input in order to "improve the product." This process of field research and feedback, where teacher and participant responses directly shape the teaching tool itself, is a hallmark of NAMI peer educational **programs.**

For Information call:

Joyce Burland, Ph.D, National Director

Joyce@nami.org / 505/988-2737

AMI PROVIDER EDUCATION PROGRAM: GOALS

1. To validate the subjective, lived experience of consumers and family member caregivers as a **Primary Knowledge Base** for developing staff skills and competencies in public agencies serving individuals with serious and persistent mental illness.

2. To emphasize the **Bio-Psycho-Social Perspective** necessary for a global understanding of neurobiological brain disorders and a full appreciation of the consequences of these serious illnesses on those who suffer them:

   Bio: The biological bases of Schizophrenia, Bipolar Disorder, Major Depression, Panic Disorder, Obsessive Compulsive Disorder, and Co-occurring Brain and Addictive Disorders; their probable causes, symptomatic distresses, and variable responses to medications.

   Psycho: The psychological dimensions of coping with these brain disorders and comprehending their traumatic impact on consumers' and families' personal lives.

   Social: Rebuilding capacities to reconnect, to live with dignity and hope, which includes advocacy for improved community services and expanded opportunities.

3. To introduce **Clinical Principles and Strategies of Secondary Intervention*** as a durable working concept for effective provider/consumer/family collaboration, based on knowledge of family and consumer stages of adaptation to the traumas and life dislocation caused by serious brain disorders. **Course Motto: Once you know where someone *is* in the adaptation process, you can "provide" what they *need* to support and strengthen them to come through it.**

   (* Pragmatic, concrete, practical steps taken to keep things from "getting worse.")

4. To demonstrate **Principles of Empowerment and Strength-Based Collaboration** by presenting a collective, cooperative "model" Teaching Team -- an actual "in vivo" colleagueship of 2 family members, 2 consumers, and a family member or consumer mental health professional, specifically trained and legitimized to direct a comprehensive 30 hour educational program for line staff.

5. To create a **Safe, Compassionate Learning Environment** for family members and consumers to disclose to providers the painful, emotional, human aspects of their experience; to affirm a shared sense of family with providers as an alternative to the traditional division of "them and us"; to foster mutual appreciation for the hard work and dedication required by everyone who lives with, cares for, or works with these serious brain illnesses.

CLASS 1: <u>ORIENTATION:</u> Introductions; Principles of Medical Family Therapy and Family Consultation; Principles of the bio-psycho-social model of treatment; Radical issues of status realignment in the collaborative model; **Group Exercise in building mutual protection.**

CLASS 2: <u>CLINICAL BASES:</u> Basic principles of secondary prevention/intervention in Community Psychiatry: Secondary intervention clinical strategies applied to families; Secondary prevention stage models of family/consumer emotional adaptation to mental illness; **Group exercise: Experiencing a thought disorder.**

CLASS 3: <u>THE 3 MAJOR MENTAL ILLNESSES:</u> Clinical usefulness of diagnosis; Diagnostic checklists for schizophrenia, major depression and mania; Symptoms of psychosis; Our recollections of the trauma of psychosis; **Group Exercise in determining family/consumer needs in "critical periods" of mental illness.**

CLASS 4: <u>TYPES/ SUBTYPES OF MOOD DISORDERS/ DIAGNOSIS OF PANIC DISORDER, OBSESSIVE COMPULSIVE DISORDER AND CO-OCCURING BRAIN AND ADDICTIVE DISORDERS:</u> Sharing our stories of the illness experience; **Review of specific secondary prevention clinical interventions which are effective for families in Stage I: Crisis.**

CLASS 5: <u>RESEARCH INTO THE BIOLOGICAL BASES OF MENTAL ILLNESS:</u> Review of research indicating structural and functional brain abnormalities in mental illness; Genetic research; Understanding the "Biology of Recovery" in mental illness; **The normative clash of family/consumer emotions in Consumer Stage 1: Recuperation.**

CLASS 6: <u>MEDICATION REVIEW:</u> Basic psychopharmacology of the Mood Disorders, Anxiety Disorders and Schizophrenia; Medication side effects; **Stages of consumer adaptation to taking psychiatric medications; issues of adherence to medication.**

CLASS 7: <u>INSIDE MENTAL ILLNESS:</u> Gaining empathy and understanding of what it is like to contend with brain disorders; Understanding "defensive coping strategies" which protect against social blame and loss of self-esteem; **Group Exercise: What's wrong with this case conference? What's *right* with this one?**

CLASS 8: <u>RESPONDING EFFECTIVELY TO FAMILIES IN STAGE 2:</u> The cascade of secondary traumas when families cope alone; Handling issues of confidentiality with families and consumers; **Case Study: How to frame our work with families and clients.**

CLASS 9: <u>MEETING THE WHOLE FAMILY/PROBLEM SOLVING:</u> Learning about the experience of siblings, spouses and adult children; **Group Exercise: Using a structured approach to help families and clients when they are feeling stuck.**

CLASS 10: <u>WHY ADVOCACY?/HELPING FAMILIES IN STAGE 3/CERTIFICATION</u>: The power of stigma; Recovery as conscious choice and action; Restoring family inter-connectedness; **Certification, Celebration.**

PREFACE TO THE NAMI PROVIDER EDUCATION PROGRAM FIELD GUIDELINE

The NAMI Provider Education Program is designed to be taught by 5-person Teaching Teams, each comprised of 2 family member Family-to-Family Education course teachers, 2 consumers and a family member or a consumer mental health professional. It is to be presented to line staff at public mental health agencies in your state. It is optimal to train 3 teams to inaugurate the program in a state; the information in this Guideline is based on 3 teams participating.

The impact of the program rests in large measure on choosing teaching team members who can speak frankly about their lived experience with the pain and trauma of coming through serious and persistent mental illness, and who endorse the practice of consumer/family/provider collaboration.

The choice of target mental health centers is vitally important as well. As a start-up strategy in your state, it is wise to select progressive mental health agencies whose administrative leadership is supportive of the concept of family/consumer/provider collaboration.

It is essential to involve your State President and Executive Director in these negotiations "at the top," and to make every effort to enlist the support of the State Division of Mental Health. Your initial Provider Course training will, we hope, be the launching of a NAMI program that will become a permanent staple in staff training in your state.

It is understood that agencies signing up for the program will require participants to make a commitment to attend all 10 classes, and tat clinical supervisors and division directors will attend as well.

States inaugurating the NAMI Provider Education Program should have their funding in place, and target agencies for the course should be selected and contacted prior to the Training Workshop.

The training component of this program enables team members with different perspectives to model the collaborative team approach and to maintain composure in any kind of agency culture. Because this preparation is so critical to the comfort-level and confidence of teams in the field, all training in the program is conducted by Dr. Joyce Burland.

Be sure you have reviewed the information on the Provider Program NAMI has already sent (Overview of Program and Expanded Text for Grant Proposal). After you have read the material in this Guideline, please call Joyce Burland (505) 988-2737 to schedule a planning call. At this time, we will go over all the details and focus on the specific questions and concerns you might have.

Lakeside Alternatives, Inc.

Memo

To: Marsha Mathes, NAMI-Orlando

From: Peg Seykora, LMHC, NCC, ACS, Vice President. Clinical Services

Date: 04/29/05

Re: NAMI Provider Education Training

Marsha, I want to acknowledge the fantastic job that NAMI did with our provider training last fall. As you know, I attended all of the sessions and found each of them to be informative and interesting.

At first, I wondered of the necessity of having such a range of staff attending, from CEO to line staff. However, I did not find one person who didn't benefit from this well designed program. The presentation was professional, even though the volunteers were not professional presenters. The material was timely and up-to-date.

More importantly though, I see results a few months later with more positive staff interaction with not only clients but also with their families. I am appreciative that Lakeside's staff had an opportunity to grow in compassion and quality treatment from the experience you provided for us. Thank you so much and hopefully, we can have another opportunity for another group in the near future.

We are just completing our third course and hope to routinely hold two classes each year. So far we have had over 50 participants including administrators, physicians, social workers, nurses, secretaries, an occupational therapist, and therapeutic assistants. Just the fact that we chose to support 30 hours of classroom time for each person is a strong statement about the value we place on this training.

We are committed to providing high quality care and believe that our services must be consumer-focused and informed. In pursuit of this goal we established a Consumer Advisory Council, have consumers talk with our new employees during their orientation and sponsor an internal Consumer Service Committee. Being able to provide the NAMI Provider Training has been a wonderful "next step" in our journey to become a provider of services that consumers can truly experience as competent, compassionate, and healing.

All who have participated, including myself, have walked away with a deeper appreciation for the experience of living with a serious mental illness and how we as providers can impact that experience in positive and negative ways. This class has caused us to rethink our policies about privacy and confidentiality and how we can be helpful to families even if their family member does not give us permission to discuss them specifically. We have also re-examined our processes for partnering with patients and their families in determining plans for treatment and aftercare. I have had numerous conversations with attendees who have relayed stories of how they responded to a situation differently because of what they learned in Provider Training.

Needless to say, I couldn't be more pleased with the impact that Provider Training is having in our organization. I would love to see all providers in all locations have the opportunity to participate in this class!

Joan M. Herbert, M.S., R.N., C.S.

Administrator

Institute of Psychiatry

Medical University of South Carolina

May 16, 2006

THE ANNAPOLIS COALITION
ON BEHAVIORAL HEALTH WORKFORCE EDUCATION

May 24, 2004

Dear Dr. Burland

The Annapolis Coalition on Behavioral Workforce Education has completed its review of the nominations for Educational Innovations. We are pleased to inform you that your program entitled "NAMI Provider Education Program" has been selected as one of the 20 Innovative Educational Practices to be highlighted in an article to appear in a special issue of Administration and Policy in Mental Health, a peer-reviewed journal that aims to improve the effectiveness of behavioral health programs. As an Innovative Educational Practice, a description of your program will also be included on the Annapolis Coalition Web site, www.annapoliscoalition.com.

The NAMI Provider Education Program will be included in the above article entitled "Innovative Approaches to Education: Promising Directions for Behavioral Healthcare Reform. This article details the process by which innovations were selected as well as a brief description of the selected Innovative Educational Practices. I have included description of each of the innovative programs along with this letter.

At some point in the future, we will be mailing a certificate to you recognizing this award. We congratulate you on this award and applaud your efforts to improve the quality and relevance of education and training in behavioral health.

John A. Morris, Co-Chair
The Annapolis Coalition on Behavioral Health Workforce Education

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EXECUTIVE COMMITTEE
Coalition-Co-Chairs Michael A. Hoge, PhD Yale University School of Medicine
John A. Morris, MSW University of South Carolina School of Medicine
Members Neal Adms, MD, MPH California Department of Mental Health
Allen S. Daniels, EdD University of Cincinnati
Leighton Y. Huey, MD University of Connecticut Health Center
Gail W. Stuart, RN, CS, PhD, FAAN Medical University of South Carolina

It is my privilege to speak to the quality and benefit of NAMI Provider Training. Our hospital currently has its 5th class in this training. In this time when each training effort has to be cost-effective, it is clear that our leadership has a strong appreciation of the benefit of this experience.

We have shared with the consumer and family instructors some of the most personal experiences of their lives of consumers and their families. The sessions are personal and powerful. They teach us and move us to tears. We become humble as they challenge to reexamine our constructs of psychiatric illness and treatment. We walk in their shoes. We are moved, embarrassed, challenged, and we come away changed. The format is at first different, but it is the format that later facilitates the intimate sharing that has to occur.

I envy you the opportunity to embark on this journey with new eyes, an open heart and mind. You will be changed.

Susan Hardesty, M,D., Medical Director
Institute of Psychiatry
Medical University of South Carolina
April, 2007

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April 30, 2007

To Whom It may Concern:

The Santa Clara County Mental Health Department is pleased to support NAMI Santa Clara in their pursuit of a grant to further develop their Provider Education Course. NAMI Santa Clara County is a wonderful organization that serves our consumers, family members, staff, and the community at large. Their work continues to shine the way toward helping individuals and family members deal with mental health issues.

NAMI Santa Clara County has offered the Provider Education Course or our staff during the past two years. This course is one of the highest rated trainings that we offer. We view this course as one of the key learning experiences for our staff as we transition to an organization that values wellness and recovery for our consumers. The attendees learn so much about the consumer and family member's experiences and point of view, which helps to bridge the gap between providers and consumers. Most of the attendees have expressed that the course has profoundly affected their work. Many have stated that this was the best training they have every taken.

The Mental Health Department has successfully collaborated with NAMI Santa Clara County on many projects through the years. Their leadership is strong, and their trainers and volunteers have made a significant difference in our county. We fully support their effort to expand their services for our staff.

If you would like more information, please feel free to contact us at 408/ 885-5770.

Sincerely,

Nancy Peña, Ph.D.
Mental Health Director

Michael Ichinaga, Ph.D.
Quality Improvement Manager

The Department of Mental Health is a division of the Santa Clara Valley Health & Hospital system. Owned and operated by the County of Santa Clara.

“EXPERT CONSENSUS” CONTACT LIST FOR INFORMATION ON THE NAMI PROVIDER EDUCATION PROGRAM

The following state mental health administrators who are bringing the Provider program into their states may be contacted by NAMI state organizations. They are all willing to talk with the administrative counterparts in the mental health system in your state who may want direct testimony on the effectiveness of the program:

- **Karen Evertson, Director**

  Western Connecticut Mental Health Network

  203-805-6403
- **Karen Kangas, Ed.D., Director**

  Office of Community Education and Recovery Affairs

  Connecticut Department of Mental Health and Addiction Services

  860-418-6948
- **Paul Meyer, Director**

  Western Montana Mental Health Center, Building T-9

  Fort Missoula Road

  Missoula, MT 59804

  1-406-728-6870, ext. 108
- **Dorn Schuffman**

  Director, Department of Mental Health

  1706 E. Elm Street

  Jefferson City, MO 65101

  573-592-4100
- **Dallas Ernshaw, MS, APRN***

  Assistant Clinical Director

  Utah State Hospital

  Provo, UT

  801-344-4203
- **Felix Vinsenz, M.D.**

  CEO, Fulton State Hospital

  600 East Fifth St.

  Fulton, MO 65251

  573-751-4122

True North: The NAMI Provider Education Program Comes of Age

by Joyce Burland, Ph.D

The final report of the President's New Freedom Commission on Mental Health concluded that the nation's mental health system was "in shambles", and proposed a set of guidelines designed to fundamentally re-invent mental health care. The urgent tone of the report has inspired an outpouring of commentary calling for innovation and "seismic" change. In part, this shift in direction reflects the influence of leaders within the system whose progressive views on mental health reform have gained ground once the ailing system was officially declared beyond resuscitation. But the real credit for advocating radical transformation in the way people with mental illness are served in America belongs to the foot soldiers in the family and consumer movement.

This is another way of saying that our unwavering insistence on inclusion, validation, and respect over the last generation has not been in vain. A review of the recent system-change literature reveals that our ideas, and our ideals, inform many of the papers and proposals currently in circulation. Chief among these is a concept, staggering in its potential to revolutionize mental health care service delivery, called "True North."

In navigation, true north defines an ordinal point determined with reference to the earth's axis, rather than its magnetic poles. Synonymous with "accurate", "legitimate", "trustworthy", this term signifies an absolute reality rather than something which is manifest or assumed. A craft navigating by true north will unfailingly find its intended destination. In health reform, True North stands for an unerring guidance point in system transformation. Donald Berwick, the originator of this metaphor, proposes that in planning for reform, "the experience of consumers and families and communities" must serve as True North. This means the ordinal point for system quality derives from the *recipients' reality*-- our lived experience, our needs, our beliefs and strengths, as well as our reactions to services extended in our behalf. In their *Quality Vision for Behavioral Health,* authors Allen Daniels and Neal Adams advance this concept, stating that in reinventing mental health care, "nothing is more important in the end than maintaining focus on the experience of recipients of care and their families. This commitment must set the compass and serve as 'True North" on the roadmap for change."

Rarely do we get a more telling correction, or subliminal analysis, suggesting why the mental health system veered so far off course. If the truth be told about our perceptions right now, the most significant feature of our reality is that so few people know anything about it. How many times have we heard families and consumers say that no one can possibly fathom the excruciating dislocation of mental illness, until it has actually happened to them or to someone they love? The late Senator Paul Wellstone observed that most Americans learn about mental illness only through "intense involuntary immersion in it." Most others are oblivious to the enormous pain and trauma of this passage, and remain totally unaware of the tragic insufficiencies of our nation's response to it.

Many observers have attributed this cluelessness to the social distance (actually social isolation) imposed on those stigmatized by brain disorders. However, relatively few cite the drastic impact of professional and academic misdirection affirmed throughout most of the 20th century. The claim that mental illnesses derive from poor parenting and/or weak character suggests that the source of our trouble is more a private failing than a legitimate national concern; such a view from authorities in the mental health field deeply anesthetized the moral awareness of civic responsibility in the public mind. Furthermore, this same mistaken certainty supported the clinical premise that since the experts already "knew" the causative personal details of our reality, there was little left of any importance to learn from us. Inevitably this assumptive error jarred the compass off True North; a mental health system evolved to assist people

stricken with serious mental illness without an accurate or sufficient understanding of the true nature of this human experience.

In 1995, NAMI-Vermont developed and piloted the Provider Education Program in each of the state's ten public mental health agencies. This training model specifically targeted agency line staff – the yeoman workers who provide most of the day-to-day services to consumers and their families. Many of these direct care providers have no prior education or training in clinical interventions of any kind; they comprise a segment of the mental health workforce estimated at 40% of public agency clinic staff, and 60% of patient care staff in county and state psychiatric hospitals. We invited this group to undergo intense *voluntary* immersion into the private universe of families and consumers, promising that this experience would help them to offer what we needed most-- an understanding, empathetic, well-informed partner to work with us toward recovery.

Setting our compass squarely on True North; we trained NAMI family members, consumers and providers to teach the course in teams of five. They vowed to come to class prepared to reveal every raw emotion, personal truth and unedited response to mental illness, relating to the course content , as a core part of the curriculum. Operating from our no-fault educational mantra that "You Can't Know What No One Has Told You", we opened the door to our subjective, often chaotic world. We trusted that in ten weeks of working through the course together, the cumulative accounts of our lived experience with mental illness would tap into a common humanity and compassion more powerful than any socially or professionally conditioned belief system. And it worked: By the end of each course in the pilot project, the participants had witnessed the immense challenges involved in coping with mental illnesses, and acknowledged the elemental value of learning how to collaborate with supportive family caregivers.

Since 1997, NAMI organizations in 20 states and the Province of Ontario, Canada, have joined in to offer the program. Over 750 consumers have been trained as teachers, and over 9,000 staff members have taken the course. From every quarter we hear from providers that our commitment to "True North" has opened their eyes to suffering and heroism they hadn't seen, warmed their hearts to consumers and family members they hadn't understood, and made the Commission's call for a "consumer-and- family centered system" a tangible reality. Recounting our lived experience has demonstrated that recovery and resiliency can be achieved; it has reinforced the principle that our shared humanity must govern every domain of mental health care. Most radically, the program has called into question the claim that authority accrues only to an "all-knowing" professional elite. This model of training is a potent catalyst of transformative *empowerment*—of advocacy-through-education -- enabling consumers and family members to take their rightful place as frontline experts and legitimate instructors on the subject of living with mental illness.

In 2004, the NAMI Provider Education Program was selected as an outstanding innovative training program by the Annapolis Coalition on Behavioral Workforce Education. This coalition of progressive mental health administrators and clinicians argues that "without conscious, concerted and urgent attention to improve workforce education", meeting the goals of the President's Commission may elude us altogether. To speak of system transformation, without insisting on cutting-edge training programs for the workforce at all levels, defeats the purpose and spirit of reform. If we ignore this "elephant in the room," the workforce will retain the old attitudes and habits which blind them to the competencies required for compassionate and collaborative practice. We must join together, as system reformers and advocates, to train and re-train the workforce, and to make True North the ordinal point for change in mental health care in America.

Building a Consumer and Family Centered Workforce in Mental Health:

The concept of patient centered care emerges in every discussion of healthcare reform. The field of substance use disorders treatment has made major strides in this area though its long tradition of engaging those in recovery as both employed and voluntary members of the workforce. In the case of mental health care reform, consumer and family empowerment will hold one of the keys to meaningful and lasting system transformation. There are multiple opportunities to build consumer and family driven systems of care by validating the historically invisible consumer and family care-giving workforce as an integral part of the delivery of mental health services.

Recommendation 5: Because consumer and family driven services are important to the delivery of patient centered care, a comprehensive consumer and family workforce development strategy should be implemented in mental health. The five core elements of this plan should include: (1) increased federal, state, and private support of consumer and family services; (2) the identification of consumer and family core competencies through a partnership of the Center for Mental Health Services with consumer, family, and professional organizations; (3) accountability among education and training programs to engage consumers and families in the redesign of training programs and as educators of all segments of the workforce, including other consumers and families; and (4) accountability among oversight organizations to ensure that all providers receive formal education and training in communication skills and collaborative decision-making with consumers and families. The *National Coalition on Workforce Development* could oversee implementation of this workforce plan.

The amount of mental health care provided by the employed workforce pales in comparison to the self-care and peer support offered by consumers and families. There are enormous, but overlooked opportunities in the mental health field, to educate consumers and family members in an effort to improve their capacity to understand their illnesses, navigate and maximally benefit from available services, and help others in distress. A competency set for consumers and families should be developed with federal support, followed by a dramatic increase in the education and training of these individuals. Consumers and families should not only serve as educators within these programs, but should also be included as educators of the pre-service and existing workforce, teaching about the lived experience of illness, treatment, and recovery. These educational initiatives require increased federal, state, county, and private support, as do organized peer support programs, which remain grossly under-funded in comparison to traditional treatment interventions. Finally, consumers and families will be better able to use their skills and obtain patient center care if providers have received formal training regarding communication and collaborative decision-making with consumers and families.

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