Working with and Through Psychosis: Considerations for APS

VIRTUAL COURSE

TRAINER MANUAL

Academy for Professional Excellence

APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

Funding Sources

This training was developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Developer, 2023

Katie Wilson, MSW

Table of Contents

Introduction

We are pleased to welcome you to **Working with and through Psychosis: Considerations for APS Trainer Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

In partnership with state and national organizations, APSWI is developing curriculum available to APS programs throughout the nation. This curriculum is developed, reviewed and approved by experts in the elder and dependent adult abuse fields.

APSWI's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)
- California's Curriculum Advisory Committee (CAC)

Partner Organizations

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Academy for Professional Excellence

https://theacademy.sdsu.edu/programs/apswi/

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Academy for Professional Excellence

https://theacademy.sdsu.edu/programs/apswi/

Jennifer Spoeri, Executive Director, National Adult Protective Services Association (NAPSA)

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Paul Needham, Chair, NAPSA Education Committee

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James Treggiari, Adult Protective Services Liaison, Adult Protective Services Division

California Department of Public Social Services

cdss.ca.gov/Adult-Protective-Service

Melinda Meeken and Carey Aldava, Co-Chairs, Protective Services Operations Committee of the County Welfare Director's Association (PSOC)

https://www.cwda.org/about-cwda

Acknowledgements

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. APSWI would like to thank the following individuals and agencies:

Agencies

California Department of Social Services, Adult Programs Division National Adult Protective Services Association

Curriculum Advisory Committee

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Committees

National Adult Protective Services Association (NAPSA) Education & Development Committee

Curriculum Developer

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How to Use This Manual

This curriculum was developed as a virtual **3.5 hour** workshop (excluding breaks) using the Zoom platform, paying close attention to virtual training best practices. It can be tailored to a different virtual platform (WebEx, GoTo Training, etc.), if necessary. If training in-person, refer to the In-Person Tip Sheet to modify content.

Use of language: Throughout the manual, APS professional is used most often to describe APS staff conducting interviews and assessments. The term client is used most often to describe the individual at the center of the APS investigation. However, if concept or material was directly quoted from copyrighted material, another term may be used.

"He" and "she" have been replaced with the gender-neutral "they" throughout this manual, unless quoted from copyrighted material. This should not be thought of as plural persons, but rather a gender-neutral term describing all humans.

Customizing the Power Point: This manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide.

Hide a Slide Instructions

1. On the Slides tab in normal view, select the slide you want to hide.
2. On the Slide Show menu, click Hide Slide.

The slide number will have a line through it to show you have hidden it.

NOTE: The slide remains in your file even though it is now hidden when you run the presentation.

The course outline, provided in the later in this manual, is the class schedule used for development of this curriculum. It can be used to help determine how much time is needed to present each section. However, times will vary based on the experience and engagement of the audience.

Participant Manual:

The Participant Manual should also be sent ahead of time as a fillable PDF if using Adobe Acrobat or to allow participants to print a hard copy.

Trainer Guidelines

It is recommended that someone with education or experience in the behavioral health field facilitate this virtual workshop. Co-presenting with an APS professional is encouraged.

Suggestions for virtual training when possible:

- Have a moderator or co-host who can primarily focus on the virtual aspects of this training (e.g., monitoring chat box, launching polls, assigning breakout groups, monitoring participant reactions, etc.).
- Test out the use of the breakout room feature prior to conducting this training as well as audio.
- Log in 30 minutes prior to the training to ensure the virtual classroom is fully functioning and that you are comfortable navigating it.
- Your equipment and platform may dictate how you do some activities or discussion. There are times you may not be able to see everyone's faces, names or reactions (thumbs up, mute/unmute, etc.). There is a need for both verbal discussion and chat discussion. At such times, the moderator will fill a critical role monitoring those features you cannot. Practice during a run through how you will use the various functions for each section.
- The optimal size for this virtual training is 20-25 participants.

Teaching Strategies

The following instructional strategies are used:

- Lecture segments
- Interactive activities (e.g. breakout rooms, chat box discussion, polling activities)
- Experiential Activity (case scenario/documentation, audio, transcript)
- Question/answer periods
- PowerPoint Slides

Materials and Equipment

The following materials are provided and/or recommended:

- Trainer Manual
- Participant Manual (fillable PDF)
- PowerPoint Slides
- Headset with microphone
- Computer

Virtual Training Tips

Training and facilitation have always been an art. Virtual training is no exception. Below are some helpful tips to remember and implement when training in a virtual environment.

Assume nothing.

- Do not assume everyone has the same knowledge/comfort level with technology or has access to equipment like printers, video camera, headsets or even reliable Wi-Fi.

Distractions are everywhere.

- Participants have greater access to distractions (email, phone, others at home) which can take their focus away from the training. Therefore, explain everything and summarize before asking participants to complete an activity and check for clarification.

Over explain when possible.

- The virtual room doesn't allow for participants to see everything you're doing as they can in- person. Share as you navigate the virtual environment. If you are silent while looking for something or finding a screen, they may think something is frozen.

Mute with purpose.

- "Mute all" function can help ensure we don't hear conversations we're not supposed to. However, it can also send a message to the participants that they are a passive participant and may not make them feel comfortable taking themselves off mute when you want them to speak.

Two screens can be a lifesaver.

- This allows you to move your chat box or participant gallery view away from your presentation so you can see more of what's going on.

Rely on practice, not luck.

- Winging it during an in-person training or facilitation may work from time to time, but doesn't work in the virtual environment. In addition to covering the content, you have to manage all of the technology issues, learning styles in a virtual room, and it will show if you're not prepared.

Bring the energy.

- As trainers, we are no strangers to being "on," standing and moving around. However, some of the body language, subtle nonverbal skills we relied on the in-person training room do not translate well in the virtual environment. While this may make you more tired, it's important to up your enthusiasm, voice, and presence in order to engage with attendees.

Be mindful of your space.

- Training virtually brings an entirely new component of what we're willing to share with others. Learners can get distracted with what's in your background, whether what is physically there or if you set your video to use a virtual background.
- It's important to reflect on questions of privilege, diversity and equity when thinking of your training space.
- Are there objects in your background that can symbolize status, privilege and/or power? If so, consider removing them to dismantle any added power dynamics that already exist with you as the Trainer.
- Unknowingly, objects can come across as offensive or can activate unpleasant or traumatic memories, and can instantly discredit your rapport building. Think of neutral backgrounds that are not distracting and allow you to be the focus of what learners see.

Executive Summary

Working with and Through Psychosis: Considerations for APS

This course provides APS professionals with foundational knowledge and tools needed to work effectively with individuals actively experiencing serious mental health symptoms, such as psychosis. In this course, participants will learn general information about psychosis, including the symptoms and behaviors one may observe when an individual is actively experiencing symptoms and when these symptoms may require an immediate crisis response. Participants will identify techniques for adapting an interview to better engage the individual and practice documenting those interactions, using language that is objective and free of bias.

Goal

The purpose of this training is to enable APS professionals to increase engagement with individuals actively experiencing symptoms of psychosis and accurately document the interactions in an objective, unbiased manner.

Virtual Training

The following virtual instructional strategies are used throughout the course: short lectures (lecturettes); experiential activities including a case scenario, audio, and transcript; interactive activities/exercises including breakout rooms, chat box discussions, large group discussions, self-reflection, and poll options. PowerPoint slides are used to stimulate discussion.

Participants will need access to a computer with video conferencing capability and be able to connect to the virtual platform being used to deliver this training. A headset or earbuds with microphone and a video camera are highly encouraged. Participant Manual is a fillable PDF if using Adobe Acrobat. Participants are encouraged to either print a hard copy or ensure access to Adobe Acrobat to allow for highlighting, typing in comments, and filling out worksheets.

Course Requirements

There are no course requirements, but it is recommended that participants have some experience with interviewing clients. It is also recommended that participants have taken the Mental Health in APS instructor-led training and/or eLearning course.

Intended Audience

This course is intended for all levels of APS professionals investigating allegations of maltreatment. APS Supervisors are encouraged to attend as well.

Learning Objectives

After completing this course, participants will be able to:

- Define psychosis and specify mental disorders that may have psychotic features.
- Recognize misconceptions of psychosis that may lead to biases when working with people experiencing psychosis.
- Identify behaviors and symptoms of psychosis that may indicate a crisis situation, requiring immediate intervention.
- Discuss appropriate communication methods when working with a person actively experiencing symptoms of psychosis.
- Document mental health observations in an accurate, objective, and unbiased manner.

Course Outline

Content	Materials	Time
Welcome, Introduction, & Course Overview		**Total: 30 minutes**
Activity 1: Agree, Disagree, or Unsure (*Individual, Large Group*)	Reactions/Emojis	15 mins
Psychosis Discussion		**Total: 50 minutes**
Psychosis Defined: Symptoms, causes, mental disorders, and the psychosis continuum		15 minutes
Psychosis and Crisis: De-escalation, suicide risk		20 minutes
Communication Methods	Handout #1: Communication Tips	15 minutes
Case Scenario Application		**Total: 80 minutes**
Activity 2: Review Initial Report (*Individual, Large Group*)	Handout #2: Initial Report	10 minutes
Activity 3: Initial Home Visit (*Breakout groups*)	Breakout Group Handout #3: Initial Home Visit	30-35 minutes
Activity 4: Follow-Up Phone Call	Handout #4: Transcript of Audio Audio File Documentation	10 minutes
Activity 5: Interview Critique (*Breakout Groups*)	Breakout Group Handout #1: Communication Tips	20-25 minutes
Documenting Mental Health Observations		**Total: 35 minutes**
Activity 6: Rework the Documentation (*Individual/Large Group*)	Poll Questions	25 minutes
Activity 7: Personal Documentation Review (*Individual/Large Group*)		10 minutes

Wrap-Up		**Total: 15 minutes**
Activity 8: PIE Wrap-Up (*Individual/Large Group*)	Evaluations	10 minutes
TOTAL (Excluding Breaks)		**3.5 hours**

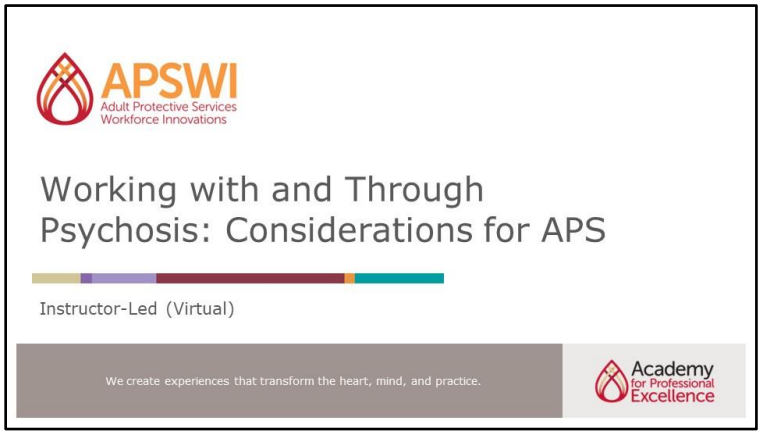
Welcome, Introductions, and Course Overview

Time: 30 minutes

Associated Objective: NA

Method: Lecture, chat features

Slide #1: Working with and Through Psychosis: Considerations for APS (Title Slide)



Welcome participants and allow everyone to settle in.

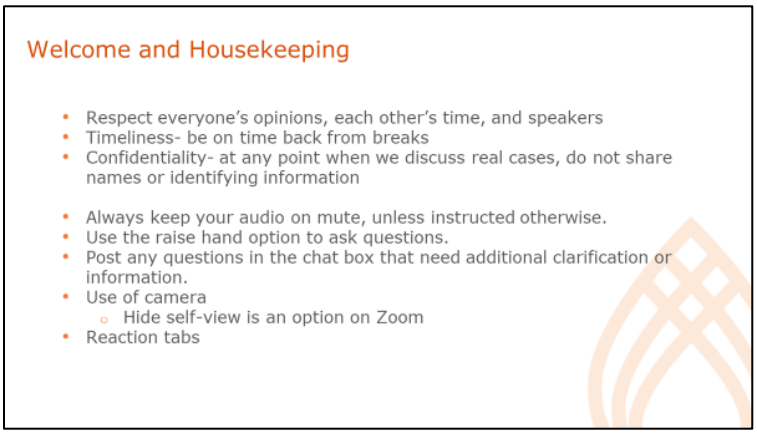
Chat Box: Ask participants to type in their names, titles, and counties (or APS programs) for attendance purposes.

Slide #2: About the Academy and APSWI

Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations, and communities.

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide #3: Welcome and Housekeeping



Welcome participants to class. **Introduce** yourself by name, job title, organization, and qualifications as the trainer for this topic.

Review the following housekeeping items:

- Respect everyone's opinions, each other's time, and speakers
- Timeliness- be on time back from breaks.
- Confidentiality- at any point when we discuss real cases, do not share names or identifying information.

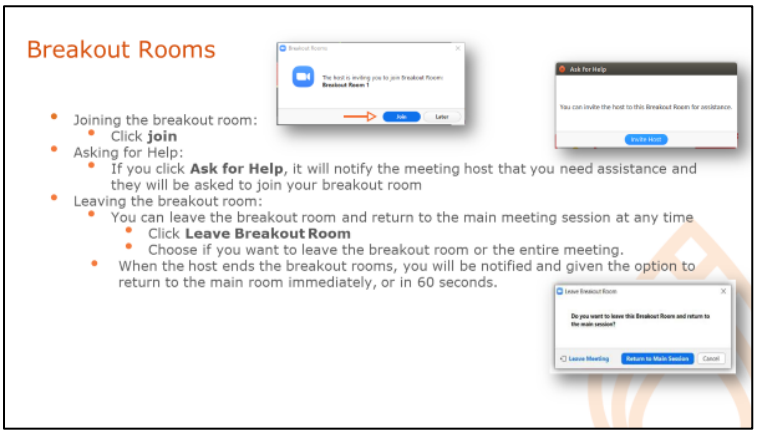
Virtual Additions:

- Always keep your audio on mute, unless instructed otherwise.
- Use the raise hand option to ask questions.
- Post any questions in the chat box that need additional clarification or information.
- Use of camera
  - Hide self-view is an option on Zoom
- Reaction tabs

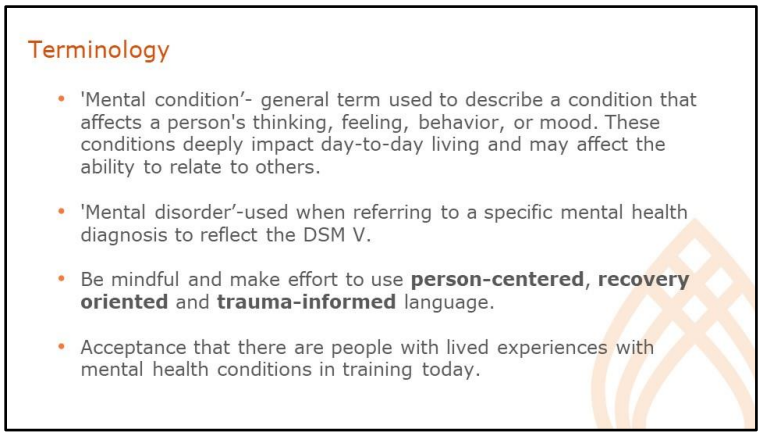
Share the following content warning for today's content:

- We recognize that APS work is both challenging and rewarding and APS professionals are whole human beings who have their own experiences before and during APS work. Content and discussion today may activate feelings based on personal or professional experiences, including vicarious trauma and we encourage everyone to do what they need to do in order to safely engage in the training today.

Slide #4: Breakout Rooms



Slide #5: Terminology



Explain for many organizations, mental health conditions, mental illness, and mental disorders are often used interchangeably. For this training, we will use the following terms:

- 'Mental health condition' is a general term used to describe a condition that affects a person's thinking, feeling, behavior, or mood. These conditions can deeply impact day-to-day living and may affect the ability to relate to others.
- 'Mental disorder' is used when referring to a specific mental health diagnosis to reflect the terminology used in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5).
- We will refrain from using mental illness due to its stigmatization and stereotypes associated with that term. Instead, we'll be using the above terms and welcome you to do so when participating in today's training. When needing to discuss someone living with mental illness, it's suggested to use "someone living with or experiencing mental illness" as opposed to "mentally ill".

Share that this curriculum was developed to intentionally and mindfully use person-centered, recovery oriented and trauma-informed language. People in the training may have personal lived experiences with various aspects of mental health and participants are asked to be mindful and respectful of the language they are using. We can all learn from each other and we may make mistakes. That's okay; it's being mindful and willing to hear others which make this work.

Activity 1: Agree, Disagree, or Unsure

Time: 15 minutes

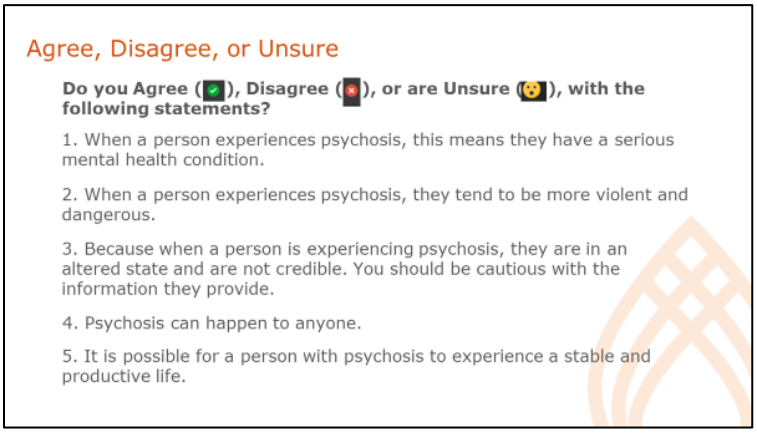
Associated Objective: Recognize misconceptions of psychosis that may lead to biases when working with people experiencing psychosis.

Purpose: Used as icebreaker to build rapport with trainer and participants. Create a comfortable learning environment for participants to encourage class participation. Allow participants to begin thinking about the topic of psychosis and associated misconceptions/biases with the condition.

Trainer Instructions: Trainer will project statements and allow participants to choose an emoji reaction to signify "Agree," "Disagree," or "Unsure" for each statement. Participants may be called upon to share their reasoning for their selection.

Virtual Tools: PowerPoint slide, Emoji reaction (green check, red x, open mouth emoji), chat feature, Raise Hand Feature

Slide #6: Agree, Disagree, or Unsure



Trainer Note: *This activity has the potential of running long if participants feel they have to plead their case or can't make a decision. Remind them that the material in today's training will help give context to the activity. You may want to pick just a few of the statements that you feel are most commonly misunderstood and read those only. #4 can be omitted if the discussion in #1 reveals similar sentiment.*

Explain that psychosis has gained a lot of attention in recent years due to its representation in media, films and work done in Behavioral Health. As a result, there are a lot of opinions and thoughts when discussing psychosis.

Explain that you will read off statements about psychosis to set the stage for this training and to see what experience or thoughts each participant is bringing to today's training so that we can come to some common ground.

Ask participants to decide whether they agree with the statement, disagree with it, or are unsure and make their corresponding choice using one of the following emoji reactions:

- Agree = Green check
- Disagree = Red X
- Unsure = Open mouth emoji

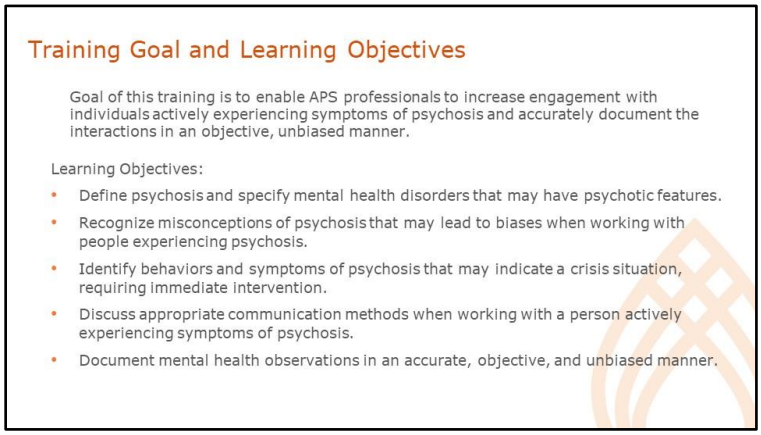
Explain that whatever they choose, they should be prepared to explain why. **Share** that they can change their answer if someone says something that makes them change their mind.

Instructions: Project and read each statement using the PowerPoint slide and allow participants to make their decision. **Ask** for 1-2 participants from each group to share their reasoning and then **ask** for those with check marks and x's to remove them.

1. When a person experiences psychosis, this means they have a serious mental health condition.
2. When a person is experiencing psychosis, they tend to be more violent and dangerous.
3. Because when a person is experiencing psychosis, they are in an altered state and are not credible. You should be cautious with the information they provide.
4. Psychosis can happen to anyone.
5. It is possible for a person with psychosis to experience a stable and productive life.

Thank everyone and **explain** that many of these statements touch on common myths that many APS professionals will encounter when working with situations involving psychosis. The concepts and skill practice in today's training will help clear up some of these common myths.

Slide #7: Learning Objectives, Guidelines, and Outline for the Day



Explain: The goal of the course is to better equip you with the knowledge and tools you need to work with individuals actively experiencing psychosis. During our time together, you will learn how to identify when someone is experiencing symptoms, techniques on how to best adapt your interview to engage with them, and how you can best document those interactions.

Review the Learning Objectives.

Upon completion of this training session, you will be able to:

1. Define psychosis and specify mental health disorders that may have psychotic features.
2. Recognize misconceptions of psychosis that may lead to biases when working with people experiencing psychosis.
3. Identify behaviors and symptoms of psychosis that may indicate a crisis situation, requiring immediate intervention.
4. Discuss appropriate communication methods when working with a person actively experiencing symptoms of psychosis.
5. Document mental health observations in an accurate, objective, and unbiased manner.

Share that there will be an opportunity to participate in an experiential activity and it's understandable that this can bring up uncomfortable feelings for some individuals, for a variety of reasons. You won't be forced to participate in the activities. However, everyone is encouraged, if there is discomfort (and they feel safe enough to do so), to develop awareness of their uncomfortable feelings and allow them to simply be there. It is

possible that exploration of these feelings could bring about personal insights, growth, and increased resilience, if handled with care, curiosity, and sensitivity. Striving to foster a learning environment that harnesses the power of experiential learning while also respecting an individual's sensitivity to particular topics and/or learning experiences is the goal.

Psychosis Discussion

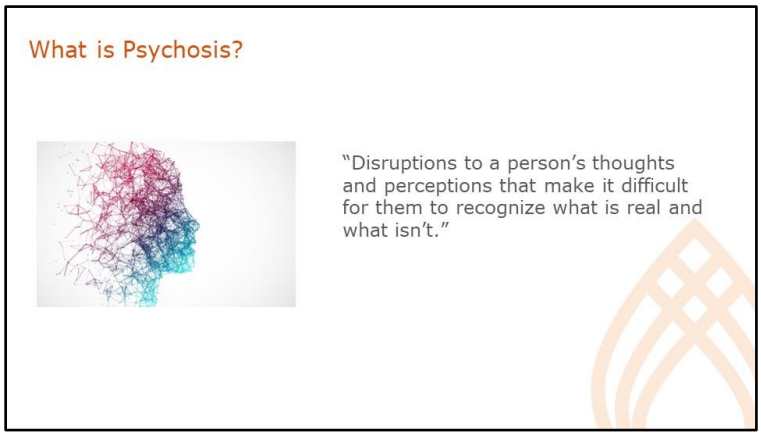
Time: 50 minutes

Associated Objectives:

- Define psychosis and specify mental disorders that may have psychotic features.
- Recognize misconceptions of psychosis that may lead to biases when working with people experiencing psychosis.
- Identify behaviors and symptoms of psychosis that may indicate a crisis situation, requiring immediate intervention.

Method: Group discussion, Chat Feature,

Slide #8: What is Psychosis?



Trainer Note: *During lecture portion of the curriculum, it is advised that you facilitate virtual learning platform features such as raise hand or chat feature to encourage participation throughout to generate class discussion.*

Share the following: National Alliance on Mental Illness (NAMI) defines the word psychosis as "disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't." (2023).

These disruptions are often experienced as seeing, hearing, and believing things that aren't real or having strange, persistent thoughts, behaviors, and emotions. When a person actively experiences these symptoms, it is called a psychotic episode.

Slide #9: Symptoms and Behaviors

Trainer note: this slide is animated.

Explain: Psychosis includes a range of symptoms but typically involves hallucinations and delusions.

Ask: Can anyone tell me the difference between hallucinations and delusions?
Allow participants to respond and provide examples they have observed during their casework. Be sure the **cover** the following information:

Hallucinations are sensory perceptions that no one else is experiencing. Examples of hallucinations include:

- Auditory - Hearing voices.
- Visual – Seeing lights, objects, people, or patterns.
- Olfactory and gustatory – Experiencing good or bad smells and tastes.
- Tactile – Feeling of things moving on your body.

Delusions are fixed beliefs which do not have a basis in reality. Some themes for delusions include:

- Persecutory delusions - Someone is coming after them or trying to kill them.
- Grandiose delusions - They believe they have exceptional abilities or fame.
- Erotomanic delusions - They falsely believe that another person (such as a celebrity) is in love with them.

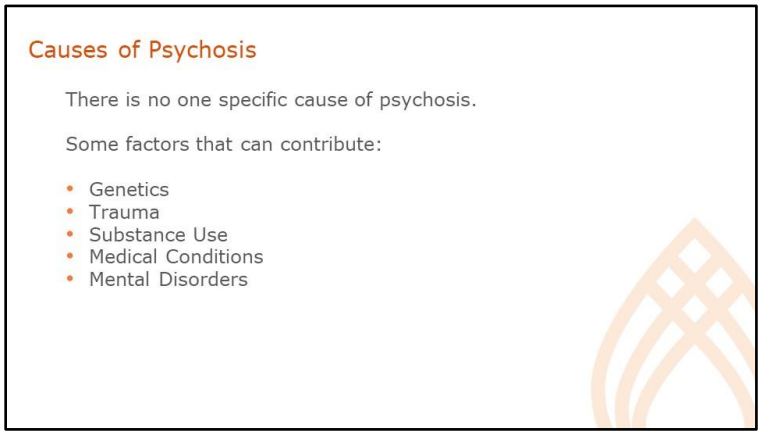
Other symptoms include:

- Disorganized speech: Speaking very quickly or very slowly, changing topics frequently, making up words

- Disorganized behavior: behaving unusually, repetitive hand movements, childlike silliness or unpredictable agitation
- Confused thinking: Words and ideas may lose their meaning or take on meanings that make no sense.
- Difficulties in concentration, memory, or decision making
- Feeling or showing less emotion
- Increased sensitivity to light, noise, and sensory inputs

Psychosis is a symptom, not an illness. There is no one specific cause of psychosis.

Slide #10: Causes of Psychosis



Share: Some of the fear around psychosis may be because no one knows exactly what causes it. Research is still uncovering how and why psychosis develops.

There is no one specific cause of psychosis. However, there are several factors that can contribute to psychosis:

- Genetics: Psychosis can run in families, but no specific gene has been identified as responsible.
- Trauma: Traumatic events such as war, sexual abuse, or death of a loved one can trigger a psychotic episode.
- Substance use: Marijuana, LSD, amphetamines, some prescription medications, etc.
- Medical conditions or physical injury: Traumatic brain injuries, brain tumors, strokes, HIV, and some brain diseases such as Parkinson's, Alzheimer's disease, and other neurocognitive disorders

Psychosis can be a short, one-off event with an obvious catalyst, such as a traumatic event or substance use. For others, it can be a long-lasting challenge with no obvious catalyst.

Slide #11: Symptoms in Some Mental Disorders

Trainer note: this slide is animated.

Share: Psychosis may also be a symptom of some mental disorders.

Ask: What are the major mental disorders that have psychosis as a possible symptom?

Allow participants to respond before revealing the list of mental disorders with psychosis as a possible symptom:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Major Depression
- Post-Traumatic Stress Disorder (PTSD)

Discuss briefly how symptoms may appear in each disorder.

Schizophrenia/Schizoaffective Disorder:

- Hallucinations and delusions are defining symptoms of these diagnoses (types of psychotic disorders in the DSM 5).
- A diagnosis of schizophrenia can sometimes follow a psychotic episode, but there are additional symptoms needed to meet the diagnostic criteria.

Bipolar Disorder:

- Research estimates a little over half of people with bipolar disorder will experience at least one episode of psychosis (Burton et. al., 2019).

- Psychosis can happen during the peaks of manic or depressive episodes, but it is more common during manic episodes.
- Psychosis in bipolar disorder tends to be more "mood congruent" and happen for a shorter duration than that of schizophrenia.
- Grandiose delusions are noted as one of the more common psychotic symptoms during psychosis in a manic episode.

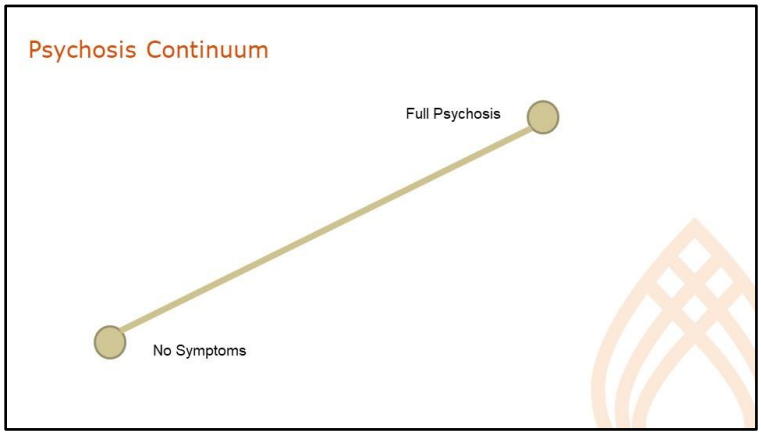
Major Depression:

- 20% of people diagnosed may develop symptoms of psychosis (called psychotic depression) (NAMI, 2022).
- Delusions tend to be related to guilt, paranoia, and related to the body.
- Example: A person experiencing psychotic depression believes a parasite is eating their intestines and that they deserve it because they is so "bad."

Post-Traumatic Stress Disorder:

- Psychosis experiences vary depending on the severity of the trauma exposure.
- Hallucinations and delusions are usually related to the trauma in some way.

Slide #12: Psychosis Continuum



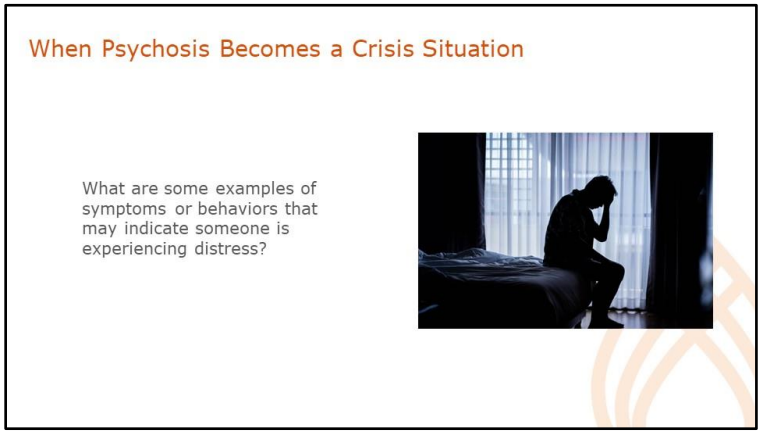
Explain that anyone can experience psychosis.

- Not a 'black and white/ yes or no' type of situation.
- Happens on a continuum across the general population.
- Symptoms range from non-existent, to very subtle and minor, to more extensive and life impacting.
- Symptoms can worsen for individuals when they are stressed, overwhelmed, tired, sick, or under the influence of drugs or alcohol.
    - This is because our brains are more prone to sensory misinterpretations or illogical thoughts when we're worn out.

Provide an example to help illustrate the point. The following example is provided if needed:

Let's say you just left a client's house. You receive a phone call an hour or so later with them telling you they have a bedbug infestation. As you're on the phone, you're remembering that you sat on their couch for a good 30 minutes while you were there. You start to feel some strange sensation of bugs crawling on your skin. Technically, in that moment, you experienced a hallucination. But it was fleeting and likely didn't cause you any distress.

Slide #13: When Psychosis Becomes a Crisis Situation



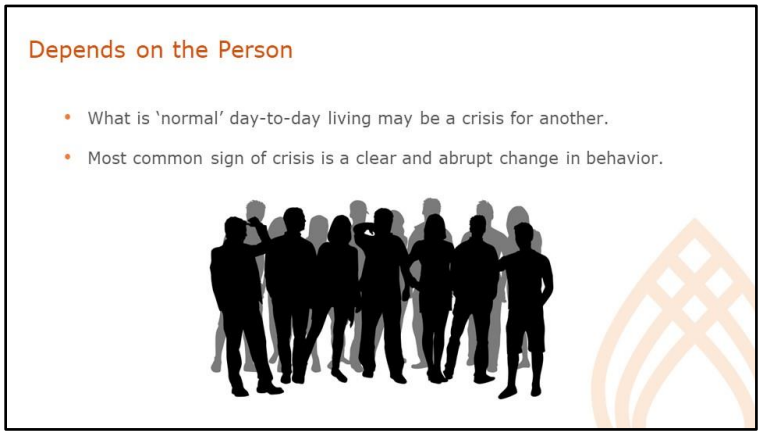
Discuss that as an APS professional, it can be difficult to know when you can engage a person in a psychotic episode or when it makes sense to call 911, a mental health crisis team, or other resources.

Ask: What are some examples of symptoms or behaviors that may indicate that someone is experiencing distress?

Allow class to provide responses and supplement with the following information:

- Decline in functioning (poor hygiene, unkept home environment, etc.)
- Intense or sudden changes in mood
- Increased agitation or anger
- New or intensified hallucinations or delusions
- Responding to stimuli that only they can hear or see
- Extreme paranoia

Slide #14: Depends on the Person



Discuss that assessing the tipping point of when something escalates to the point of emergency will be different from person to person.

What is 'normal' day-to-day living for one person may be a crisis for another. The most common sign of a crisis is a clear and abrupt change in behavior. (APA, 2023).

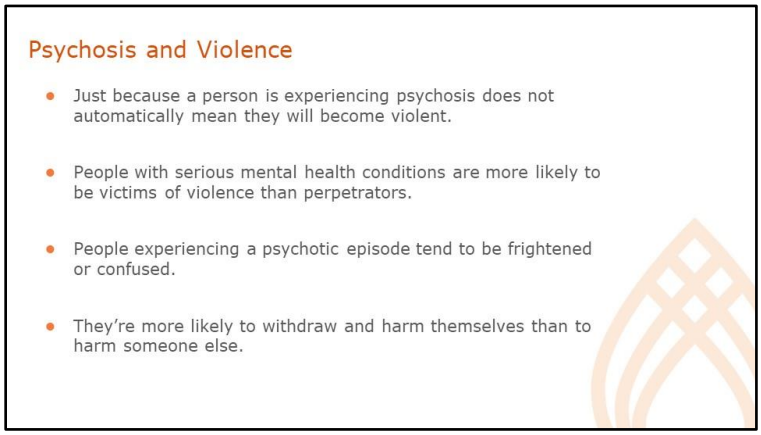
Example: You are interviewing a person that has a schizophrenia diagnosis and they told us that they hear voices sometimes. That alone would not be a strong indicator that a crisis situation is looming, and emergency intervention is needed. This is why it is important to objectively identify the symptoms and behaviors that would escalate a concern.

Explain that it also depends on the APS professional.

How a situation is perceived will depend on the comfort level of the APS professional. This will vary widely depending on someone's knowledge, personal or professional experience, or even personal biases.

Example: An APS professional with prior experience working an internship in a psychiatric unit may respond to a situation differently than a newer APS professional with limited experience with mental health situations.

Slide #15: Psychosis and Violence



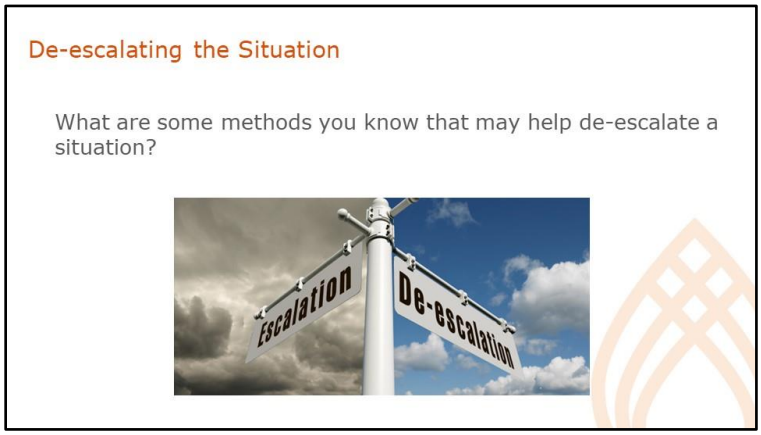
Ask: When a person experiences psychosis, should we anticipate that the situation will escalate to violence?

Allow participants to respond. Be sure to **discuss** the following points:

- Just because a person is experiencing psychosis does not automatically mean they will become violent.
- People with serious mental health conditions are more likely to be victims of violence than perpetrators. (DeAngelis, 2022/Stuart, 2003)
- People experiencing a psychotic episode tend to be frightened or confused.
- They're more likely to withdraw and harm themselves than to harm someone else.

As you notice behaviors or agitation increasing, deescalating the situation may prevent things from escalating into a crisis.

Slide #16: De-escalate the Situation



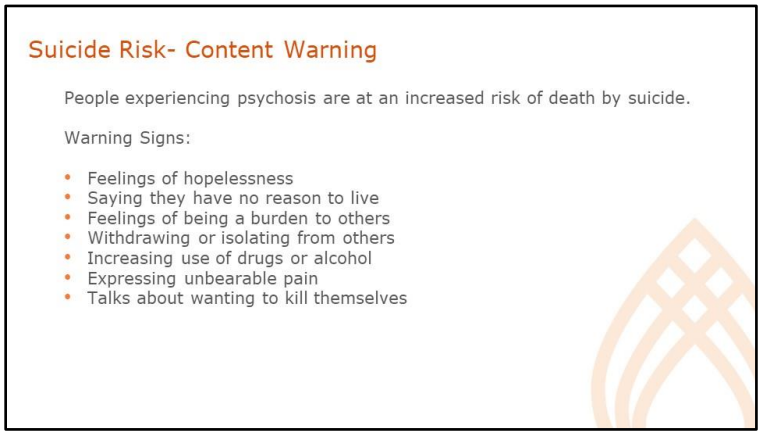
Ask: What are some methods you know of that may help de-escalate a situation?

Allow participants to respond before covering the following points:

- Stay calm and keep your tone and body language neutral. Avoid nervous behaviors (shuffling feet, fidgeting, abrupt movements).
- Use your active listening skills to try and understand the source of the distress, if any.
- Avoid raising your voice or talking too fast.
- Try to empathize with how the person feels about their beliefs and experiences without stating any judgments about the content of those beliefs and experiences.
- Never respond in a hostile, disciplinary, or challenging manner towards the person.
- Telling the person to calm down is not helpful and sometimes has the opposite effect.
- Reassure the person that you are there to help them. Ask them what will help them to feel safe and in control.
- When possible, offer the person choices of how you can help them.

Reminder, if de-escalation is ineffective and the person's distress appears to be increasing, it is time to treat the situation as an emergency. If a person's aggression escalates to a point where it's likely to cause them, you, or others harm at any time, you should remove yourself from the situation and call for immediate intervention. Never put yourself at risk.

Slide #17: Increased Suicide Risk



Emphasize: People with psychosis are at increased risk of death by suicide, so it is important to be alert for warning signs.

Ask: What are some warning signs for death by suicide?

Allow time for participants to respond before covering the following points:

- Feelings of hopelessness
- Saying they have no reason to live
- Feelings of being a burden to others
- Withdrawing or isolating from others
- Increasing use of drugs or alcohol
- Expressing unbearable pain
- Talks about wanting to kill themselves

The best way to know if someone is thinking about suicide is to ask them. This is especially important for people experiencing psychosis given the elevated risk of suicide for these individuals.

***Trainer Note**: If participants are interested in more information on Suicide Risk Assessment, the Mental Health Issues in APS eLearning goes into more depth about protective factors, risk factors, and warning signs.*

Emphasize that the biggest indicator that a situation is a crisis and emergency intervention is needed is when a person is expressing suicidal thoughts, thoughts of harming themselves, or thoughts of harming others.

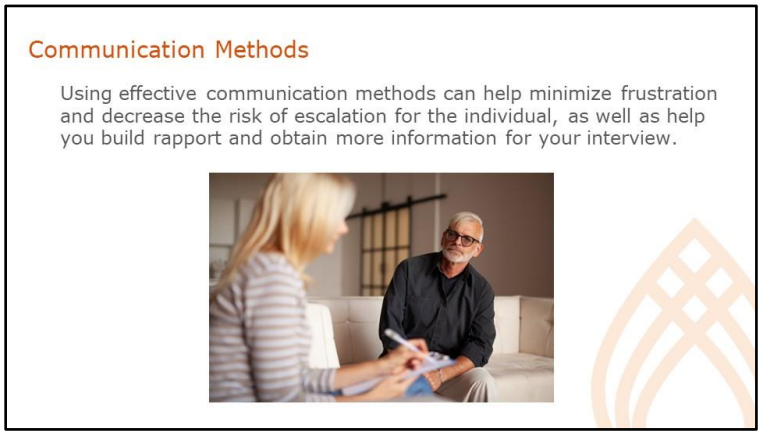
Ask: When a person you are working with is experiencing a crisis and you need immediate intervention, who do you call?

Validate responses and reiterate that calling 911 for emergency assistance is sometimes necessary, though some people are hesitant to call due to previous encounters with law enforcement or power dynamics between law enforcement and the person in crisis. Be sure to tell dispatch the situation involves mental health. Some counties/area may have a special team that handles mental health crises (or involve a separate agency/entity specifically trained for mental health situations).

In some situations, it may be helpful to explore if there is a trusted individual involved with this person. This person may have assisted them in the past through crisis situations and may be able to help the person feel safe again.

***Trainer Note**: This discussion may lead to deeper discussion about other considerations when involving law enforcement. It will be important for the trainer to be mindful of the time, acknowledge this important dynamic, redirect and remind the participants that the focus of this curriculum is on working with people experiencing psychosis, which is usually not a crisis situation.*

Slide #18: Communication Methods



Discuss that not every situation with a person experiencing psychosis is a crisis. Using effective communication methods can help minimize frustration and decrease the risk of escalation for the individual, as well as help you build rapport and obtain more information for your interview.

Ask: When someone talks about their delusions or hallucinations, how should you respond?

Allow participants time to respond but be sure to highlight the following points:

- It is important to recognize that the delusions and hallucinations are very real to the person experiencing them.
- Validate their experience but be honest about your own observations.
- Do not dismiss, minimize, or argue with the person about their delusions or hallucinations.
- Do not act alarmed, horrified, or embarrassed.
- Do not laugh or make fun of the person's symptoms, or use sarcasm.
- If the person is experiencing paranoid behavior, do not encourage or inflame the person's paranoia.

Ask: People experiencing psychosis may have difficulties with communication. What are some ways you can adapt your interview to help with this?

Direct participants to **Handout #1 in their Participant Manuals**. Highlight the points during class discussion.

Handout #1

Communication Tips for Working with Individuals Experiencing Psychosis

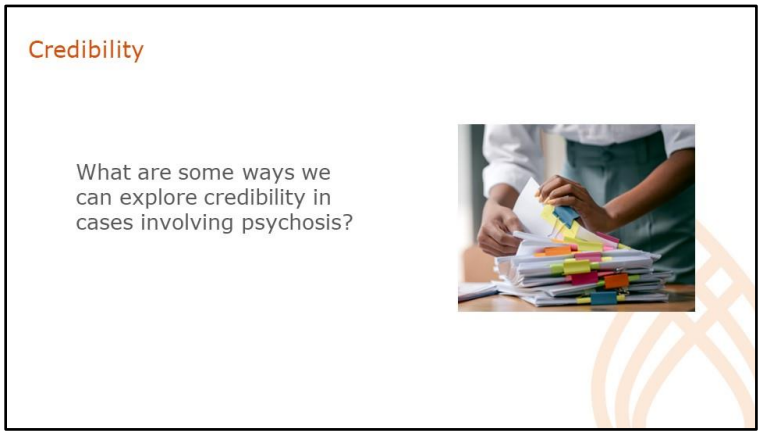
- When possible, let the person set the pace and style of interaction.
- Try to arrange for the interview in an uncrowded and quiet space.
- You may need to break up your interview into segments, meet on different days or take breaks.
- Be patient and allow time for the person to process the information and respond. Be prepared to repeat instructions and directions.
- Keep the content of the communication simple and concrete. Only cover one topic or direction at a time.
- Try to limit the number of decisions a person has to make during a single conversation.
- Gently assist the person to remain on topic by assisting them to re-focus by checking that they recall the question.
- Do not presume the person cannot understand what you are saying, even if their response is limited. Follow up with a simple, concrete question to elicit further details.
- If the person is showing a limited range in emotions, it does not mean the person is not feeling anything.
- Be honest and do not make promises you can't keep.

Responding to Hallucinations and Delusions

- Recognize that the delusions and hallucinations are very real to the person experiencing them.
- Validate their experience but be honest about your own observations.
- Do not dismiss, minimize, or argue with the person about their delusions or hallucinations.
- Do not act alarmed, horrified, or embarrassed.
- Do not laugh or make fun of the person's symptoms, or use sarcasm.

If the person is experiencing paranoid behavior, do not encourage or inflame the person's paranoia.

Slide #19: Credibility



Discuss that one of the stigmas for people with psychosis is that they are not credible and the information they provide should not be trusted.

While it may be difficult for a person experiencing psychosis to differentiate reality from their hallucinations/delusions, it does not mean the information they are sharing with you should be outright dismissed.

Emphasize there may be some truth mixed in with the delusions.

Ask: What are some ways we can explore credibility in cases involving psychosis?

Allow participants to respond while highlighting the following points:

- Complete a follow-up interview when the person is not experiencing active psychosis. How does the information differ from the first interview?
- Gather information from collaterals: It is especially important to gather additional information from medical professionals, friends, family, neighbors, and anyone else with information that could help with your investigation and help assess credibility in the information.
- Gather any other evidence (such as bank records, police reports, medical records) that may support or refute information the information you've obtained.

Case Scenario Application

Time: 80 minutes

Associated Objectives:

- Identify behaviors and symptoms of psychosis that may indicate a crisis situation, requiring immediate intervention.
- Discuss appropriate communication methods when working with a person actively experiencing symptoms of psychosis.

Method: Case scenario review, audio recording, individual writing exercise, breakout rooms, group discussion

Activity 2: Review Initial Report

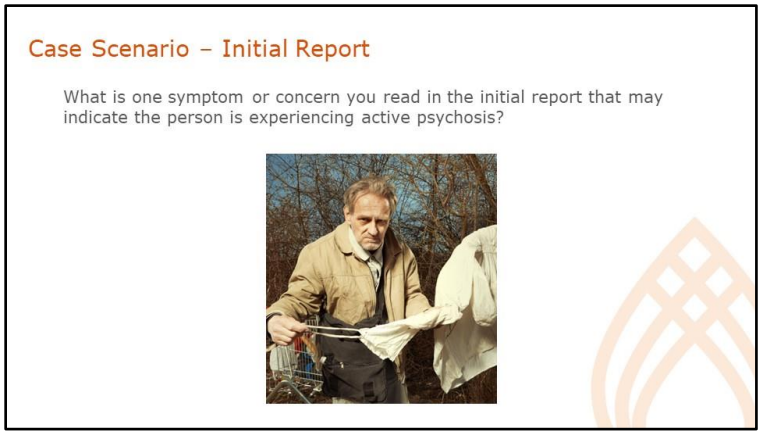
Time: 10 minutes

Purpose: Allow participants to identify possible symptoms of psychosis from an APS initial report. Participants will discuss how they can use the information from the initial report to help prepare for the initial visit.

Trainer Instructions: Participants will review an initial report for an APS case involving a person experiencing psychosis. Participants will notate for themselves possible symptoms noted in the initial report that may suggest concerns for active psychosis.

Virtual Tools: Handout, chat feature

Slide #20: Case Scenario - Review Initial Report



Explain that in this section, we'll be spending time applying what we've covered so far using a case scenario involving an APS client experiencing psychosis.

Instructions: Refer participants to Handout #2-Initial Report in their Participant Manual to review the Initial Report Document. **Explain** they have 5 minutes to read the report.

Ask: What is one symptom or concern you read in the initial report that may indicate the person is experiencing active psychosis? Is this symptom or concern a hallucination, a delusion, or something else?

Direct participants to use the chat feature to enter their response. **Use** the responses to generate a group discussion.

Ask: What can we do to prepare for this interview? What questions would we want to ask this client to gain more information?

Allow participants to share their responses. Some suggestions to incorporate may include: Review (if applicable) any previous history on the client, allow plenty of time for the interview, identify social supports, learn about diagnoses/medical conditions and possible medications, supplements or substances they are taking (are they taking as prescribed?), assess current risk for death by suicide (ask client about suicide).

Transitional Statement: We will continue working with this case scenario and now move forward with completing the initial/home visit with this client.

Handout #2: Initial Report

Client Name: Alexander Murphy
Age: 65
Ethnicity/Race: White
Marital Status: Single
Living Situation: Lives alone
Reporting Party: Anya Vargas, Neighbor

Allegation:

Client lives alone in his small home. Client has no known medical conditions and does not take any medications. Reporting party is unclear if client has a mental health diagnosis, but his recent change in behavior has brought up concerns that "something is going on."

Starting a month ago, client seems to be preoccupied with the neighbors and says they are monitoring him. He claims to hear them talking "all the time." He believes the FBI has implanted a chip into his brain and that they can change his thoughts.

Client appears to have difficulty taking care of himself and his home. His yard is unkept, which is unusual for him. In the times the reporting party had seen client, he appears to have stopped bathing and is wearing the same beige shirt every time he is seen. Reporting party has attempted to offer help but client always refuses. Reporting party is worried that if client doesn't get help, he will continue to decline.

Activity 3: Initial Home Visit

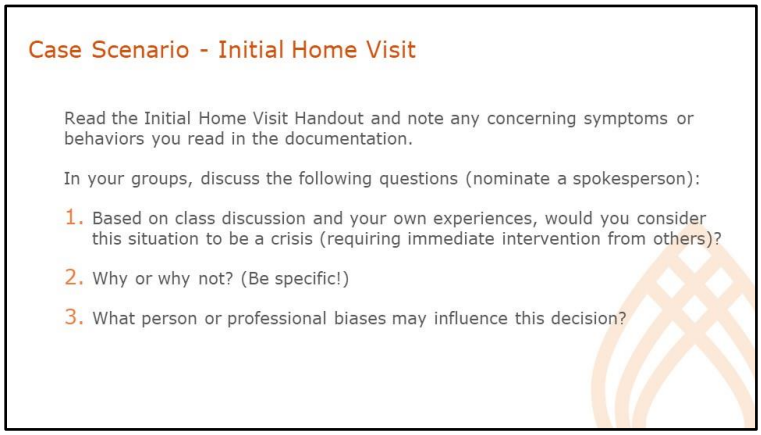
Time: 30-35 minutes (5 minutes to read scenario, 10-15 minute breakout room discussion, 10 minutes to debrief as a group)

Purpose: Allow participants to identify when a situation involving a person with active psychosis may escalate to a crisis situation.

Trainer Instructions: Participants will review the continuation of the case scenario with the next portion describing the initial home visit with a client exhibiting symptoms of psychosis. In breakout rooms, participants will discuss some questions pertaining to concerning symptoms and the likeliness of obtaining immediate intervention. Participants will report out to the larger group with a summary of their discussion.

Virtual Tools: Handout, Breakout Groups, group discussion

Slide #21: Case Scenario - Initial Home Visit



Instructions: Share that participants have 5 minutes to read the continuation of the case scenario on **Handout #3-Initial Home Visit** in their Participant Manual. As they read the scenario, participants should imagine they are reviewing another APS professional's documentation. Participants should note any concerning symptoms or behaviors they read and be prepared to discuss why they are concerning with their breakout groups.

Allow *5 minutes for the participants to review the case scenario before launching breakout rooms.*

Instructions continued: Participants will now be split into breakout groups of 3-4 (no more than 4 per group, if possible). Each group will be given 10-15 minutes to discuss the following questions:

1. Based off the class discussion earlier and your own experiences, would you consider this situation to be a crisis (requiring immediate intervention from others, such as 911, a mental health crisis team, or someone else?)
2. Why or why not? (Be specific about your observations that led to your determination).
3. What personal or professional biases may influence this decision?

Each group will nominate a spokesperson for the group to report out and share with the larger group a summary of their discussion.

Launch breakout rooms. After 7-12 min, **cascade** a message to breakout rooms that there are 2 min. left. After 10-15 minutes, **close out** the breakout rooms and return participants to the larger group. **Allow** each

spokesperson from each group an opportunity to summarize their discussion. **Allow** 10 minutes for large group discussion.

During the group discussion, **compare and contrast** any differences between findings (crisis or not?).

- For those that determined it to not be a crisis, ask what additional observations could tip it in the other direction for them?
- For those that determined it to be a crisis, ask what symptoms concerned them the most to lean in this direction?

***Trainer Note**: Acknowledge the challenges of making this determination based off only documentation. When we are in a real home making these determinations in real life, we may come to a different conclusion. It is still important that you are able to provide specific observations to what led you determine a situation as a crisis. This will assist you with explaining your concerns to other agencies that may become involved.*

Handout #3: Initial Home Visit

APS professional arrived at the home and client Alexander Murphy cautiously allowed her to enter, but only through the backdoor. Upon entry, the home had a stale odor of sweat, cigarette smoke, and trash. Several filled trash bags were piled in the corner of the kitchen. The tabletops were covered in various clutter, newspaper, and empty containers. Mr. Murphy said he has plenty of food to eat as long as he has "coffee, ramen, and cigarettes."

Mr. Murphy had a disheveled appearance. He had a strong body odor and his clothing was dirty (beige shirt with stains under the arms, jeans with dirt stains). It did not appear as if he had taken a shower for some time. During the interview, Mr. Murphy would pace back and forth in the living room and while seated, he seemed fidgety and distractible. He would move his hands in a rhythmic way and shake his leg.

Mr. Murphy would look around the room as if he was checking for something. When asked about it, he responded, "I could hear the neighbors talking about me" and that he "hears them all the time." He described it as sounding like they're in the other room and that they always comment on everything he's doing. He continued and said, "I don't own my thoughts anymore. It's like they're putting stuff into my brain. It's coming from the chip the FBI put in my brain. It's a tracking device so they know where I'm at all the times. I don't know why they're doing this to me."

When asked how he is coping, he responded "I don't leave the house much anymore. I covered the windows so they can't see me as much." Mr. Murphy denied feeling suicidal and denied thinking of hurting anyone else. He added, "I don't want to hurt anyone, I just want them to stop."

Mr. Murphy confirmed that there aren't very many people he trusts but he has a sister that he trusts. He is hesitant to involve her because he doesn't want the FBI to start tracking her, too. He hasn't seen the doctor in a while because he says he hasn't been sick. He denied having any medical or mental health diagnoses.

Mr. Murphy explained that he doesn't have time to clean the house because he has to listen to the radio for "coded messages from the FBI" in hopes he can learn of a way to remove the chip from his brain.

Activity 4: Follow-up Phone Call (Audio Observation)

Time: 10 minutes (5 minute audio clip, 5 minutes to document)

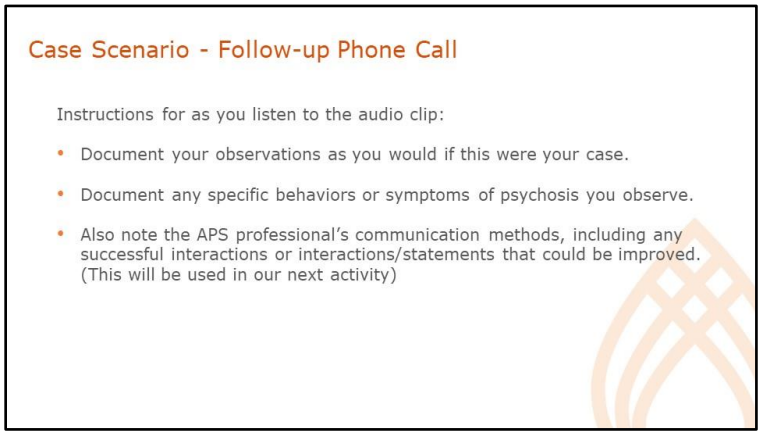
Purpose: Allow participants to apply the information gained from previous discussion by observing an APS professional conducting a follow-up interview with a person experiencing psychosis.

Trainer Instructions: Participants will listen to the audio clip and note their observations of the 'client's' behaviors. Participants will be given time to document their observations as they would if this were their case, paying special attention to specific behaviors or symptoms of psychosis.

Participants will also note any positive or negative observations of the APS professional's interview to discuss in the next activity.

Virtual Tools: Audio clip, individual documentation, handout

Slide #22: Case Scenario – Follow-up Phone Call



Instructions: Participants will listen to an audio recording of the APS professional from the initial home visit conducting a follow-up phone call with the client. While listening to the audio recording, participants will document their observations of the entire interaction in their participant manuals. Recommend that participants should document this interaction as if it were for their own case, paying special attention to specific behaviors or symptoms of psychosis.

Advise participants that for the next activity, we will be discussing the APS professional's interviewing methods so be sure to also make note any successful interactions or interactions/statements that could be improved.

Share that the audio transcript is provided in **Handout #4-Audio Transcript**. **Play** the audio clip (5:00 minutes) for the participants.

Provide 5 minutes for the participants to document their observations.

Handout #4: Transcript of Follow-up Phone Call

APS: Hi, Mr. Murphy, this is Morgan from Adult Protective Services calling. I was just wanting to call to check in on you and see how you were doing.

Client: C'mon just work already.

[Radio static can be heard in the background of the call]

APS: [slight pause in conversation before asking] Mr. Murphy, are you there?

Client: Huh? Oh, now's not a great time, I'm trying to get this radio working. It's just not quite picking up the right frequency.

[Radio static continues in the background]

APS: What's going on with your radio?

Client: I just can't…it's just barely out of range. Everyone knows the feds use radio signals to communicate with their undercover agents. But it's just outside the normal FM bands. If I can just get….ah! Damn!

[More noise and sounds of tools].

APS: Mr. Murphy, are you okay?

Client: [tone increasing in agitation] No, I'm not okay. I can't hear a damn thing. I can't focus.

APS: What do you mean?

Client: The radio….I'm trying to intercept their transmissions. They're getting scared I'm on to them. I can hear them talking about me.

APS: You hear them talking to you right now?

Client: Yeah, they won't shut up to let me think. That's their plan. That's their goal. Throw me off so I can't figure out what they're up to. They're controlling my brain. They need a fall guy. What's this is all finished, they're gonna pin it all on me.

APS: It sounds like you're really getting worked up about this. You should take a moment to calm yourself down so we can talk and explore some options about…

Client: [interrupting with sarcastic laugh] Calm down? I'd like to see *you* calm with a goddamn chip in your brain.

APS: [in a calm tone] Hey, I'm sorry. I'm sorry, Mr. Murphy. This sounds frustrating and I'd like to work with you on getting you some help.

Client: Right. You're going to find someone to get rid of this chip? I'd like to see that.

APS: You're just sounding really upset right now and I'd like to talk about some options to try to help you feel better. Do you remember some of the things we talked about last time?

Client: [sounding distracted] My neighbors, ever since Sylvia moved in, she recruited Lionel and she's converted him. He's FBI, undercover, he's one of them. He snuck into my house to implant the chip into my brain. Now it's changing my thoughts. Lionel used to be my friend, but Sylvia turned him.

APS: Okay so it sounds like there's a lot of people you don't trust. Is there anyone that you do feel safe with?

Client: [sounding frustrated] I've told you already. I've told you a million times. Lionel is working uncover with the FBI.

APS: Okay, so Lionel, your neighbor, is not someone you feel safe with. Is there any else in your life that you do trust?

Client: There used to be plenty. The FBI turns everyone against me. I have to stay home and keep them from following me. I can't sleep because they won't stop talking. That's all part of their plan. To wear me down so I can't do anything about it.

APS: Okay so it sounds like you're really worried about the FBI and that you believe that's the cause of the difficulties you're having right now. I just wanted to check with you – do you think it could be because of something else? I've worked with other people who have had similar experiences as you and sometimes they're extremely stressed or feeling overwhelmed and I just wonder if you might be feeling this way, too?

Client: No. No, because I'm not sick. It's them. I've read books laying all this out. They do this to tons of people and I don't know how they keep getting away with it. And I haven't done anything wrong. I don't know why they're doing this to me. I just want it to stop.

APS: Yeah, sure, I can understand that. I guess what I'm wondering is if you thought about the options we talked about last time. We talked about seeing a doctor, maybe looking at medications that might help you feel better. Do you think any of those things would help you?

Client: I don't know. No one believes me. Even my sister. I tried telling her about it and even she doesn't believe me. Do you? Do you believe me?

APS: I believe you're having a really hard time right now and I want to come up with a way to try to get you through this. It sounds like your sister might be someone you trust through. And I'm wondering if maybe we can set up a meeting with her and we can work together to figure out a way to get you some support. Would you be okay with that?

Client: [Sounding distracted] Alright, fine, call her. Whatever. But uh, hey, I gotta go. I'll call you back.

[Call ends abruptly]

[Total time of audio: 5:05 minutes]

Activity 5: Interview Critique

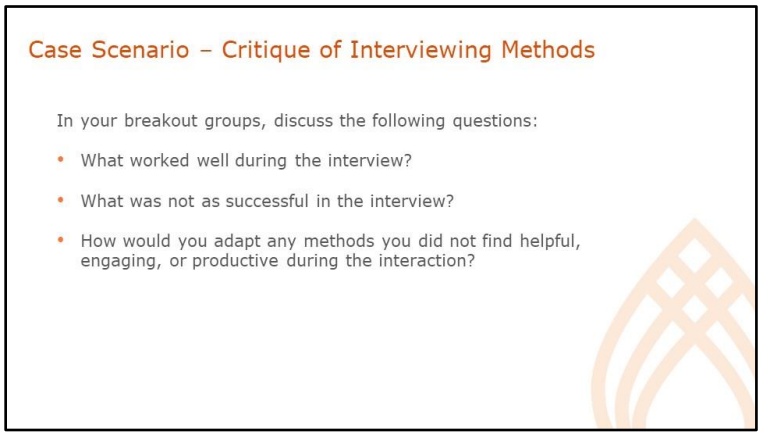
Time: 20-25 minutes (5-10 minute breakout room discussion, 15 minutes to debrief as a group)

Purpose: Allow participants to apply the information gained from previous discussion by analyzing the interview methods used by the APS professional in the audio phone call. Areas of strength and opportunities for growth will be evaluated.

Trainer Instructions: Return participants to their break-out groups to share any notes of what the interviewer did well and what could be improved upon. A spokesperson from each group will share one observed interaction from the audio with the larger group.

Method: Breakout-group, group discussion

Slide #23: Case Scenario - Critique of Interviewing Methods



Instructions: In your breakout groups, you will have 5-10 minutes to discuss what worked well during the interview and what was not as successful in the recorded interview. Identify how you would adapt any methods you did not find helpful, engaging, or productive during the interaction.

Afterwards, each group will have a spokesperson provide at least one observed interaction from the audio clip, either successful or opportunity for growth.

Trainer Note: Refer participants to Handout #1 Communication Tips to help identify the tips the APS professional did or did not use during the interaction.

Launch breakout groups and after 3-7 minutes, **provide** a 2 minute warning that groups will be closing.

Close breakout groups and **welcome** everyone back.

Allow each spokesperson from each group an opportunity to summarize their discussion. **Allow** 10 minutes for large group discussion.

If not already discussed, be sure to add the following consideration:

Ask: The APS professional asked about seeing a doctor or considering medications. Are there any non-medical interventions she could have offered?
Allow class to discuss.

Explain: While medications can help many individuals that are experiencing psychosis, it is not the only means of recovery. There are resources available that do not rely on medical intervention, such as peer support and networking. Meeting and talking with other people with similar experiences can be helpful and less intimidating to those experiencing psychosis. These networks are available across the US.

Documenting Mental Health Observations

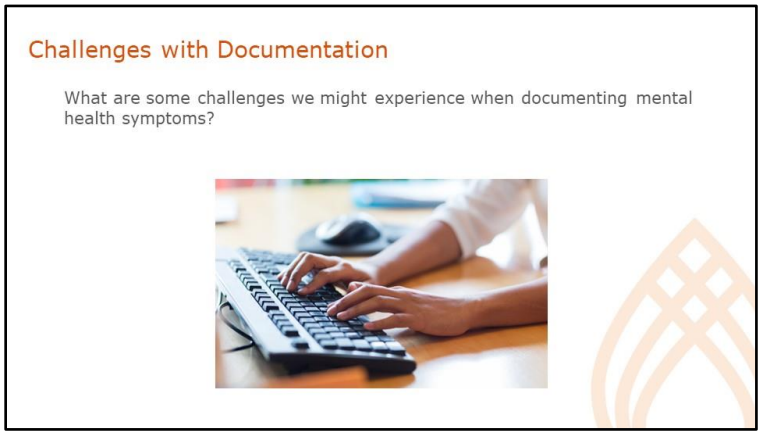
Time: 35 minutes

Associated Objectives:

- Document mental health observations in an accurate, objective, and unbiased manner.

Method: Interactive discussion, poll questions, chat feature

Slide #24: Challenges with Documentation



Explain: Documentation is such an important part of what we do with APS:

- Captures relevant information from our interactions with clients.
- Justifies the actions we take on cases.
- Our documentation is read by our supervisors and our coworkers.
- May be reviewed by outside entities such as law enforcement or legal staff.

This is why it is so important that our documentation is accurate and objective. This can be particularly challenging with cases involving mental health concerns.

***Trainer Note**: While psychosis is not always related to mental health diagnoses, the way in which observations of psychosis are documented will be very similar to how mental health symptoms are documented.*

Ask: What are some challenges we might experience when documenting mental health symptoms?

Allow participants to share their experiences. **Validate** responses and **add** these points for consideration if needed: Avoiding bias/stigmatizing language, using Person-First language, staying up to date with changing terminology, writing objectively, etc.

As a reminder, Person-First language emphasizes the person before the disability or disorder. For example, "a person with schizophrenia" as opposed to "schizophrenic."

Ask: What is objective language?

Allow participants to respond. **Ensure** the following information is provided: Writing can be subjective or objective. Subjective writing is written from perspective and is influenced by personal feelings. Objective writing is based on concrete facts that can be verified, without personal feelings, prejudice, or interpretations. Ideally, with objective writing, two people that observed the same thing would agree upon a written description of an observation.

When documenting observations about mental health symptoms, it becomes especially important we are capturing our observations free of judgment.

Activity 6: Rework the Documentation

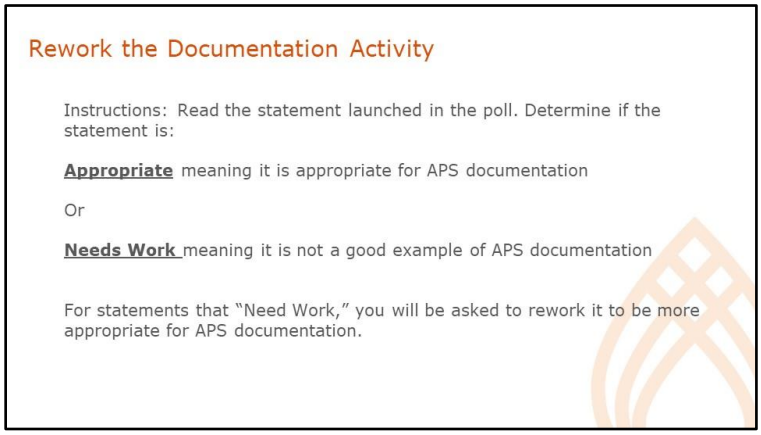
Time: 25 minutes

Purpose: Review examples of documentation to use as discussion points of what works and doesn't work for objective documentation. Participants can practice transforming 'problematic' documentation into objective, unbiased documentation.

Trainer Instructions: For this activity, the trainer/moderator will project each statement using the 'poll feature.' Allow participants 30 seconds to make a selection on if the statement is 'appropriate' or 'needs work.' After the poll closes, allow time for discussion. After all statements are discussed, each participant will select one statement to 'rework' to a more appropriate documentation. Each poll should be entered prior to training.

Virtual Tools: Polls, Chat feature

Slide #25: Rework the Documentation Activity



Instructions: Participants will practice identifying appropriate documentation by evaluating some sample documentation from casework.

Launch the poll one at a time and read each sentence to the participants.

Allow time for them to select if they find the statement to be "appropriate" as in, appropriate for APS documentation or "needs work," as in it is not a good example for APS documentation.

*Trainer Note: **Remind** participants that these are just snippets and not full documentation so they could all use work. The intent for this activity is to evaluate the specific statement as written.*

Statement One: Mr. Patel refuses to eat the meals from Meals on Wheels because he believes the government is poisoning his food. He has lost 5 pounds in the last month. (**Appropriate** or Needs Work)

Discussion: This is a good example of documentation. It is objective and clearly documents this caseworker's concerns for possible delusions.

Statement Two: Ms. Kinsington started to act psychotic. She's angry that APS is involved. (Appropriate or **Needs Work**)

Discussion: This is stigmatizing language and does not use person-first language. A reminder that person-first language emphasizes the person before the disability or disorder.

Statement Three: Ms. Wong is experiencing paranoid delusions. She is not credible. (Appropriate or **Needs Work**)

Discussion: We have a lot of power in our documentation. Be careful about making judgments and conclusions about a client's credibility. If you have concerns about a person's credibility, your objective documentation can reflect that in a way that allows the reader to come to same conclusion.

Statement Four: Mr. Ellison left a voicemail stating, "Bingo, Bingo. I'm a close friend to the president and you left me no choice but to call him so he can tell you to close my case and fire you. I told you already that you can't have my taxi money. I left you my paper. Back off my social security." (**Appropriate** or Needs Work)

Discussion: This is a good example of objective documentation. By quoting Mr. Ellison, this APS professional was able to show their concerns with Mr. Ellison possibly experiencing delusions and symptoms of disorganized speech. Some agencies may have restrictions on using quotes in documentation to be sure to check first before using them.

Instructions (continued): Direct participants to the **Rework the Documentation Activity** in their Participant Manuals. Allow participants 1-2 minutes to select one of the sentences they determined "Needs Work" and rework it into more appropriate documentation. Participants are invited to add details if needed to help improve the documentation.

Revisit each statement and prompt participants to share their selected rewrite as the original statement is read. **Point out one or two** that seem most objective.

Wrap-Up: Language is powerful and your choice of words can break down misconceptions and the stereotypes that feed into them.

Activity 7: Personal Documentation Review

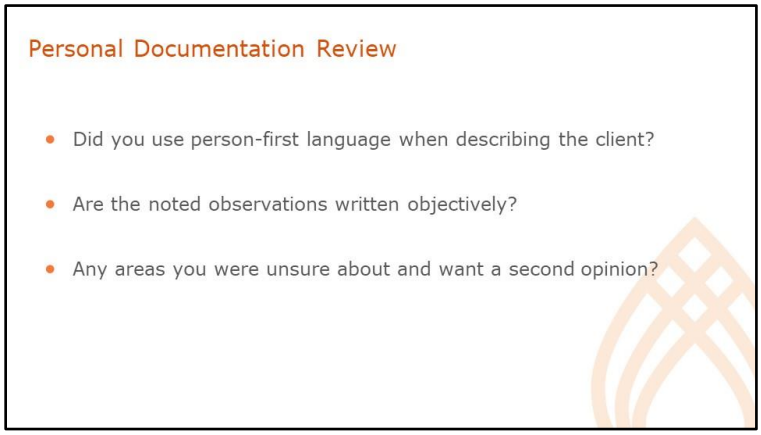
Time: 10 minutes

Purpose: Participants will have the opportunity to apply the discussed documentation standards to their own documentation from the case scenario.

Trainer Instructions: Using the documentation participants have taken from the audio activity, they will review it again and determine if it is objective and unbiased. Participants are invited to make modifications as needed and are welcome to share their experiences as they feel comfortable doing so.

Virtual Tools: Individual documentation review, Raise Hand/Emoji reaction

Slide #26: Personal Documentation Review



Instructions: Now that we have reviewed some documentation practices when it comes to documenting possible mental health symptoms, let's revisit your documentation from earlier. With these points fresh in your mind, how do you feel about what you documented?

Ask participants to take 5 minutes to look over the documentation they completed for the audio activity with the following questions in mind:

- Did you use person-first language when describing the client?
- Are the noted observations written objectively?

- Any areas you were unsure about and want a second opinion?

Once time is up, **ask** by show of hands/emoji reaction, if they were happy with how their documentation was written? Did they make any changes to it?

Invite participants to share any changes they have made.

Trainer Note*: Expect that participants may not be inclined to share but offering them the opportunity can be helpful for those that do want to share.*

Ask participants to individually reflect on if there are any changes they would like to incorporate in their future documentation. If so, make note of it in their participant manual or other things that have come up for them during the training today.

Wrap-Up

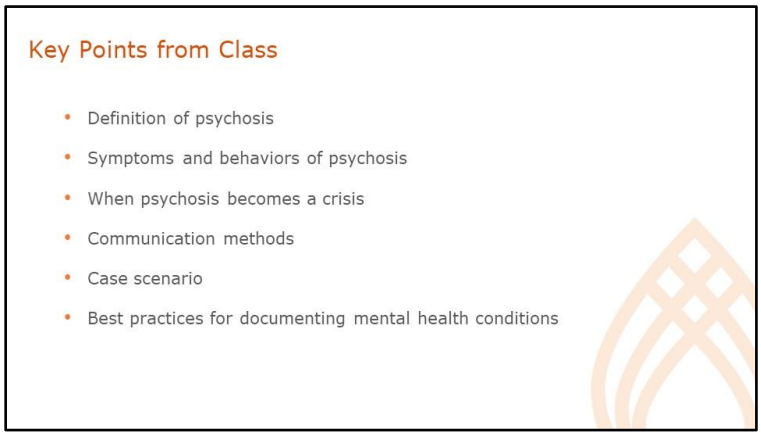
Time: 15 minutes

Associated Objectives:

- Identify how to apply knowledge gained from the training to casework.
- Demonstrate knowledge of the content covered in the course.

Purpose: Provide participants the opportunity to identify how they will apply knowledge learned from the training to their current casework practice

Slide #27: Key Points from Class



Summarize key points from class including:

- We defined psychosis as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't.
- We discussed some common symptoms and behaviors of psychosis, including hallucinations, delusions, disorganized thinking, disorganized behaviors, and confused thinking.
- We discussed some helpful communication methods to use when interacting with those experiencing psychosis and how to de-escalate a situation.
- We discussed how to determine when an interaction with a person experiencing psychosis becomes a crisis situation, involving immediate intervention.
- You worked through a case scenario and practiced identifying symptoms and behaviors of psychosis, assessed the situation to determine if it was a crisis situation, and analyzed an APS professional's communication methods during a phone call with a client experiencing psychosis.
- We reviewed best practices for documenting mental health conditions, including ensuring your observations are documented using objective and non-stigmatizing language.

Activity 8: P-I-E Wrap-Up

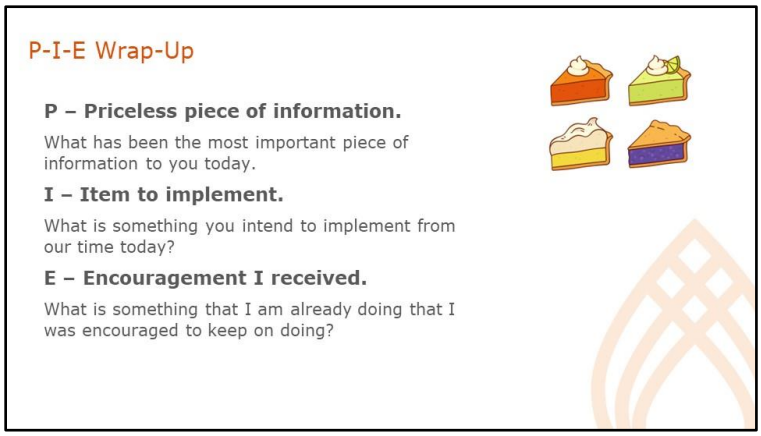
Time: 10 minutes

Purpose: Allow participants to reflect on the learning from the training and decide what is most relevant and important for implementation on the job.

Trainer Instructions: Follow the talking points and associated prompts.

Virtual Tools: PowerPoint Presentation, Raise Hand Feature, Participant Guide.

Slide #28: P-I-E Wrap-Up



Instructions for Participants: Based on what we have talked about during our time together, I want you to answer a few questions.

1. P – Priceless piece of information. What has been the most important piece of information to you today?
2. I – Item to implement. What is something you intend to implement from our time today?
3. E – Encouragement I received. What is something that I am already doing that I was encouraged to keep on doing?

You have five minutes to answer the questions on your own.

Once complete, **ask** for volunteers to share what they wrote down. **Request** the participants to use the "Raise Hand" feature to volunteer to speak.

Use the following questions for debrief:

- What were some of the key words that you heard while you shared?

- What were the common themes that kept coming up?
- What would it mean for APS if we implemented the things on your PIE?
- What would it mean for APS if we did not implement the things on your PIE?

Evaluations and Plus/Delta

Time: 5-10 minutes

Purpose: Provide end of class information and evaluation.

Trainer Instructions: Follow procedure for completing evaluations.

Virtual Tools: PowerPoint Presentation

Slide #29: Evaluations/Thank you

Provide instructions on evaluations.

Slide #30: Thank you

Thank the participants for their time and participation today with a complex topic and for the work they do each and every day. Remind participants that self-care is an important aspect of APS work, and today's training is no exception. **Encourage** them to be intentional about participating in self-care today.

Appendix A: In-Person Modification Tip Sheet

This training manual was developed to be used in a virtual format. However, with some minor adaptations, this training can easily be adjusted to work in an in-person learning environment.

Materials Required for In-Person Instruction:

- Printed Participant Manuals
- Card stock for Name Tents
- Projector for PowerPoint
- Computer Speakers for Audio
- Signs taped on the wall: Agree, Disagree, and Unsure
- Flipchart Paper/Markers

Specific Activity Modifications:

Welcome, Introductions, Course Overview

Invite participants to write their name and pronouns on the provided card stock to display in class.

Activity 1: Agree, Disagree, or Unsure

Create and tape three signs around the room with “Agree”, “Disagree” and “Unsure”. It’s best to have Agree and Disagree at opposite ends with Unsure in the middle. Ensure there is space for participants to move. Create a few extra sets of signs to provide to anyone who is unable to physically move. They can hold the signs up to participate.

Activity 2: Review Initial Report

Only minor adjustments needed for this activity. Instead of using a chat feature, allow participants to take turns by table groups shouting out a response to the question.

Activity 3: Initial Home Visit

For the breakout room activity, instead use table groups or split people off into new groups. Participants will write their responses using flipchart paper and markers and refer to it as the nominated spokesperson for their group reports back with a summary of their responses.

Activity 4: Follow-up Phone Call

Only minor adjustments are required for this activity. Audio/video will be played for the class so ensure you have working speakers with appropriate volume.

Activity 5: Interview Critique

For the breakout room activity, instead use table groups or split participants into new groups. Participants will write their responses using flipchart paper and markers and refer to it as the nominated spokesperson for their group reports back with a summary of their responses.

Activity 6: Rework the Documentation

Direct participants to their Participant Guides on page XX. While the trainer will still read each statement, the statements are provided in writing for the participants to review visually as they consider their responses. They may use their Participant Guide to write out their reworked documentation.

Activity 7: Personal Documentation Review

Only minor adjustments are required for this activity. Participants will use their Participant Manuals to write and edit their documentation.

Activity 8: P-I-E Responses

Only minor adjustments are required for this activity. Participants will use their Participant Manuals to write their responses to the PIE questions.

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