



Mental Health Infrastructure and Training (MHIT) Project

MENTAL HEALTH OUTREACH: GUIDELINES & RESOURCES FOR COMMUNITY HEALTH WORKERS

**REACH NOLA
2009**

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I. BACKGROUND

REACH NOLA Mental Health Infrastructure and Training Project

In the wake of the hurricanes of 2005, the New Orleans community experienced increased stress and depression. REACH NOLA (www.reachnola.org) is a collaboration of community-based and academic non-profit organizations addressing public health issues in New Orleans and surrounding areas. Thanks to a Behavioral Health Grant from the American Red Cross Hurricane Recovery Program, REACH NOLA developed the Mental Health Infrastructure and Training (MHIT) project to support mental health training and recovery efforts in New Orleans. MHIT aims to build community capacity to improve mental health services delivery for depression, post-traumatic stress disorder (PTSD) and other mental health issues. MHIT project activities include:

- 1) Training health care and social services agencies in how to use a collaborative care model, or team-based approach, to treating depression and trauma;
- 2) Training people in how to do mental health outreach;
- 3) Promoting team building activities to support agencies in implementing these programs; and
- 4) Developing relationships across diverse agencies to more effectively serve individuals with depression and trauma symptoms and disorders.

One part of capacity building is to provide support for outreach workers and community caseworkers and to develop their role as a community-based complement to other health and mental health services for depression and trauma. Community workers, leaders and caseworkers interact on a daily basis with many community members in need on the “ground level”—and often feel unsure of how they can best make a difference. This manual can be used both as a guide to on-going efforts in New Orleans and as a template or toolkit for efforts in other communities recovering from a disaster or facing capacity shortages for mental health services. To help make the REACH NOLA approach more generally useful, we have identified areas where we have considered our own local needs in developing the

approach, and suggest that other communities consider how they may best adapt the approach to the local context, culture, and policy and procedures that apply in their area. As in our MHIT initiative, that work can be done through a community-based participatory approach partnered with academic institutions, so that the knowledge of local context and strengths are considered along with local knowledge of health and social services systems and clinical approaches.

REACH NOLA MHIT project partners include the following organizations:

Holy Cross Neighborhood Association
Tulane Community Health Center at Covenant House
Tulane University School of Medicine
St. Thomas Community Health Center and Wellness Center
Catholic Charities Archdiocese of New Orleans
Episcopal Diocese of Louisiana Office of Disaster Response
Louisiana Public Health Institute
Trinity Counseling and Training Center
Common Ground Health Clinic
St. Anna Medical Mission and Health and Resilience Center
RAND Health
University of Washington
UCLA Health Services Research Center

For further information on joining the growing number of partner organizations, please visit www.reachnola.org, or contact MHIT Project Manager Ashley Wennerstrom at awenners@tulane.edu or 504-988-4007.

INTRODUCTION

Mental health outreach in New Orleans is an important part of helping people get quality care. For decades, outreach workers, community health workers, health promoters, and other individuals have been reaching out to members of their communities to make sure they receive the health care they need. Yet, outreach for depression and PTSD is a newer role in the collaborative care model. This outreach manual, developed for the Mental Health Infrastructure and Training Project, is intended to serve as a guide to conducting mental health outreach. We truly hope that it will help you in your efforts to ease the stress and depression so many suffer from in New Orleans and the surrounding areas.

PURPOSE

The purpose of this manual is to give individuals and organizations ideas, materials, and guidance on how they might develop, implement, and/or improve upon effective outreach efforts for the mental health needs in the New Orleans area, as well as in other communities. The manual is based on evidence-based practices developed by researchers and community-based organizations to address depression and PTSD. It has been designed to be flexible in order to meet the unique needs of each organization and the communities, neighborhoods, and individuals each serves.

WHO SHOULD USE THIS MANUAL?

This manual is intended for outreach workers, case managers, and any other staff from community-based organizations interested in conducting or supporting mental health outreach efforts in their local area. Mental health outreach efforts are activities performed by trained, non-medical professionals that bring resources to people who might be suffering from depression and PTSD by providing screening, education, information and referral. We also provide a framework for basic education in behavioral management (problem solving and behavioral activation or support for return to participation in pleasurable activities) to help outreach workers, caseworkers, and their clients to be more effective in accomplishing their goals.

ADDITIONAL RESOURCES

This manual is designed as a resource together with:

- *Beating Depression: The Journey to Hope*
- Two educational DVDs entitled *Beyond Depression* (English and Spanish versions) or other educational videos available for your area
- Educational brochures about depression (also in English and Spanish)
- The New Orleans Community Resource Guide assembled through local organization efforts and maintained to be up-to-date as organizations, providers and services eligibility criteria change, which should be replaced in other areas by a comparable Community Resource Guide.

A CD containing documents from this manual, in addition to other resources that may be helpful, has also been included. It is intended that you make copies of any materials on the CD that you find useful (other than the *Beating Depression* book) as well as modify templates for the unique purposes of your organization. Please check with your supervisor for previously established forms and protocols or procedures at your organization that concern your outreach role.

II. THE ROLE OF OUTREACH IN COLLABORATIVE CARE

This section includes the following topics as an orientation to outreach as a part of the Collaborative Care Model.

- A. *The Collaborative Care Model Applied to Depression and Stress*: A brief overview of the expanded model, including a focus on outreach in the community
- B. *Care Management Key Components*: A guide to considering the training level required by staff to fulfill different functions or roles in comprehensive collaborative care management
- C. *Path to Wellness*: A flow diagram that illustrates the flow of activities for clients, from outreach into treatment practices
- D. *Scope of Work*: Descriptions of the activities for outreach/case management

A. The Collaborative Care Model Applied to Depression and Stress

The Collaborative Care Model of Chronic Disease Management is a systems-based approach to managing illness. It suggests that most healthcare delivery systems are not well designed to promote best practices in chronic illness management. For example, chronic illness management requires coordination for providers, patients and family members to be on the same page about how to approach and treat illness and come up with ways to help patients manage their illness. Today's healthcare systems are often more focused on immediate problems and it is hard to coordinate and connect people, even when people work in the same place, and especially when they work in different agencies. The Collaborative Care Model is designed to: bring providers, patients, and care coordinators onto the same page about the illness and treatments through education programs; provide ways for patients to become active in their own care; address challenges in sharing information; and train care managers to use these systems to track clients and coordinate clinical care needs. This approach has been applied to treating depression in primary care systems and in large

managed healthcare system programs with considerable success in improving quality of care and outcomes.

In applying the Collaborative Care Model for depression to New Orleans in a post-disaster context with high documented levels of need for mental health services in underserved communities, we have considered the same principles that inform this model and applied them to a broader community context. The model can also be applied to support an outreach role that extends these principles to people living in the community who may or may not have had contact with formal healthcare providers.

In the community, we often find that people may not want to identify themselves as having a mental disorder or symptoms of depression or post-traumatic stress disorder. They may be afraid of being labeled as “crazy” or weak. They may expect to be able to lift themselves up or recover on their own. So the Collaborative Care approach for clinics, for example, may not reach them in their homes or on the streets. Therefore, we need to extend Collaborative Care with outreach through social services and community organizations, as shown below.

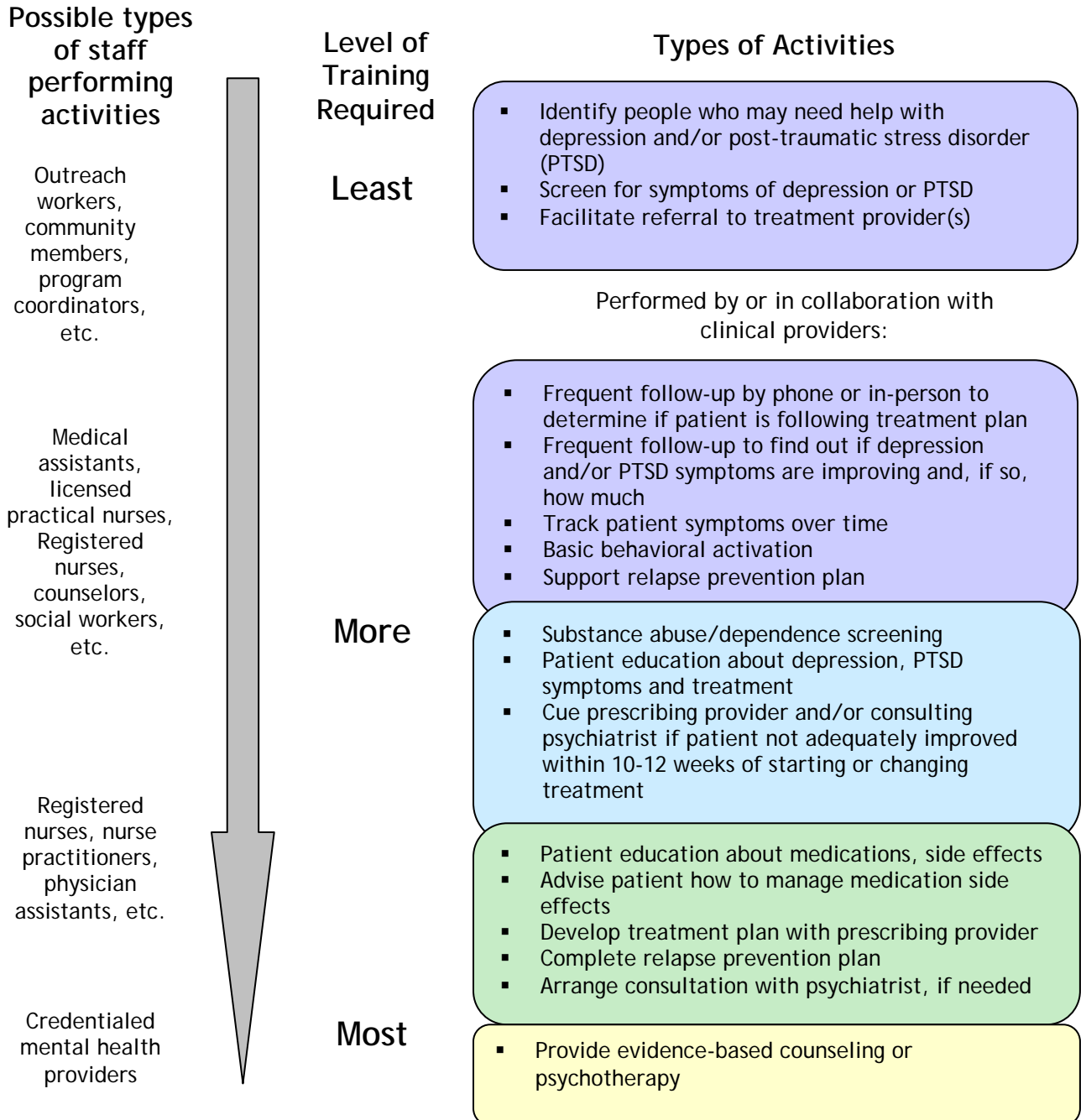


Already working in a social service capacity, outreach workers focusing on other issues, such as housing or job training, can play a new role in helping people to address depression and stress in their lives and communities. From screenings to referrals, education, behavioral management skills, and follow-up, the role of the outreach worker can be an important starting point to encourage patients to get to healthcare settings that offer the treatment they need. Outreach workers can be a kind of “coach” to help assure follow-up or reinforce coping strategies suggested by their providers.

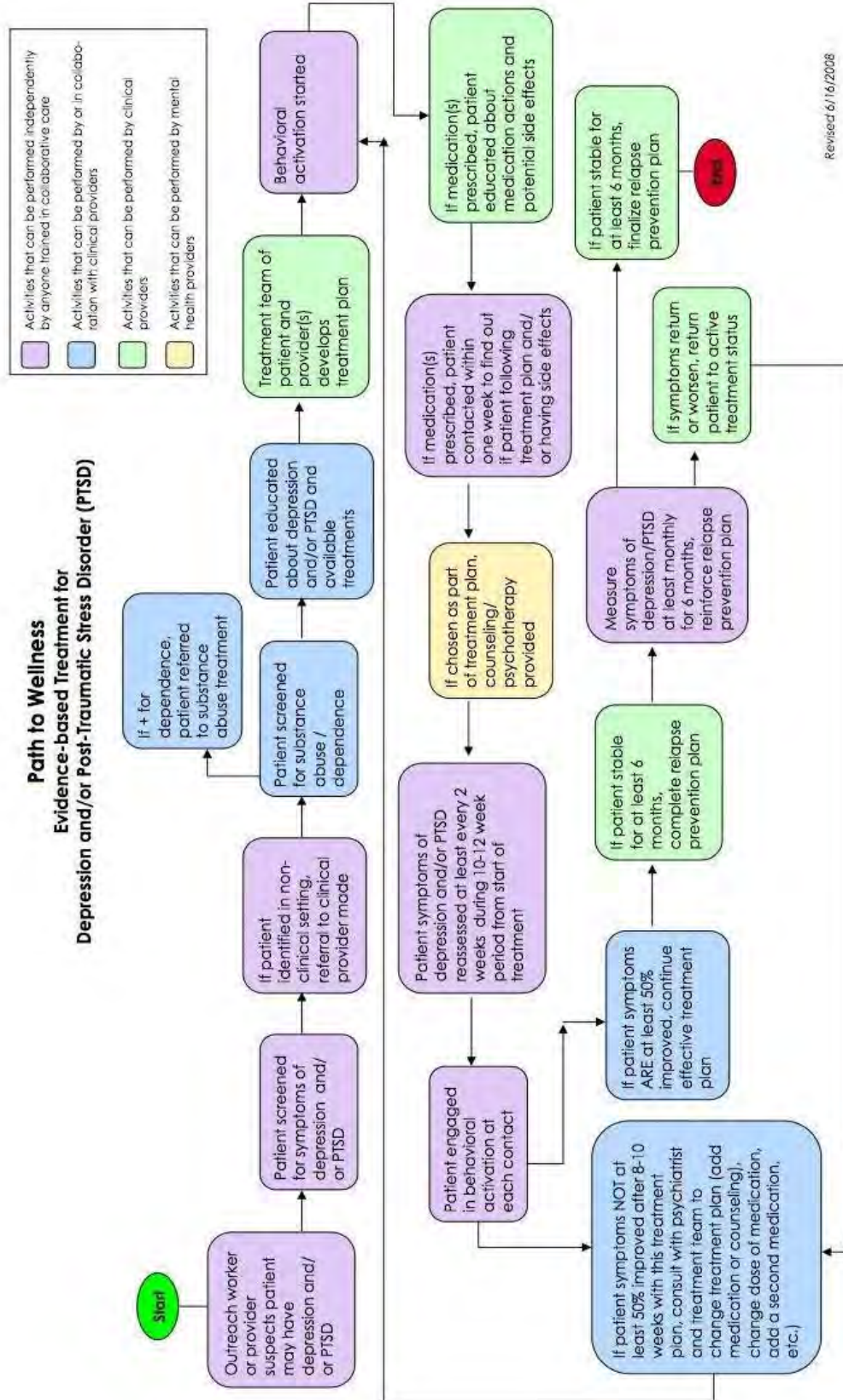
Working across agencies is important when one agency cannot offer everything that people need. As a non-medical outreach worker, you will be identifying and encouraging people to seek the help they need from a medical provider. Partnering with medical providers will allow faster access to care and take the burden off the client to find help on their own.

B. CARE MANAGEMENT KEY COMPONENTS

This chart explains how staff members play different roles in the functions of Collaborative Care, while the next graph indicates the flow of care (note the colors coordinate to the first chart). Using the guide below for the level of training of staff for each function of Collaborative Care, networks of organizations can best consider how to implement Collaborative Care functions, using the staff available.



Path to Wellness Evidence-based Treatment for Depression and/or Post-Traumatic Stress Disorder (PTSD)



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D. SCOPE OF WORK

This section describes the scope of work, or “job description” for the caseworker and outreach worker for depression and post-traumatic stress disorder. The scope of work should be tailored to the needs, capacities, and limitations of each organization. For example, in some organizations “follow-up” may include on-going record keeping of appointments and scoring of outcome measures, while in other organizations it may involve simply asking questions such as “Were you able to see the therapist I recommended?” and taking note of the response.

CASEWORKER / OUTREACH WORKER

Job duties and activities could include:

- Screening – use a tool to identify people with depression and stress
- Education – provide and explain materials about depression and stress, mental health services and programs
 - To individuals and communities
 - To promote treatment
 - To prevent the onset of mental health problems
- Help make and follow up on referrals if a client’s screening shows that they may have depression or stress. This involves using resource materials or existing referral processes at your agency
- Provide support through behavioral activation and problem solving skills
- Advocacy – promote and encourage positive health behaviors; possibly work closely with Clinical Care Managers to check on client’s progress and coordinate care for patients
- Follow-up – check client progress and continue providing assistance, working closely with clinical care managers, to connect to services if needed, to track outcomes and coordinate care for patients, within the scope outlined by your organization;
- Organize and/or participate in task forces, coalitions, self-help groups, community support networks, community coordinating councils

- Help identify community mental health needs and objectives, locate appropriate resources and initiate problem-solving actions

These activities may take place in settings such as clinics, churches, schools, and community centers.

Overall goals :

- Promote mental health and wellness of community-at-large
- Reduce stigma of mental health disorders and symptoms, and of seeking help
- Reduce risk or severity of mental disorders among underserved clients
 - Assist in making and following up on referrals for treatment and care
- Assist those who are experiencing stress to change the way they deal with problems and to help themselves
 - Strengthen ability of individuals to cope more effectively with stressful life situations
- Provide outreach and care in a culturally competent/sensitive manner
 - Use knowledge of language, cultural practices, beliefs, etc., to structure plan of care and strengthen relationship with client
- Expand and/or enhance the abilities of agencies and other groups or individuals to respond to the mental health needs of the community-at-large

Key Chapter Terms

Behavioral Management Skills: A set of educational techniques that outreach workers or caseworkers can use to get clients moving forward on things they want to do. The two main skill sets are “behavioral activation,” an approach to help clients return to their usual, pleasurable activities; and “problem solving,” an approach to help clients solve specific problems. Both rely on helping clients pick an action and then break it down into a series of manageable steps.

Caseworker: A member of an agency or organization who may or may not have a medical background, whose job entails assisting with social services for the public, such as housing, job search, financial, etc.

Clinical providers: Medical and/or mental health professionals.

Consulting Psychiatrist: A doctor who specializes in mental health who provides advice and consultation to other members of the collaborative care team.

Evidence-based: A term used to describe medical and mental health therapies that have been proven through rigorous research to be effective.

Outreach Worker: A member of the community who may or may not have a medical background who helps identify community members who may need help, connect them to clinical providers and support the community members in their path to wellness. In this manual this term may be used interchangeably with “caseworker”.

Prescribing provider: A medical professional with authority to prescribe medications; for example, doctor, nurse practitioner, physician assistant.

Relapse prevention plan: A plan to help prevent relapse of depression and to take steps if a relapse occurs to get back into treatment and cope with symptoms early.

Screen/Screening tool: A short, standardized questionnaire that measures symptoms to determine if a person might need help.

Substance abuse: Use of drugs and/or alcohol in a manner that causes problems in a person’s life.

Substance dependence: Addiction to drugs and/or alcohol that severely affects the person’s life.

III. RESOURCES TO SUPPORT CLIENT STEPS FROM DEPRESSION TO RECOVERY: A COMPANION TO *BEATING DEPRESSION*

WHAT IS CLINICAL DEPRESSION?

Dealing with depression is likely to be a new kind of role for many outreach workers and caseworkers, even though they probably work with clients who have depression nearly every day. But it's one thing to do outreach for healthcare generally, or to deal with housing or family preservation needs, for example, and another to focus for a time on the client's depression.

Being comfortable with dealing with depression and related mental disorders, and conducting outreach activities around depression, requires skill and training in specific activities, such as screening, providing information, and referral, as well as resources to make it easier or even possible to conduct those activities. We strongly recommend that, prior to training in outreach activities, people seeking that training read *Beating Depression: A Journey to Hope*. This book provides basic information on what depression is, how it is treated, what challenges people face in trying to get care, how to overcome those challenges, and how people can also help themselves and their families on their way to recovery, to get well faster and stay well through their life. The chapters of this book are sequenced to address seven key client questions about recovery, shown in the Figure below. Because outreach workers and caseworkers might structure their work around such questions, we have organized our training materials, along with the book chapters, to provide the resources needed to answer each of these questions and achieve the steps toward recovery. We will not be repeating all of the basic information about depression, treatment, barriers, and

coping strategies in this manual, but instead will assume that the outreach worker or caseworker who is training in this role will read those chapters and then consider what they have learned from those chapters in determining how best to use the resources that match them. The Figure below gives an outline of how the tools in this manual or those available on the DVD or CD that accompanies it, can help the outreach worker or caseworker guide and educate clients through the steps toward their recovery, provided that the client is also effectively engaged in care—an important task that the outreach worker can help their client achieve and stick to.

But we do want to make sure that everyone at this stage has a good, basic understanding of what depression is:

Clinical depression is a medical condition that affects a person's mood, thoughts, behavior, and body. It changes the way a person feels, thinks, and acts. Things that used to be easy or enjoyable, such as spending time with family or friends, reading a good book, or going to the movies, takes more effort. Even basic things like eating, sleeping, and sexual activity can become difficult.

Clinical depression is more than just a case of bad nerves, the blues, or the blahs. From time to time, and throughout our daily lives, we all feel a little sad, blue, or edgy. Usually, we soon begin feeling better, perhaps after hearing some good news or visiting with a friend. But, with clinical depression, unhappy or anxious feelings and thoughts don't go away. They are present almost all of the time. Good news doesn't cheer us and we just don't feel like visiting with friends or doing anything else we used to enjoy. If not treated, depression can seriously affect one's work, personal life, and the lives of one's family and friends.

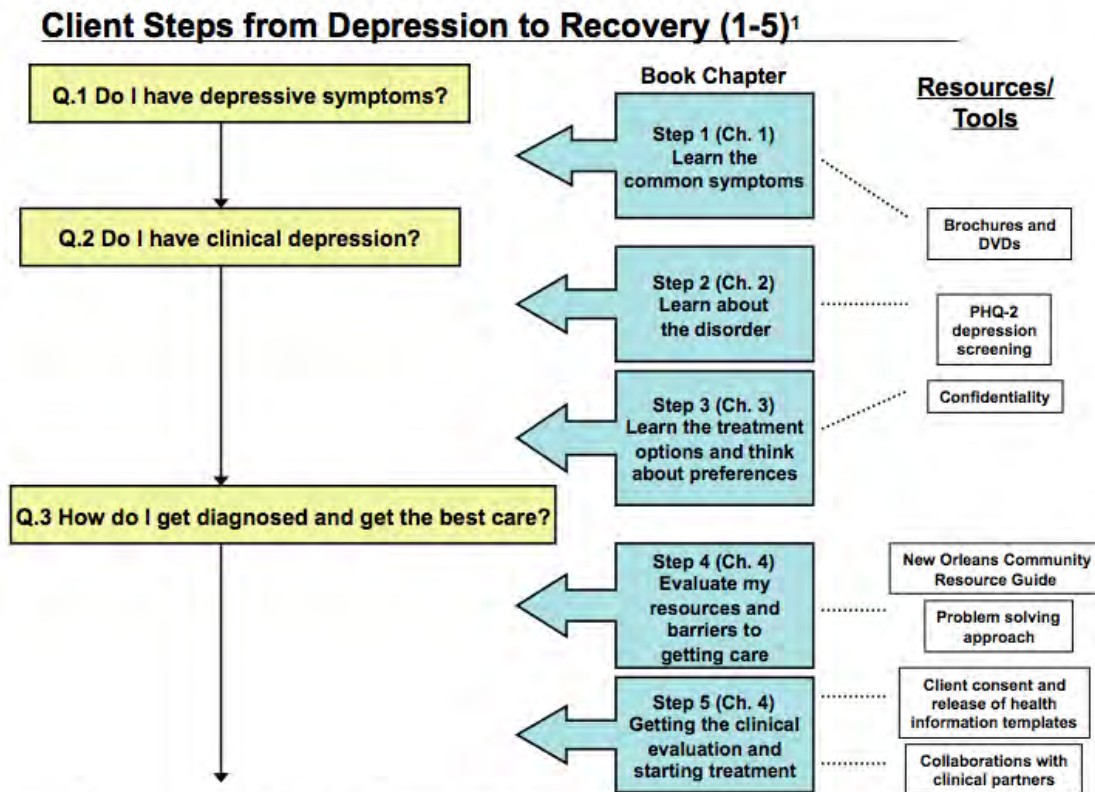
Whether one has a temporary mood change or clinical depression, a doctor understands the connection between one's physical, emotional, and mental health. A doctor can help sort out one's feelings and take the next step towards getting better.

USE OF EDUCATIONAL MATERIALS AND RESOURCES

As mentioned earlier, the additional resources provided to you will be helpful in gaining a better understanding of stress and depression. First, you may wish to start with *Beating Depression: The Journey to Hope*. This book was written for both those who are feeling the symptoms of depression as well as for those caring for individuals suffering from depression. *Beating Depression* addresses the causes and symptoms of depression, treatment options, how to get care, and ways to help oneself get well and stay well.

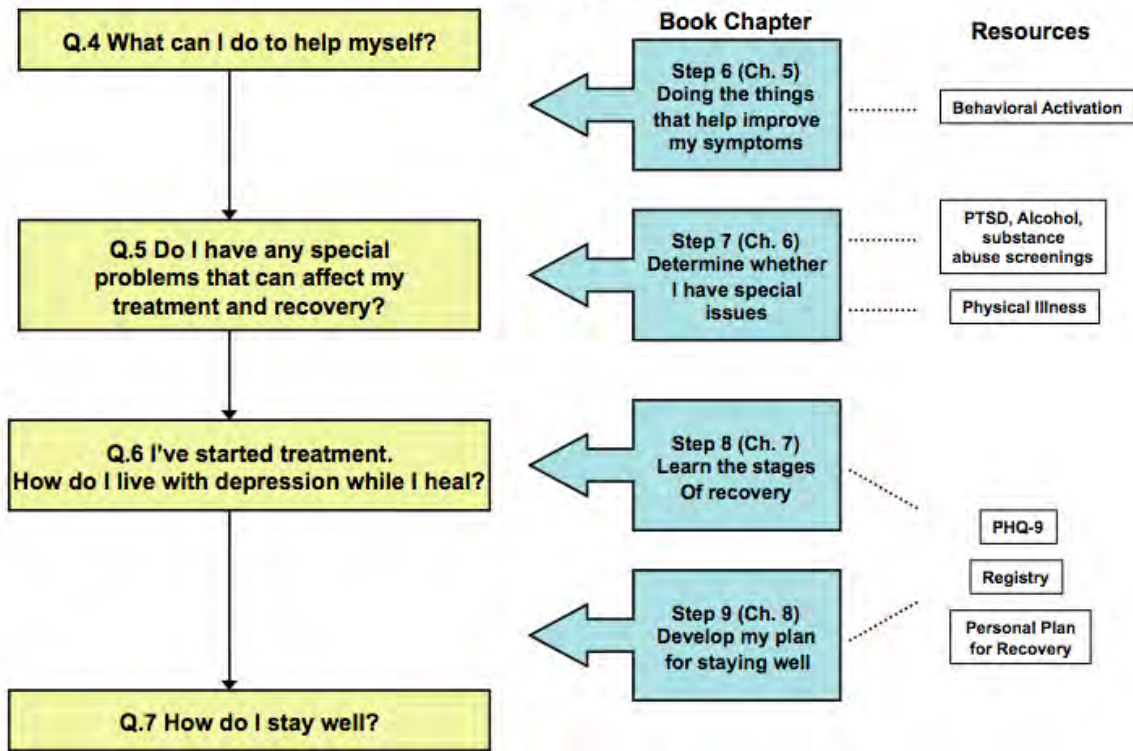
Beating Depression Flowchart

The following flowchart (continued on the next page) has been extracted from *Beating Depression*. The steps correspond to each chapter in the book and may serve as a guide to you in understanding how to help a client move from depression to recovery. The flowchart will also guide you in the use of the resources in this manual; and other resources and tools that are available to you as an outreach worker.



¹ *Beating Depression: The Journey to Hope* by Maga Jackson-Triche, Kenneth B. Wells, Katherine Minnium; Figure 8.1, p. 145

Client Steps from Depression to Recovery (6-9)



Step 1: Do I have depressive symptoms? Many people in the community, who are not healthcare professionals, do not necessarily know what depression is, or, they may have different ideas about depression. Build on what you have read above about depression, and read chapter 1 of *Beating Depression*. Then, look at the DVD which is an educational video developed for the “Partners in Care” study. There is an English version and Spanish version. They are not Hollywood-produced, but their information is correct and can be shown to your clients to help them get a feel for depression and perhaps, to get more comfortable with the idea of either being screened, or following up on a referral once they are screened. Also, look over the brochures on the CD, also in English and Spanish, because they can be printed out and given to patients to take home and share with their loved ones if they wish.

Step 2: Do I have clinical depression? Clinical depression is depression that merits treatment. Many people may not realize that depression can be a medical condition like any other health problem that requires active treatment to get well. Many people do not know

that medication and counseling are about equally effective for treating most cases of depression, and they may have a choice for what they prefer. Learn about the clinical disorder and treatment options, by reading Chapters 2 and 3 of *Beating Depression*. Then you can assist your clients in knowing whether they *might* be depressed by providing a brief, standardized screening in depression—the PHQ-2—just two items that take a minute to administer. (There is also a longer version if your agency wants to track outcomes over time). This is a screen (see key terms for Chapter 2), and not a diagnosis—only the doctor or health provider can diagnose depression and decide whether treatment is needed; but you can help people learn whether they might have symptoms that would suggest that they at least need to see a doctor and possibly receive treatment.

However, if screening for a health condition, whether depression or another condition, is new to you or to your agency, you will also need to follow standard, professional guidelines for maintaining confidentiality and for obtaining consents for screening and passing information on to a referral agency if that is needed, or to help the client to do so whenever possible. For this reason, a major focus of this manual is on confidentiality and client consent. Your own agency may already have its own protocols and forms, so check with your supervisor.

Step 3: How do I get diagnosed and get the best care? Two chapters of the book (chapters 4 and 5) provide information on dealing with barriers to care and getting an evaluation and starting on treatment. We are also providing you with some tips on making referrals, and the consent forms for referrals and confidentiality procedures as noted above.

Making referrals, however, means you need to know what your resources are for referrals, and to help facilitate that process you will likely need to have relationships with local providers. In New Orleans, the MHIT project worked with a local clinic, Common Ground, to make widely available their highly respected Community Resource Guide. For other communities trying out this approach, you should work with respected community-based agencies to develop a resource guide that is updated and current, so that outreach workers

have available the tools and connections that their clients will need for good referrals. We also provide some guidance on developing collaborations with clinical providers.

Even with places to refer people, clients often have a difficult time getting to care, due to problems such as transportation, child care, lack of resources, or just not having the energy to move around because they are depressed. This manual includes, as an educational tool, some slides that help outreach workers help their clients identify a problem that needs to be solved, and to break it into a few manageable steps they can successfully complete.

Step 4: What can I do to help myself? Read Chapter 6 of *Beating Depression*, which is about coping and self-care. Many people want to try something on their own, and with guidance there are some things that can help people recover and lead the lives they want. But most often in clinical depression, professional help also helps speed things up and assures a better outcome. One common educational tool outreach workers can use to help clients support healthy self-care activities is behavioral activation. When people get depressed, they commonly stop doing activities that make them happy, which makes them even more depressed. Using similar principles as problem solving skills, behavioral activation provides outreach workers with some basic skills in helping clients choose an activity that they used to enjoy or might enjoy, and to take small steps toward doing that activity. This alone can be a part of their recovery or make it easier for them to have the energy to seek care on their own.

Step 5: Do I have any special problems that affect my treatment and recovery? Depression often goes along with other social and health problems, such as post-traumatic stress disorder, substance abuse, and physical health problems. In the post-Katrina New Orleans environment, our experience is that depression often occurs with symptoms of post-traumatic stress disorder. Depending on your role in your agency and your level of training, you can also screen for possible post-traumatic stress disorder with a brief standardized screening tool. We suggest leaving screening for substance abuse to providers with more clinical training unless your agency is prepared to support you in this role or you have special

training. Similarly, screening for physical health problems requires other tools or additional training and resources, and should be provided by professionals or those clinically trained to do so. Chapter 6 of *Beating Depression* addresses these kinds of issues.

Step 6: I've started treatment, how do I live with depression while I heal? Chapter 7 of *Beating Depression* concerns stages of recovery, and what people with depression can do to build on their treatment to complete getting well. An important part of helping people at this stage, where outreach and caseworkers could play a role, is tracking outcomes and documenting whether or not people are staying in treatment and in contact with their providers. The MHIT project provides two tools for that purpose: the PHQ-9, a longer version of the PHQ-2 used for screening and a case registry. The scores from giving the PHQ-9 at several different times over the course of their treatment can be used to show whether people are getting better or worse in terms of their depression symptoms. The case registry is a system of registering clients and keeping track of their provider visits, services, and outcomes. These tools can be pen and pencil (note cards, forms), or they can be put into an internet-based health information system. The MHIT program has been supporting some healthcare systems in using an internet-based case registry for depression while providing a pen and pencil format for tracking clients and outreach services (but not services of other providers) for other organizations or agencies (template included in this manual) which could be fed into the internet-based registry used by another system. You can determine with your agency what is best for your agency and what is feasible.

Step 7: How do I stay well? Depression can come and go over a lifetime so naturally people would like to be well as much of the time as possible. When people are depressed, they may lose their energy or motivation to stay well, but when they are well, they can plan more effectively with their providers and family for what to do if they become depressed again, and what they can do to increase the chances that they will stay well as much of the time as possible.

In the Collaborative Care Model, an important tool for helping people remember how to stay well and what to do if they become sick again is the “relapse prevention plan.” This is a written plan that is usually filled out in a healthcare system by the healthcare provider and a nurse or Care Manager that is specially trained to support depression care.

Because the outreach worker and caseworker is in the community with the client, they could become an important part of the “community collaborative care team” either working directly with the client, or as part of a team led by the provider, to reinforce the relapse prevention plan. If the plan is shared with the outreach worker, who also may be tracking outcomes and services in the community, and who has training in confidentiality and client consent procedures for referrals and transmitting information, then the outreach worker can become a sort of “community coach” supporting their client through different stages of illness and remaining well, as an informed partner in the team. This would be a somewhat new role for community outreach workers, and we are actively exploring its potential in ongoing projects. We have provided some information on a relapse prevention plan for interested agencies and outreach workers.

When talking to clients about depression and stress, you might consider showing them the brochures and DVD provided. These resources address similar topics to those in *Beating Depression*, but in an abbreviated manner. Also, the Appendix contains a set of presentation slides entitled “About Depression” (A1) that can be used to educate clients and other outreach workers about depression. Additional materials in the training folder will be helpful in learning more about the collaborative care model and specific ways to address PTSD. Finally, the New Orleans Community Resource Guide will help you in identifying resources in the New Orleans community to facilitate referrals and assistance for your clients.

IV. CONFIDENTIALITY, BUILDING TRUST & CULTURAL COMPETENCE

Before we get started on the steps you can take to help someone move from depression to recovery, we need to address the issue of confidentiality.

As an outreach worker, you may have access to some of your clients' personal health information. Many people consider information about their mental and physical health to be highly sensitive. Long-standing laws in many states and the age-old tradition of doctor-patient privilege are very important for protecting privacy. All outreach and referral records must be handled and stored in a way that protects an individual's privacy and limits access to only those who genuinely need to know.

"The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being" (U.S. Department of Health and Human Services, 2003).

These rules apply to any health care provider including health outreach workers like you, who transmit health information in connection with many things, including referrals.

The Privacy Rule protects all *"individually identifiable health information"* also called *"protected health information (PHI)."* PHI is information, including demographic data (name, address, birth date, and Social Security Number) that relates to any aspect of the individual's past, present or future physical or mental health, treatment or payment for health care that identifies or could potentially identify the individual. Authorization should be obtained before sharing information with others. Generally, only a patient can authorize the

release of his or her own medical records. However, there are some exceptions to the rule and generally the following can sign a release:

- Parents of minor children
- Legal guardian
- Agent (someone you select to act on your behalf in a Health Care Power of Attorney)

There are no restrictions on the use or disclosure of de-identified health information (information that neither identifies nor provides a reasonable basis to identify an individual).

Sometimes providers may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence, as well as information that they believe is necessary to prevent a serious and imminent threat to a person. We suggest that your organization develop policies to follow after reviewing local laws in the event a client suggests doing harm to him/herself or others.

The other major concern with confidentiality is speaking where others can hear you. Be aware of who is nearby, how far your voice travels, etc. Do not share information with co-workers. Think to yourself, “Do they NEED to know this information in order to provide a service for the client?” If the answer is no, then don’t share.

The following documents may serve as samples or templates for modification based on your organization’s needs. In order to use them, you may access them in Microsoft Word on the attached CD. Please note areas in brackets as these will need to be replaced with information specific to your organization. If your organization already has forms for these services, please follow your organization’s procedures.

In this section, we have included “HIPAA and Confidentiality Rules” and “Mental Health Emergencies.” In the Appendix, you will find the following additional templates:

- Confidentiality Agreement (A2)
- Client Consent for Health Screening (A3)
- Authorization for Release of Health Screening Information (A4)
- Referral Form (A5)

HIPAA AND CONFIDENTIALITY RULES

May we use email?

NO, email is not considered secure and may not be used for confidential information.

Is email OK if the document containing confidential information is password protected?

NO, email is not considered secure and may not be used for confidential information, even with password protection.

Is email OK if the document containing confidential information uses unique client identifiers but not names?

NO, email is not considered secure and may not be used for confidential information, even with unique client identifiers.

Is it OK to use information that has been sent to us using email from outside providers if it contains confidential information?

Yes, this information may be used.

Is it OK to ask that outside providers to send information to us using email if it contains confidential information?

No.

Does HIPAA address the use of cell phones and PHI?

HIPAA does not specifically address cell phone use. However, HIPAA addresses avoidance of incidental disclosures whenever possible. In practical terms, when using a cell phone to discuss patient information, do so in an area where unauthorized individuals are not likely to overhear your conversations. Communicating information via cell phone increases the risk of exposure because transmission is wireless, unlike with landlines. You may choose to document this as an acceptable risk, and although it would not necessarily constitute a HIPAA violation, it nonetheless represents a risk of which you should be aware. The use of cell phones to transmit text messages or e-mail messages about patients is generally an unwise practice (HIPAA Weekly Advisor, 2008).

HIPAA AND CONFIDENTIALITY RULES (continued)

So how can we quickly send information between organizations if we can't use email or cell phones?

Email and cell phones can be used to advise the recipient that printed confidential information is coming by fax. Initials can be used when communicating using email and cell phones, *so long as other information is not included in the communication that would identify the client*. This includes the names of parents, addresses, insurance/Medicare/Medicaid numbers, diagnoses, other personality descriptors, etc.

If we can't use email, why are we using a registry?

The registry is web-based, not email based. The programs have built in security systems (encryption) that meet the standards of HIPAA.

May case managers release information from a client's file to other parties in the course of a referral to a *new* provider?

Yes, a case manager can release information IF:

1. The client or the client's guardian has signed an authorization to release the information; and
2. The author of the information has not forbidden a re-release.

Outreach services, *up to the point that actual mental health services are being delivered*, are not covered under HIPAA. When staff is sharing confidential health information in the course of arranging for services, signatures on releases are required.

MENTAL HEALTH SAFETY AND EMERGENCIES

CHECK OUT EMERGENCY POLICIES WITH YOUR AGENCY BEFORE YOU START FIELD WORK WITH SCREENING FOR DEPRESSION

Mental Health Safety Guidelines:

Screening for depression can prompt some clients to bring up subjects that you might not otherwise discuss with them, such as a wish to harm themselves. For this reason, it is best to have some training in handling emergency situations, especially stated intentions for self-harm, or a “suicide threat.” In most cases where this comes up spontaneously, people may be looking for help so it is not as difficult to offer basic help in accessing services as it might seem.

It is a goal of our program to provide a safe environment for both staff members and clients. In order to prevent injuries or potentially dangerous situations, and to provide an optimal environment for health, the following safety guidelines should be followed at all times. **Any questions, concerns or suggestions about safety are to be presented to your supervisor immediately.**

- DO NOT attempt to “TALK DOWN” an agitated or threatening client!
- If you feel unsafe LEAVE THE ENVIRONMENT IMMEDIATELY
- CALL 911

Warning Signs for Dangerous Behavior

Factors to Watch For:

- Agitation
- Severe emotional changes or mood swings
- Rage
- Agitated psychosis, such as active delusions or paranoia or hearing voices and seeing visions, but with agitated or threatening behaviors

Combined Factors That Increase Risk:

- Paranoia – define
- Angry victim stance – describe
- Active mental illness including hallucinations and/or delusions

Even Greater Risk Increase:

- Combined severe mental illness with substance abuse

(Crowley, 2003)

Specialty Referrals and Emergencies

Some types of clients should be prioritized for specialized attention, such as expediting their referrals or referring to a more specialized type of agency. While outreach workers are not clinicians, they are often on the “front lines” of services organizations in the community and may encounter situations where they feel that specialized or urgent attention is needed. Some of these may be emergencies, and others may be just special types of clients or illnesses requiring more specialized attention, although not urgently.

Urgent or Non-urgent Special Need?

1. Actual or threatened HARM TO SELF—this is an urgent situation and needs immediate, specialized attention. See below.
2. Actual or threatened HARM TO OTHERS—this is an urgent situation and needs immediate, specialized attention. See below.
3. Gravely disabled—this is an urgent situation and needs immediate, specialized attention.
4. Individuals with substance abuse issues or who are suspected to be intoxicated—this often requires more specialized help from a substance abuse provider and depending on the level of intoxication or behavior problem, may or may not require urgent assistance.
5. Individuals who have a history of violent behavior—this may not be known to the caseworker and while it suggests more specialized help is needed, will likely depend on the particulars of the behavior and situation in the community.
6. Children or Adolescents—most often require providers with special training in assessing and treating this age group. Pediatricians or family doctors can be an important first step in referring clients. Unless they have urgent problems such as a threat to harm self, this is not necessarily an urgent situation.
7. SMI (Serious Mental Illness)—persons with psychotic disorders, such as delusional thinking, paranoia, seeing visions, or hearing voices (hallucinations) often require specialized help from a mental health provider, but it may or may not be urgent depending on whether criteria are met for the first 3 above.

To Access the Mobile Crisis Service (6512):

1. Call 911
2. State the nature of the call.
 - a. Describe the behavior or comments made prompting your call. Do not downplay the situation. If it was important enough to make you call 911, then explain the importance to the operator.
 - b. Ask the police to come with the Mobile Crisis Service (6512).
 - c. Stay on scene until police arrive.
3. This does not mean that the person will be taken away for evaluation- if there is an alternative solution to the condition then the Mobile Crisis Service Technicians and the on-scene officers will determine what is appropriate at that point.

What we have learned from talking to 911 is in most emergency situations involving a threat to harm oneself, it is best to have the individual affected call if they are able to do so. For example, if a client is concerned about harming themselves, then it is best to support them in calling 911 or a suicide crisis line. This is a situation you likely will want to discuss with your supervisor first if possible. This process gives the client direct contact with someone trained to deal with such situations and avoids their not being there when the emergency service arrives.

For persons threatening to harm others, it is probably best to report this situation to your supervisor or follow your agency procedures. In most of these situations, you or someone in charge does the reporting, unless the person threatening to harm someone wants the help. For grave disability, the individual may be unlikely to be able to make the call or act on his or her own behalf.

In many cases it can be helpful to role-play handling a suicidal emergency. Here is an example:

Scenario 1:

Client: I have been feeling so down lately. I've thought of taking my own life.

Outreach Worker: I'm so sorry! Let's figure out how to help you. Do you feel that way right now? We can call 911 and get some help right away, to get to an emergency room.

Client: No, I won't do anything right now.

Outreach Worker: Are you sure you are safe? This is very important to talk to your provider about. Are you talking to your counselor or doctor?

Client: Yes, all the time. He says I have to keep hoping. He thinks the medications will help in a week or two. I'm just blowing off steam.

Outreach Worker: Please tell you counselor you mentioned it to me. Also, I will tell my supervisor about our conversation, as I think it's important we all know how to support you. If you begin to consider hurting yourself, I want to make sure you call 911 or go to an emergency room. Do you know where you would go?

Scenario 2:

Client: Yes, I've even been thinking of taking my own life. I have a gun at home, I find myself just holding it and looking at it, thinking.

Outreach Worker: That sounds really serious and is something you need help for right away.

Client: Oh, I'll be OK.

Outreach Worker: No, really. That's too serious a risk, now that you've told me. The best thing is to get help now. I am going to tell our supervisor so that he (she) can help us. We need to call 911 or go to an emergency room.

Client: I have a counselor. He told me to call him anytime. Let's do that first.

Outreach Worker: OK, let's do that now, and I'll just make a call to my supervisor.

OR:

Client: I really don't want to go to an emergency room.

Outreach Worker: You need help. {Options: I can call 911, right now, but it's best if you do it so that they know how to reach you and help you see it through. OR: Here is a suicide hotline number, let's call it right now because you need the support right away; while you do that, I'll let my supervisor know}.

Client; Well, OK, if you really think I should.

Outreach worker calls supervisor and notifies him/her and gets support for next steps.
DOCUMENT WHAT HAPPENED IN A WRITTEN NOTE FOR YOUR SUPERVISOR

Non-Emergency Mental Health Transportation (Local information):

For clients meeting criteria for a psychiatric evaluation, and are **not** an imminent threat of violence to self or others:

1. Call NOPD Psych Team:
821-2222
2. Request a **“103 M Truck”** for mental health transportation

Children with Mental Health Issues:

Central City NOAH Children’s Mental Health Clinic

(504)897-4850

210 State St (@ Tchoupitoulas)

New Orleans, LA

M-F 8-4:30

Provides mental health services and medications to children 6-17 years old who are residents of Orleans Parish.

Or go to Children’s Hospital Emergency Room.

GUIDELINES FOR BUILDING TRUST in POST-KATRINA NEW ORLEANS

These are general ideas that were formulated by outreach workers, caseworkers, clinicians, and community members living in New Orleans following the devastation of Katrina. These principles were proposed as general guides that can be adapted to different cultures and neighborhoods. Building trust is important to all community outreach, but this was a first step for outreach in the MHIT project because many people, even if new to New Orleans, had not experienced this type of devastation before. Everyone was shaken, and trust was viewed as a very important starting point for addressing many important community issues in this context. Our motto is “We can reach across groups and boundaries to establish trust.” For groups in other areas, whether or not you are suffering from a recent disaster, consider these lessons in trust building and discuss with your own local communities and leaders what principles and examples apply best to your communities.

Show Interest

- Be watchful that others may need someone to talk to.
- Show a willingness to talk. Invite people to share. “What’s going on?”
- Meet them on their terms: when, where it will work for them.
- Be patient. Many people may not feel safe talking at first.
- Maintain eye contact.

Assure Confidentiality

- Let them know that what they say to you will be held in confidence. (This means it is their private business and others in the community will not know.)
- Tell them you will only contact others with their consent, except in an emergency.
- Explain that in an emergency, like a threat of harm to someone, you may have to let an authority know.

Listen with Empathy

- Take the time to develop a relationship.
- Demonstrate warmth and tact.
- Do not pass judgment and avoid giving advice right way.
- Show respect and humility at all times. Relate as equals.

Show Understanding

- Acknowledge people’s issues and circumstances.
- Show an interest in or ask about, their family and community.

Reassure and Acknowledge

Help them understand that many in the community may feel similarly.
Acknowledge their spirituality and culture.
Reinforce their strengths and value.

Offer Encouragement and Hope

Help them to see that there is always hope.
Encourage them to seek help for problems.
Offer follow-up as appropriate.
Suggest they turn for a part of each day to their faith or other source of hope.

Consistency in Support

Do not miss appointments; call to apologize and reschedule if you must.
Be on time and stay for the entire time scheduled.
Be patient if they are late or don't show up; it may be due to an underlying problem like depression.

Your Community:

Consider how these principles may apply to you and your community. You can convene a work group of community members, service providers and academic partners to ask yourselves the following questions:

What does trust mean in your community?
What are good practices to establish trust?
What special circumstances do people in your community face today, or historically, that may challenge trust?
What are the strengths of the community that serve as a source of trust?
Who can help build trust in moving forward?

Lastly, share stories of successful trust building in your community or for your organization.

CULTURAL COMPETENCY

In order to meet the needs of clients, outreach workers should practice cultural competence, or interacting positively with people from other backgrounds. To do this, each of us must realize that our attitudes about the world are shaped by our culture and life experiences, and that these attitudes may not be the same as those of the people we work with. It is important for us to be aware of differences between ourselves and others, but to avoid making assumptions about the differences. One of the most important things we can do to is communicate effectively and, above all, treat everyone with respect.

Principles of cultural competence:

- Respect for all
- Recognizing how our backgrounds shape our beliefs
- Avoiding assumptions
- Communicating effectively
- Seeing differences as positive

Here are a few examples of how you can use the principles of cultural competence:

Faith

Think about what role faith or religion plays in your life. You may be a very religious or spiritual person who believes in God or you may not have any spiritual beliefs at all. When you are interacting with clients, remember that they may have a very different view of religion and the role that religion plays in their beliefs about overall health and well-being. It may be best to leave religion or spirituality out of your discussion, unless a client has talked about his/her faith. If you do choose to bring it up, try to ask questions that are open-ended and non-judgmental. For example, “Does faith play a role in your life?” is a question that allows someone to answer yes or no and provide details, if they choose to. Again, if you learn that someone has beliefs that are different from your own, respect the difference and do not try to change the person’s views, and work to see if there is a way to use it to promote their health.

Race/Ethnicity

We all have ideas or stereotypes about racial/ethnic groups that are different from our own. Some of these may be positive and some may be negative. It is important to avoid using stereotypes because they are often incorrect and lead us to false conclusions about people's behavior. For example, you may notice that one of your clients is always late for every meeting you have with him. He belongs to an ethnic group that is "known" for running late. You might come to the conclusion that he is late because he is a member of that group. However, if you simply ask him why he is late, he might tell you that it is because he has to pick his kids up from school at the time of your meeting, which has nothing to do with his ethnicity. Remember the importance of avoiding assumptions about anyone, especially those most different from us.

Culture

A person's background or the culture of the area may play a large role in how they perceive illness, especially mental illness. We need to understand that perception in order to work with it. For example, a client has grown up in an area where being "depressed" is "being crazy" and a person who is discovered to be "crazy" loses credibility and their leadership role. This person may resist going to traditional mental health care services so as not to lose their stature in their community. Others may be more receptive to "Eastern Medicine" rather than "Western Medicine".

Post-Disaster Attitudes

Since the disasters in 2005, many people from other areas of the state and country have come to New Orleans to help with disaster recovery. Sometimes those of us who are from New Orleans can get frustrated when it seems like these out-of-towners are trying to tell us what we need, rather than listening to us. In this situation, we can work across cultures by

putting aside our assumptions about people from out of town based on previous experiences. We can listen to what they have to say first, and then see if their offers of help are useful to us or not. If the help they have to offer might do us more harm than good, it is ok to politely let them know that we, as locals, are the best ones to make decisions about our recovery. If we think they have some good ideas, we can communicate with them to see if there is a way that we can combine their knowledge and desire to help with our local skills so that we can find solutions to our challenges.

V. MENTAL HEALTH OUTREACH ACTIVITIES

We reviewed above the general features of collaborative care and described the outreach role within that approach to care; we then described the resources available to support outreach according to a flow chart of seven client questions, beginning with learning about depression and treatment, through self care and learning to stay well. Now the next chapter reviews specific activities and skill sets for outreach workers to fulfill a number of those roles.

#1. Introduce Clients to Screening and the American Red Cross Project

The first activity is screening for depression. Recall that screening is using a standardized, brief survey, that you read and score, to help clients understand whether they might have a need for further assessment for depression. The reason that screening is needed is that while some people know that they are feeling depressed, many do not. Instead, they may feel that their condition is normal for someone in their circumstances, or they may mainly have physical symptoms and not be aware of the underlying depression. For this reason, you can't really effectively screen by deciding in advance which clients are "at risk." Rather, it's better, especially in highly stressful circumstances such as following a disaster, to screen everyone once initially, and later, if a new need arises.

To screen for depression you will first have to raise the subject in a way that people can hear and understand what you mean.

We provide below an example of a "script" that we used in the MHIT project in New Orleans that may help you in speaking about the screening tools and how to interpret them once they have been administered. Remember to use words appropriate to your client...some people may know what you mean by a "clinician" others may have a different idea.

Make sure to ask questions about depression in a confidential environment. Either ask the questions when you are alone with them in a separate space or room, or have them complete answers on their own in writing, so that no one sees their answers. What someone says about depression should be his or her own business, and yours as a trained outreach worker.

Sample scripts:

“Our agency is participating in a new program supported by the Red Cross to help identify people who may be suffering from depression or stress and the blues, and who may need help in finding someplace to get help. We all know that many in our community have been struggling since the storms, and we all might use some extra help. What I’d like to do if you are willing is ask you a few questions about how you are feeling now. Based on your answers, I can tell you whether your score suggests you might have depression and should talk to a professional about that, or whether you seem OK right now. Would you be OK with my asking you those survey questions?”

For others, screening may not necessarily be introduced in a post-disaster context. Here is another version:

“Our agency is participating in a new program [add FUNDER if desired] to help identify people who may be suffering from depression or stress and the blues, and who may need help in finding someplace to get help. Depression or stress is a common condition in most communities, and can improve with treatment, but many with depression or stress may not know that this is the problem or realize that help might be available for them. What I’d like to do if you are willing is ask you a few questions about how you are feeling now, from a survey for depression that I will read to you. Based on your answers, I can tell you whether your score suggests you might have depression and should talk to a professional about that, or whether you seem OK right now. Would you be OK with my asking you those questions?”

#2. Conduct Screening

“OK, here we go.” Read each question and the responses from the PHQ-2 or PHQ-9, per your agency’s protocol, and score them exactly as they are. Remember to ask the questions in a safe environment where others can’t hear the answers!

The following screening tools may be used to determine whether a client **may** be suffering from depression - you are not diagnosing them; only a medical professional can do that. Please see section A6 of the Appendix or the CD for blank versions of both the PHQ-2 and PHQ-9.

PHQ-2 SAMPLE

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)				
NAME: <i>Jane Smith</i>		DATE: <i>2/6/09</i>		
Over the last two weeks, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	0	✓	2	3
2. Feeling down, depressed or hopeless	0	1	✓	3
Add columns:		1	+	2
TOTAL:		WRITE TOTAL 3 SCORE HERE		

Scoring

If the total score is 3 or more, client may be experiencing symptoms of stress that should be evaluated.

PHQ-9 SAMPLE

If you have received or anticipate that you will receive training on how to administer the PHQ-9, we have provided a sample here. Please see section A6 of Appendix for a Spanish version of the PHQ-9.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3

add columns: 2 + 10 + 3
TOTAL: 15

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult ✓ _____

Very difficult _____

Extremely difficult _____

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PHQ-9 SCORING CARD

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

#3. Interpretation of Screening

If screening is **positive**, read or paraphrase the meaning of the positive response.

“The answers to the questions you were asked show that you could be clinically depressed, but only a doctor or counselor can make a diagnosis of depression. These materials contain information about depression and I can help provide you with a list of places you could possibly go for treatment. Depression is treatable. There is hope! You can feel better!”

If screening is **negative**, read or paraphrase the meaning of the negative response.

“The answers to the questions you were asked show that you may not currently have a problem with clinical depression or that it is mild. If you have had serious clinical depression in the past, you may still wish to discuss your current symptoms with a clinician/doctor or counselor. At this time, however, your symptoms are not severe enough to suggest that immediate treatment is required. I am happy to offer you educational materials to better understand the problems that you might encounter if additional symptoms develop or that other people you know might have with depression.”

AGAIN, REMEMBER TO READ THOSE INTERPRETATIONS IN A SAFE ENVIRONMENT WHERE OTHERS CANNOT HEAR WHAT YOU ARE SAYING!

#4. Be Prepared to Provide Brief Education about Depression and Stress

Sometimes, people will agree to screening or listen to an interpretation of the result, without asking further questions about depression. But sometimes it may be important to provide information about depression, just to overcome the stigma of being screened or to help people think through what your answers may mean before they even consider a referral. For this reason, we want to make sure that outreach workers know how to provide education and can learn to move back and forth between screening for depression, giving an interpretation, and providing education smoothly, as they need to, to help individual clients learn about their depression (or not having depression), and the condition in general.

To explain “depression” to clients, you may wish to use the definition provided on page 14 of this manual. You can also provide them with a brochure from the CD, show the DVD, or use other materials available to you. Many people are not comfortable with the term “depression” itself because it sounds too clinical and/or they feel that they are “crazy,” so “stress” or “bad stress” may be more acceptable. The terms you use should be adapted to the terms that people use in the local community. Ask the client what depression and stress mean to them and what words they use or are comfortable with in describing stress and depression – then use their language.

#5. Be Prepared to Provide a Referral

After you have completed a depression screening, you will need to determine if your client is in need of a referral for mental health services. It is also important to determine whether your client is *ready* to receive such a referral. If it appears that your client may be in a state of crisis, please refer to page 25 of this manual regarding mental health emergencies.

These are a few questions you can ask to see if a client is ready for a referral:

- Have you ever received care for depression or stress? What was that like? Was it helpful?
- Do you think you need help with depression or stress now?
- What do you think about the possibility of getting care for depression or stress?
- If you were given a referral to a place to get help would you go?
- Do you think that treatment for depression would help you?

If the answers to these questions show that the client is ready for a referral, make a referral. Be sure to follow the protocol established by your agency with any collaborating clinical partners. You may also refer to the previous section on CONFIDENTIALITY as well as the Appendix (A2-A5) and CD for appropriate forms and templates.

Tips for making a referral:

- Additional screening may be done
- They will be asked to describe how they feel and what makes them feel that way
- Questions will be asked about their past, their family their health and more

If the answers to the questions above indicate that the client is not ready for a referral, identify reasons and factors that may hamper access to the appropriate services. Strategize on how to overcome barriers; for example, if the barrier is an attitude, or lack of knowledge, then provide education. Show them the DVD on your computer or at their home. Review the pamphlet with them. Let them know that depression is one of the most common of all health conditions, and that they might have a problem but you can't be sure; only a doctor can make the diagnosis and provide them treatment.

If there are important barriers such as transportation, then you can also use the problem solving skills taught as part of the outreach worker training to help them break the problem down into a solvable step. Avoid the temptation to just solve the problem for them; solving the problem themselves can give them a source of pride and accomplishment!

#6. Offer Follow-Up

Offer to follow-up with your client to see how they are doing; give them a call, schedule a personal visit, or follow your agency's protocol to see if they made it to the referral; repeat education and screening as needed at that time.

#7. Offer "Tips"

Offer some tips for returning to pleasurable activities or solving a problem (like going to a referral), using behavioral activation and/or problem solving (see following sections).

#8. Record Interactions

As a way to keep track of your outreach efforts, write down basic information about your interactions with clients. This will be organization-specific, but could include use of the Services Log (see page 49), patient data registry, completing and sending a referral form to a partnering organization, filing all paperwork in a client's folder, and/or use of other record-keeping methods.

#9. Review Activities with Your Supervisor

Review how it's going with your supervisor. Discuss the techniques and skills you have been using. Discuss problems or case-specific issues where assistance could be used.

VI. PROBLEM-SOLVING SKILLS

ABOUT BETTER PROBLEM SOLVING

There is often a strong relationship between depression and feeling overwhelmed by life-problems. The relationship goes both directions—depression can make it difficult to address life-problems, and avoiding life-problems or not knowing how to solve life-problems can make a person feel depressed. Once the cycle gets started, it can cause a person to get completely stuck. One way to help people who are depressed is to teach them some simple, but important skills related to better problem solving.

The following pages contain a set of slides that can be used to train people in better problem solving skills. In reviewing the slides you will learn a seven-step process to better problem solving.

An important thing to keep in mind when working on problem solving skills is that it isn't always necessary to "solve" a problem in order to feel better. Indeed, many problems in life are not entirely within our control. However, we almost always feel better when we make an effort to take care of life's necessities and even to engage in some of the pleasurable experiences life has to offer.

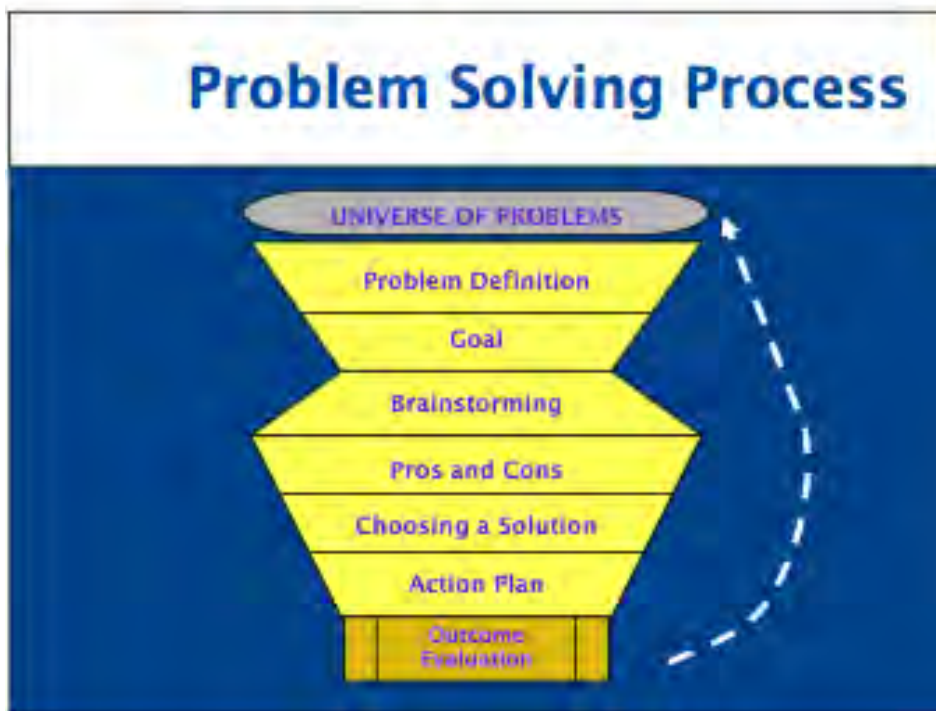
BETTER PROBLEM SOLVING PRESENTATION SLIDES

Better Problem Solving

**Developed for REACH NOLA
Mental Health Infrastructure & Training
Project**

February 2009

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Seven Steps of PST - PC



1. Clarify and Define the Problem
2. Set Realistic/Achievable Goal
3. Generate Multiple Solutions
4. Evaluate and Compare Solutions
5. Select a Feasible Solution
6. Implement the Solution
7. Evaluate the Outcome

Clarifying and Defining the Problem

Explore and Clarify:

Who, What, Where, When, Why?
"What have you already tried?"

Break down Complex Problems into Objective & Possible

Must be objective: observable and measurable:

"Low self-esteem" is *not* objective.
Ask self: "Can I picture this?"
Think "Function"
"I stay home alone" *is* objective.

Must be possible:

Patient must have some degree of control
Life problems are potentially controllable
Symptoms are not directly controllable

Establishing a Realistic Goal

Follows directly from the Problem definition

"What do you want to change about...How would things be different?"

Goal must be objective (i.e., measurable).

Either it happened or it didn't happen.

Improved self-esteem is *not* objective.

Going out with friends *is* objective.

Must be stated in Behavioral Terms.

"Weight loss" *is* objective, but it is *not* behavioral.

Changing eating habits is both objective *and* behavioral.

Goal must be Achievable.

i.e., by next visit

Generating Solutions "Brainstorming"

Solutions come from the patient

Withhold Judgment

It's all about *Attitude*

- Throw caution to the wind!
- Number over Quality
- Combine and Modify Ideas
- "What Else?"
 - then be quiet*
- Write them down

Weighing the Pros and Cons

Pros – look for unique quality:

What is unique about this solution?

What makes this solution so good?

“It solves my problem” is not unique. Look for “it is quick”, “social”, “solves two problems in one”

Cons:

Time, Effort, Cost, Independence, Emotional Impact
Compared to other solutions?

Rating & Comparing Cons

How much does this solution “cost” in terms of:

Cons (-)	A Little	Medium	A Lot
Effort			
Time			
Money			
Emotional Impact			
Involving Others			

Choosing the Solution

Systematic Evaluation of Pros and Cons
Solution Satisfies the Goal

Negative Impact is Limited

Review the Rationale for Choice

**Especially if it does not seem to
reflect preceding decision analysis**

Empowers the client

The Action Plan

Specific Tasks Identified:
Where, When, How, Who...

Anticipate Obstacles

Realistic

Role Play to Improve Confidence

Evaluating the Outcome

Review all Tasks

Acknowledge Success

Explore Undesirable Outcome:

- Problem definition
- Goal definition
- Unforeseen Obstacles

Road Blocks to Effective Problem Solving

ROAD BLOCK	OPTION
Avoiding problems	Create a list and prioritize
Getting discouraged and giving up.	Be persistent
Getting frustrated and unable to concentrate	Be patient, break it down into small steps
Getting anxious and jumping at the first idea that comes to mind	Attend to details, weigh the consequences of each option and compare them against each other.

HOW TO USE THE BETTER PROBLEM SOLVING WORKSHEET

The problem solving worksheet is a structured tool you can use to work through the seven steps of better problem solving described above. There are no big rights or wrongs to using the worksheet. It is a tool and people use tools in different ways depending on the job they are working on and their skill in using the tool.

One thing to keep in mind is that the brainstorming in step 3 should be completed before going on to evaluating the pros and cons in step 4. Sometimes people want to move across the row of the worksheet rather than down the columns. Getting into the pros and cons interrupts the creative process, so be sure to have completed the options in step 3 before going on.

BETTER PROBLEM-SOLVING WORKSHEET

1. Problem:

2. Goal:

3. Options:

4. Pros versus Cons

a)	a) Pros What makes this a good choice?	a) Cons
b)	b) Pros What makes this a good choice?	b) Cons
c)	c) Pros What makes this a good choice?	c) Cons
d)	d) Pros What makes this a good choice?	d) Cons

5. Choice of solution:

6. Action Plan:

Write down the tasks you completed.

a)

b)

c)

d)

e)

f)

g)

VII. BEHAVIORAL ACTIVATION

Just as there is often a strong relationship between not addressing life-problems and feeling depressed, there is also a strong relationship between our daily activities and our mood. The idea behind behavioral activation is that it is generally easier to directly change our behavior than it is to directly change our thoughts or feelings, and that by doing so in a healthy way, the quality of our thoughts and feelings will improve.

Below you will find some helpful tips and tools for helping a depressed individual become involved in the kinds of daily activities that help improve our mood and promote well-being.

Behavioral Activation Introduction Script:

“When you’re depressed and feeling down, you don’t feel like doing anything, whether they’re activities you enjoyed in the past or new activities you’ve never tried before. Doing things you enjoy can help you feel better. Let’s try to think of something you might like to do. This is not therapy...I just want to help you do something so you can start feeling better.”

Using Behavioral Activation in Case Management (sample script):

“I know that the amount of work that must be done seems like too much, and it’s difficult to focus on what to do next, but it’ll help make it easier to do things if you take it step by step. If you’d like, we can work together to determine how you could accomplish some of this work so that it’s not as difficult and I think it’ll help you feel better about the progress you’re making.”

Know your limits – if the client cannot focus or discusses only things he/she has lost and cannot replace, they need professional help. Discuss options for making an appointment.

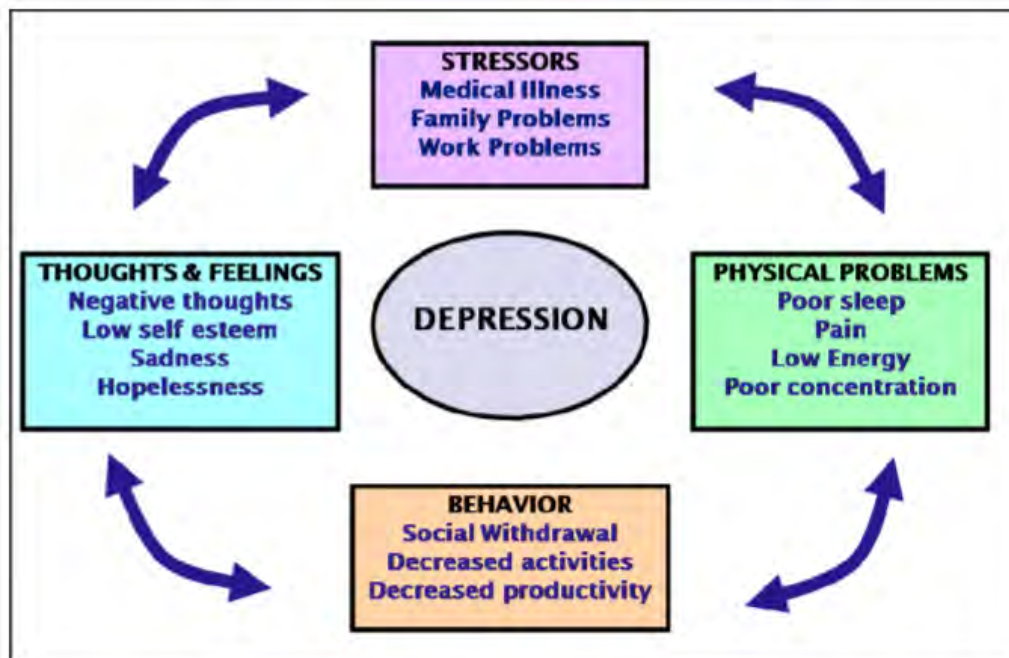
HELPING SOMEONE SCHEDULE ACTIVITIES

Why scheduling activities is important

- When people are stressed or depressed they often stop doing activities that they used to enjoy and that helped them feel good.

Spiraling Down

- It works both ways—the less you do the more depressed you feel AND the more depressed you feel the less you do.



Spiraling Up

- By doing more pleasant activities, even if you don't initially feel like it, you can break the vicious cycle of depression.

Types of pleasant activities

- Pleasant activities are ones that make you feel better because they are rewarding, meaningful, inspiring, relaxing or fun.
- They don't have to be special activities. In fact, most are everyday activities.

Remembering pleasant activities

- When a person is depressed, it's hard for them to remember that any activities have ever been pleasant.
- Ask them what it is that they used to enjoy, no matter how long ago.

SCHEDULING ACTIVITIES

On the following page, you will find a worksheet for scheduling activities intended to lift a person's mood and reduce stress. It is best if the person selects the activities themselves, but you may want to discuss those activities with him/her to be sure that they are feasible, and that the person is likely to find them rewarding. Remember, there are different strokes for different folks; it is our job to just check things out and help them think things through because depression can really cloud one's thinking.

For some people physical exercise is a solo activity, for others it is a group activity. Ideally a person is combining all three aspects, pleasant, social and physical. If they tend to lean towards one much more than the others, you can encourage them to balance things out.

Perhaps the most important part of basic behavioral activation is actually reflecting on how a person felt after doing the activity and actually recording that. By doing this, you can look back over time and see that you clearly do have the ability to affect your mood if you take the steps necessary to do so.

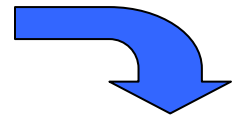
SCHEDULING ACTIVITIES

Pleasant – Social - Physical

Plan at least one activity each day. It is an important way to deal with stress and depression. Schedule out a week's worth of daily activities.

Each day should contain at least one activity that is pleasant, social, or physical. Many activities can be all three – that's great! For example, a pleasant activity might be putting together a puzzle or some hobby; a social activity might be having tea with a neighbor, and a physical activity might be going for a walk.

Be sure to rate how satisfied you felt after doing the activity



Daily Activities			How <i>satisfied</i> did you feel?
Day	Date	Type of Activity (What? Where? With whom?)	0 = Not Satisfied 10 = Super
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

STAYING HEALTHY: RELAPSE PREVENTION PLAN

On the following page, you will find the “Staying Healthy: Relapse Prevention Plan.”

Depression sometimes comes back, even after a person gets treatment. A plan to prevent relapse is completed with a clinical provider when the person has improved. Other members of the collaborative care team help make sure this plan is carried out. The purpose of the plan is to identify that person’s early warning signs that depression may be returning and to have a specific plan for how to avoid a relapse and what steps to take if a relapse into depression occurs.

STAYING HEALTHY: RELAPSE PREVENTION PLAN

MEDICATIONS:

- 1.
- 2.
- 3.

- CONTINUE MEDICATIONS at least until _____.
- VERY IMPORTANT: Do not stop taking medications suddenly or without consulting your doctor. Some medications must be stopped slowly. **Always contact your provider before stopping medication.**

OTHER TREATMENTS:

- 1.
- 2.
- 3.

MY WARNING SIGNS OF GETTING STRESSED:

- 1.
- 2.
- 3.
- 4.

HEALTHY ACTIONS TO KEEP MYSELF WELL:

- 1.
- 2.
- 3.
- 4.

WHO TO CALL:

Please call _____, at _____, if problems arise or to make an appointment.

For emergencies, you may call _____, at _____.

Adapted from Project IMPACT. 1999 - Center for Health Services Research, UCLA Neuropsychiatric Institute. 2008 - IMPACT Implementation Center, University of Washington.

VIII. TRACKING SERVICES AND OUTCOMES

It can be very helpful to keep a record of the services you provide to clients, as well as their individual outcomes. Not only will it help you keep track of your activities and your clients' progress, it will provide your agency with information often needed to maintain funding. On the following page you will find a "Services Log." You may find this document helpful in tracking the services you provide to individual clients.

IX. COMMUNITY EDUCATION

Guidelines for Community Education

Community education is no easy process. It requires a high level of cultural competency and sensitivity on the part of anyone working in this particular realm. It requires one to be careful about the language and terms used to describe a concept, project or intervention that is being offered. Below are some suggested guidelines to consider:

- Have a strong background knowledge of the community in which you will be working
- If you are not from a particular community, have someone (or more than one person) who is from the community work with you
- Appreciate any special traditions that may be practiced in a particular community; you may not understand them, but do respect and appreciate them
- In certain circumstances, be open to using some of the language of a particular community
- Ask for community feedback on the work and service(s) you are providing; there is always room for improvement

Guidelines for Providing Support In Groups

Group support can be a very beneficial mode of intervention in any project. Such support simply engages and allows the members of a particular group or community to share in their experiences and /or problems and then work collectively to resolve them. In some instances, the members of a group can offer to one another possible solutions to problems and issues.

Below are some examples of group support:

- Mind-body sessions/ other non-traditional forms of therapy
- Musicians' clinic
- Drum circles
- Community meetings/forums
- Yoga classes
- Stress management sessions

It may be helpful to ask the community being served what might be a desired form of a support group that they might wish to form. Again, consulting with the community in this regard would be very respectful in order to engage the community in the intervention as they are the ones being served. It might also be helpful to develop a standing committee of community members to routinely give feedback on a particular intervention as it is being delivered.

Integrating Treatments into Outreach Work

In order to maximize the time outreach workers spend with community clients, it might be helpful to integrate screening and good listening techniques into outreach work. For example, as outreach workers go out into the community to promote a project and recruit clients, it might be helpful for the outreach workers to administer the PHQ-2 and PHQ-9 forms as well as simply talk and listen to the clients as a means of encouraging counseling. Such actions can help to establish trust and confidence between the clients and outreach workers and help to attract the clients to participate in group support and other interventions being offered. Simple listening and empathetic conversation can always go a long way to offering beneficial results, which can be the first step to worthwhile mental health intervention.

X. SELF-CARE

Now that we've learned about various ways to be more effective in our mental health outreach efforts and helping others to help themselves, this is a good opportunity to focus on self-care. It is important to acknowledge the difficulties you may face as a disaster survivor, as someone who cares for other survivors and the effects these factors can have on your body, mind, and spirit. Sometimes it can seem difficult to make self-care a priority, especially when you know that so many people are depending on you, but it is important to remember that you cannot care for others without taking care of yourself first.

Self-Care Strategies

First, take some time to reflect on how often you are able to do the following things to take care of yourself:

Physical Self-Care

- Eat healthy meals regularly
- Exercise
- Get enough sleep
- Take time off when needed
- Get medical care when needed

Emotional Self-Care

- Spend time with others whose company you enjoy
- Allow yourself to express your feelings
- Find things that make you laugh
- Give yourself credit for the things you do well

Psychological Self-Care

- Make time for self-reflection
- Write in a journal
- Say “no” to extra responsibilities sometime

Spiritual Self-Care

- Spend time outdoors
- Find a spiritual connection or community
- Meditate
- Pray
- Sing

Workplace or Professional Self-Care

- Take a break during the workday
- Set limits with your clients and colleagues
- Get regular supervision or consultation
- Have a peer support group

If you found that you are neglecting any of the above types of self-care, choose an area that you will actively work to improve to achieve greater balance in your life. One way you might start to do this is to make a plan for how to take better care of yourself and schedule time for doing healthy activities. For example, if you decide that you would like to start taking a break during the workday, you could set aside a few minutes on your schedule each day when you plan to take a break. Perhaps you could go for a quick walk around the block or read a book for a few minutes. Take a moment to reflect on the way you feel after you've had a break from work. Chances are you will feel more relaxed and you will be more productive when you return to work. Even taking just a few minutes each day to do something you enjoy can make a big difference in how you feel physically and emotionally.

Adapted from the "Self-Care Assessment Worksheet"

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman, & Staff of TSI/CAAP (Norton, 1996)

GLOSSARY

Advocacy:	Examples include serving as a role model, mentor, conducting crisis intervention, community networking, and political lobbying
Behavioral activation:	Systematic approach to assist clients in performing basic functions by developing a step-by-step approach, discussing possible deterrents, completion dates, etc.
Community-at-large:	General public
Cultural competence:	Ability of understanding, communicating with and working within the context of the culture of the community being served
Outreach:	Effort by individuals in an organization or group to connect its ideas or practices to the efforts of other organizations, groups, specific audiences or the general public (examples include case finding; screenings; refer as needed; network with peers in the community; provide education and/or consultation; assist in establishing programs)
Stigma:	A negative label or severe disapproval of certain characteristics, which can lead to discrimination
Unserved or underserved:	Those who have inadequate services available or provided to them

REFERENCES

- Crowley, B. (2003). The Assessment of danger in everyday practice. *Psychiatric Times*, 20. Retrieved from <http://www.psychiatrictimes.com/display/article/10168/47991>.
- Health Resources and Services Administration, Bureau of Health Professions. (2007). *Community Health Worker National Workforce Study*. Accessed on-line at <http://bhpr.hrsa.gov/healthworkforce/chw>.
- HIPAA Weekly Advisor (2008, Sept. 8). Does HIPAA address the use of cell phones and PHI? *Briefings on HIPAA*. Retrieved from <http://rtacpa.blogs.com/reedtinsley/2008/09/from-hipaa-week.html>.
- Jackson-Triche, M., Wells, K.B., Minnium, K. (2002). *Beating Depression: The Journey to Hope*. New York: McGraw Hill.
- Jones, D., Franklin, C., Butler, B. Williams, P., Wells, K.B., & Rodriguez, M.A. (2006). The Building Wellness Project: a case history of partnership, power sharing, and compromise. *Ethnicity & Disease*, 16, S1-54 – S1-66.
- Los Angeles County Department of Mental Health, Program Support Bureau (2007). *Community Outreach Services Handbook*.
- U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Summary of the HIPAA Privacy Rule*. Retrieved from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>.
- Wells, K.B., Sherbourne, C., Schoenbaum, M., Duan, N., Meredith, L., Unutzer, J., Miranda, J., Carney, M., Rubenstein, L.V. (200). Impact of disseminating quality improvement programs for depression in primary care: a randomized controlled trial. *JAMA*, 283(2): 212-220.

NOTES

NOTES

APPENDIX

- A1. “About Depression” presentation slides
- A2. Confidentiality Agreement
- A3. Authorization for Release of Health Screening Information
- A4. Client Consent for Health Screening
- A5. Referral Form
- A6. Patient Health Questionnaires:
 - Patient Health Questionnaire (PHQ-2)
 - Patient Health Questionnaire (PHQ-9) (*English*)
 - Patient Health Questionnaire (PHQ-9) (*Spanish*)