

# **From Maintenance to Rehabilitation**

Lee Ann Slayton

Mary Thornton

The Technical Assistance Collaborative

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## Goals & Objectives

By the end of this training participants will be able to:

- Distinguish between case management and rehabilitation assessments and interventions.
- Identify specific skill-building interventions that can replace existing watchful oversight and caretaking interventions.
- Develop skill-building sequences and plans to assist clients with meeting their rehabilitation goals.
- Develop, with clients, transition plans to incorporate increasing amounts of skill building into their treatment plans.
- Tie specific kinds of interventions to the Community Support Team and ACT MRO service definitions.

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## “Traditional” Case Management in Connecticut

- Case Managers job is to take care of people
- Do what ever it takes to give them a full and healthy life
- Do whatever it takes to keep them safe
- Do whatever it takes to keep them out of hospital, or in their apartments or from becoming homeless
- Do whatever it takes to keep them from making mistakes
- Make sure they get whatever services they need

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## **As a result, traditional case managers may spend lots of time:**

- Driving
- Shopping
- Cleaning
- Waiting
- On the phone
- Making appointments
- Doing paperwork
- Getting entitlements
- Responding to client crises
- Doing things for and on behalf of the client

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## **MRO staff's job is to:**

- Help people take care of themselves
- Do whatever it takes to help people live a full and healthy life with only the "professional" supports they want and need
- Assist people learn how to create safe lives, and anticipate trouble, asking for help before things become unsafe
- Help people learn how to stay out of the hospital, in their own apartments, and avoid homelessness
- Help people learn from mistakes, and keep from making big mistakes
- Identify what they want in their lives, and ask for and get the resources they need from the world.

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## **As a result, MRO staff may spend lots of time:**

- Teaching
- Coaching
- Helping clients link with resources they need and want
- Helping clients develop strategies to avoid crises
- Doing documentation with client
- In ongoing functional assessment/conversations with clients
- Doing things with the client and helping the client do things for self

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## **Practice changes:**

- Risk Management to Skill Building
- Oversight to Coaching
- Providing Experiences to Empowering
- Engagement as an Active Function
- Expansion vs. contraction

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## Myths that need to be shattered

- Consumers can learn skills even if symptomatic
- Diagnosis is not indicative of rehab potential
- Medications and skill building do not need to go hand in hand
- Persons unable to function in one environment will not necessarily fail in others – different environments may lead to different results
- You do not need to be “in therapy” for rehab to be successful
- Severe mental illnesses are not always deteriorative diseases

▪ Bill Anthony

## So how do we get from here to there?

- Knowing the goal
- Taking small steps in the right direction
- Continuing to build on what we learn and know
- Learning from each other
- Identifying and using resources
- Practicing, practicing, practicing
- --- exactly the same ways that our clients will learn from us in the future

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## Some Ground Rules

- Today we are focusing on interventions, not assessments or treatment/rehabilitation planning. We will focus on those in October.
- When we talk today about what is “billable” – always understand that it is in the context of an eligible client, with an assessed need that is linked to a treatment plan that meets medical necessity.
- For billing purposes, service definitions will not be final until the federal government has approved CT’s plans. There are likely to be minor changes at that time.

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## Focus today on interventions that make up core activities in Community Support

These fall in four BIG categories:

1. Skill building
2. Assistance in identifying & accessing resources
3. Education, Support & Consultation to client, family & natural supports
4. Support to facilitate recovery and rehabilitation

(Remember that 100% of Community Support Team interventions are also billable when delivered by an ACT team.)

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## Skill Building

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## Definition

- **skill** (skil)  
n. Proficiency, facility, or dexterity that is acquired or developed through training or experience.
  - An art, trade, or technique, particularly one requiring use of the hands or body.
  - A developed talent or ability: *writing skills*.
  
- *The American Heritage® Dictionary of the English Language, Fourth Edition.*

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## What is a Skill?

- Observable: can either see it or be articulated
- Must be practiced to be mastered and maintained
- Right ways and wrong ways
- Done for a reason
- Generalizable: Can be used in a variety of situations and/or locations

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## Skill Building Steps

- Requires Kinetic, Visual and Auditory Learning
- General Pattern
  - SAY (Explain/describe)
  - SHOW (Demonstrate)
  - PRACTICE
  - DEMONSTRATE AGAIN
  - HAVE STUDENT DEMONSTRATE
  - SCORE (Feedback and Correction)
  - Practice Again
  - At Mastery, continue practice until over-learned
  - Integration in a variety of “real” settings

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## Another Look at Skills Training

- Teaching Skills
  - Instructions
  - Modeling
  - Skill strengthening procedures
- Helping Client Rehearse/Practice Skill
  - Reinforce new skills
  - Coaching and feedback
- Helping clients link various skills together
- Helping Client Generalize Skills to other Settings
  - Adaptation & Modification
  - Building self-reinforcement
  - Coaching & Feedback
  - Providing review materials/tools
  - *In vivo* practice
  - Modifying the environment to reinforce/enlisting natural supports

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## Skill Building

- We all learn in different ways: Important to use a variety of teaching and coaching strategies
- Help client link skills to problems they want to solve or goals they want to reach.
- Not necessarily linear because of psychiatric condition
- Skill retention and pace of learning are very individual
- Requires keeping fresh – may require retraining or helping client set up strategies for ongoing practice and cueing

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## Primarily Skill Building

- Individualized, restorative interventions to develop interpersonal/social, community coping, and independent living/functional skills (including adaptation to home, school, work and community environments)

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## What kinds of skills fit?

- Social interaction skills
  - Initiating conversations
  - Not interrupting
  - Appropriate activities/conversations with strangers/acquaintances/friends
- Community Coping
  - Assessing safety issues
  - Self protection awareness & strategies
- More than ADLs . . . .
- Others???

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## Primarily Skill Building

- Assistance in the acquisition of self-monitoring and management skills related to symptoms and illness (for example, medication self-monitoring and assistance in the development of self-medication skills; coping skills; or help-seeking behaviors) in order to identify and minimize the negative effects of symptoms which interfere with individual's daily living.

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## What skills?

- More than med boxes and naming medication, dosage, purpose & side effects
- Identifying symptoms in self, strategies to cope with/compensate for symptoms
- Knowing when to ask for help; who and how to ask for help
- Developing natural supports to assist with medication & symptom self management

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## Primarily Skill Building

- Assistance in increasing social support skills and networks that ameliorate life stresses resulting from the individual's disability and which are necessary to maintain the individual's independent living.
- Assisting the individual to gain skills in accessing needed services and using them beneficially.

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## Susan

- Susan has been receiving residential supports for 7 years. She has family who live about 45 miles away, but can only see them if staff drive her. She claims her only friends are her case managers and counselors.
- **WHAT SKILLS IN THIS CATEGORY MIGHT SUSAN NEED?** (Assistance in increasing social support skills and networks that ameliorate life stresses resulting from the individual's disability and which are necessary to maintain the individual's independent living.)

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## Rehabilitation Interventions Happen on a Continuum



## Sequencing

- Skills can be analyzed and broken into components
- Components can be taught separately and linked together
- OT's and other rehab professionals bring expertise in task analysis to help with this
- Sequencing helps client to gain baseline/foundational skill & knowledge and add to it.
- If steps are too large, make them smaller.

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## MRO Services Lead to Progress

- Skills should build on each other
- Skills start with where consumer is functioning now and move toward where consumer ultimately wants to be functioning
- Skills are taught in context
  - What is behind the need for the skill?

## Back to Susan

- Take the skills you identified
  - WHAT ARE SOME WAYS TO HELP SUSAN GAIN THEM? Be concrete in outlining some ways you might teach/help Susan learn those skills.
  - WHAT ARE SOME OF THE STEPS YOU MIGHT USE? For each skill, identify a learning sequence.

## Resources

*"Assisting the individual to gain access to necessary rehabilitative services, medical services, general entitlement benefits, wellness, or other services. "*

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## Active Assistance

- Some of the same steps as skill building apply:
  - Modeling
  - Explaining
  - Small steps (in the right direction)
- Knowledge and Skills in
  - Identifying resources
  - Accessing resources
  - Advocating for self
  - Asking for help and asking for advocacy

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## What might you do differently?

- Spend down
- Re-eligibility
- Doctor's appointments
- Skill Building and specific situations
- Recreation
- Socialization
  - Medication monitoring
  - Lack of socialization
  - Lack of recreation
  - Self Care
  - Decision Making
  - Recovery Ownership

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## Thinking Bigger About Resources

- More than food, money, clothing & entitlements
- Social and other supports
- Links to other systems/resources
- Community resources: libraries, health fairs, food banks, free classes
- Social institutions: churches, community centers, other nonprofits (not necessarily mental health)

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## **Education, Support & Consultation to client, family & natural supports**

Assistance and support for the individual in crisis situations; coordination and/or assistance with crisis providers as needed.

Education, support and consultation to individual's families and their support system which is directed exclusively to the well being and benefit of the individual.

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## **What kinds of interventions?**

- Not to be confused with crisis intervention by mobile crisis teams
- Skills and resources and consequences around crisis situations, including developing support and prevention plans
- Examples:
  - client who cuts self
  - Client who get in fight and breaks window
  - Client whose apartment is so dirty they may be forced to move

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## Support to facilitate recovery and rehabilitation

Support to facilitate recovery (including support and assistance with defining what recovery means to the individual in order to assist the individual with recovery-based goal setting and attainment). For those who have achieved a level of recovery stability, assistance and support to prevent relapse. Assistance in identifying, with individual, risk factors related to psychiatric and/or substance-abuse disorder relapse and strategies to prevent relapse.

Participation in the development and implementation of an individual's treatment plan which supports recovery.

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## What kinds of interventions?

- "Engagement"
- Peer-to-peer
  - Might be peer as MRO staff
  - Might be MRO staff helping client to engage with peer support in other areas
- WRAP & other planning processes
- Functional Assessments like CASIG that are shared conversations
- Decision Making/Making Choices
- Recovery Ownership
- Helping client assess their risks, and developing strategies that work for them to prevent relapse or decrease intensity/frequency of relapse

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## Participating in Rehabilitation Planning

- Active involvement with client to assist client in self assessment, making choices, self-evaluation of progress toward goals etc.
- On collateral basis, and with client permission, involvement with other parts of system to get feedback on their perception of client progress.
- NOT: staff independently developing treatment plans or doing formal assessments.

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## Putting it Together

Jack

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## Jack, July 2007

- Jack, 32 years, diagnosed with bipolar disorder, shows up for his psychiatrist appointment and is unusually disheveled. He looks like he hasn't bathed in a while, his clothes are dirty and smelly, and dirt is embedded under his cracked and ragged fingernails. He has run out of his meds, and now is not sure if he wants to take them ever again. He no longer is living with his brother and is in a rooming house with no laundry facility. The psychiatrist talks to the case manager who brought him for his appointment, and asks her to stop by Wal-Mart on the way back to his home and buy him some hygiene products, laundry materials, and clothes to replace what he has on and then make sure he uses them.

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## The maintenance approach might:

- Make suggested purchases
- Go into home - do laundry and possibly clean
- Try to get Jack (or family member) to get Jack into shower
- Tells him she will withhold cigarette money if he does not do this
- Gets him to promise to shower tomorrow as well
- Calls VNA to give him meds
- Calls pharmacy to get meds (may go pick them up)

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## What might MRO worker do?

- With psychiatrist?
- With Jack relative to his medications?
  - Immediately?
  - More long term?
- In identifying any other high-risk factors?
- Relative to hygiene? Clothing?
- Family/natural support engagement/education?
- Preventing situation from happening again?

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## Putting it All Together

Janet

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Janet, 58 years old, diagnosed with major depression, recurrent, with psychotic features, has spent the last 20 years institutionalized either in the hospital or a nursing home. She moved in a supported apartment last month. She has a complicated medical regimen because of high blood pressure, obesity, and cardiac insufficiency. She presents as clean but is disheveled and has on multiple layers of clothes on a hot summer day. She has not left the block except for the 7-11 and is afraid to go any further into the community by herself. She gets meds delivered by the VNA and they also take care of her transportation to medical appointments. She has used up most of her monthly money buying food from 7-11 because she does not know how to use a microwave. She states that her only friends were in the nursing home and she pretty much watches TV all day long. She says she cannot exercise because of her health and she does not want to go to the social club – “I would be too scared and embarrassed.” She does not like taking her psychiatric medications and says she has really bad side effects but the nurses make her take them. She does not like her psychiatrist who doesn't really talk to her. She has never been in therapy and doesn't want to do that either. She talks very slowly, requires questions to be repeated and it is not quite clear that she fully understands them. She complains that she does not know how she will get her room cleaned, bed changed, clothes washed. The nursing home took care of those things for her.

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## Short Term Assessment Issues

- Needs assessment - hierarchical
  - Readiness and risk assessment: does she see any need to change? In what areas? Are there areas where she must change?
    - Skills and resources needed
  - If you and she don't agree –it doesn't come off the table
  - What is she willing to commit to in terms of time – that may change over time.

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## Issues

- Budgeting
- Short term management of food
- Schedule – choices
- Engagement
  - HOW WOULD YOU PRIORITIZE????? WHY?

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## In small groups:

- Develop an intervention plan for the identified issues. Include:
  - Skills & Resources
    - Strategies to teach skills (steps, sequence, methodologies)
    - Time and duration likely needed
  - Support for Recovery
    - Strategies (steps, sequence, methodologies)
    - Time and duration likely needed
  - Education, support & consultation
    - Strategies (steps, sequence, methodologies)
    - Time and duration likely needed

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## Putting it Together 3

### RICO

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Rico, 50, diagnosed with schizoaffective disorder and mild mental retardation, still lives with his mother and states he would be willing to consider rehabilitation but is not sure why. He was last hospitalized 7 years ago and has been stable since then. He has been in recovery from ETOH abuse for 12 years and does not participate in any community recovery programs. His mother ensures he takes his meds and accompanies him to most medical appointments. He spends most of his time at home and is not allowed to bring any friends there. He attends the social club sporadically but doesn't engage much with others except for Jim whom he met in the hospital. Rico says he has been willing to attend the vocational program, would like to go back to school, and/or would like to move out on his own. He is not sure what happens with these ideas. His only goal is a flat screen TV for watching NASCAR. Rico laughs when he says this but then says quite seriously, "I don't like how I am living now. "

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## Discussion

- Case management: Low risk and stable client
- Rehab: this is an opportunity – potentially lots of room to grow if we can help client see possibilities for growth and change.

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## All Together

- What are the key issues?
  - How to prioritize?
- To address those issues:
  - What Skills?
  - What Resources?
  - What support for recovery/rehabilitation?
  - What support, education, consultation to family/natural supports?

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## In different small groups:

- Develop an intervention plan for the identified issues. Include:
  - Skills & Resources
    - Strategies to teach skills (steps, sequence, methodologies)
    - Time and duration likely needed
  - Support for Recovery
    - Strategies (steps, sequence, methodologies)
    - Time and duration likely needed
  - Education, support & consultation
    - Strategies (steps, sequence, methodologies)
    - Time and duration likely needed

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## Transition Plans

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## Not an overnight process

- Begin conversations with clients about what things you currently do for them that they might want to begin doing for themselves. (Small steps in the right direction.)
- Use WRAP and other tools to help clients identify goals that match up with shift to rehabilitation.
- With client, develop steps to move from here to there.

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## Exercise

- Think of a client for whom you currently provide a lot of “doing for”
- With a partner role playing the client, begin to develop joint strategies and plans for moving toward “doing with” and then “doing for self”

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## Next Steps

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## Review CST definitions

- Use definition to see which of current interventions with client are already in sync, and which might need some work.
- Focus on overview statement and the list of interventions.

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## Next MRO Training

- October 16, 17, 18
  - Focus on core clinical processes
  - Diagnostic Assessments
  - Functional Assessments
  - Treatment/rehabilitation plans
  - Core provider responsibilities
  - Core provider/specialty provider communication
  - For ACT and CS Team leaders; Clinical assessment staff at Core providers; clinical directors

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## Staff Resources

- Curricula about Making & Keeping Friends
- Life Skills
- Skills Lists from Georgia: on DMHAS website:  
<http://www.ct.gov/dmhas/LIB/dmhas/MRO/APSexcerpts.pdf>
- Curriculum list for skills building (to be updated within year)  
<http://www.ct.gov/dmhas/LIB/dmhas/MRO/curriculum.pdf>

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# Making And Keeping Friends

## A Self-Help Guide (excerpt)

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### Originating Office

Center for Mental Health Services  
Substance Abuse and Mental Health Services  
Administration  
5600 Fishers Lane, Room 15-99  
Rockville, MD 20857  
SMA-3716

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## Introduction

People seem to have a natural need for friends and with good reason. Friends increase your enjoyment of life and relieve feelings of loneliness. They even can help reduce stress and improve your health. Having good friends is especially helpful when you are going through any kind of hard time: experiencing anxiety or panic attacks, depression, phobias or delusional thinking; living with a serious illness or disability; having major surgery; having a loss in your life; or just being under a lot of stress. At times like these, good friends and supporters can make all the difference.

When you are with good friends you feel good about yourself, and you are glad to be with them. A friend is someone who —

- you like, respect, and trust, and who likes, respects and trusts you
- doesn't always understand you, but accepts and likes you as you are, even as you grow and change
- allows you the space to change, grow, make decisions, and even make mistakes
- listens to you and share with you, both the good times and the bad times
- respects your need for confidentiality so you can tell them anything
- lets you freely express your feelings and emotions without judging, teasing, or criticizing
- gives you good advice when you want and ask for it, assists you in taking action that will help you feel better, and works with you in difficult situations to figure out what to do next
- accepts your self-defined limitations and helps you to remove them
- lets you help them when they need it
- you want to be with, but you aren't obsessed about being with
- doesn't ever take advantage of you

A man in a focus group said, "Friendship is a continuing source of bonding, releasing, and creating in yourself and with the other person. There is an emotional bond."

A good friend or supporter may or may not be your age or the same sex as you; come from the same educational, cultural, or religious background; or share interests that are similar to yours. Friendships also have different depths; some are closer to the heart, some more superficial-but they're all useful and good.

**Activity:** List qualities you would like your friends, or some of your friends, to have.

## Making Friends

Making new friends can be exciting or intimidating, depending on your personality and your circumstances, but ultimately it is rewarding. To meet new people who might become your friends, you have to go to places where others are gathered. The hardest thing about going out and doing anything in the community is doing it for the first time. It's hard for everyone. Push through those hard feelings and go. Most of the time, you will be glad you did.

Don't limit yourself to one idea or strategy for meeting people. The broader your effort, the greater your likelihood of success. Try several of these ideas:

- Attend a support group. Support groups are a great way to make new friends. It could be a group for people who have similar health issues or life challenges, or a group for people of the same age or sex.
- Go to community activities like sporting events, theatrical productions, concerts, art shows, poetry readings, book signings, civic groups, special interest groups, and political meetings. Take a course or join a church. Let yourself be seen and known in the community. If money is a problem, consider going to your local library and looking in the newspaper for listings of free events. Spend time in places that are free, like a local bookstore with couches where you can sit and read for a while. You will have a feeling of connection even without any dialogue with others.
- Volunteer. Strong connections often are formed when people work together on projects of mutual concern. When volunteering, you are already with a group of people with a common interest. You could help out at a soup kitchen, read to children in day care, visit people in nursing homes, deliver flowers in the hospital, or serve on a political or social action committee. You could bring snacks for the other volunteers and arrange a time to get together and eat with them for more social contact.

**Activity:** Think about places where you have made friends in the past. Check your newspaper for community events and support groups. Which ones sound appealing to you? Make a commitment to go to at least one of these events or groups.

Note: Some people use chat groups and other connections on the Internet as a way to make friends and to relieve loneliness. While this can be a good short-term way to connect with others, avoid sharing personal information and your phone and address with people you do not know well or whom you have not met in person.

Reaching out to establish a friendship sometimes happens simply and casually. At other times, it takes special effort. If you feel you need and want to take some action so a person you have met becomes a friend, you could —

- ask the person to join you at a cafe for coffee or lunch, to go for a walk, or to engage in some other activity with you
- call the person on the phone to share a piece of good news you think they might be interested in
- send a short, friendly e-mail and see if they respond
- chat with them about something of interest to both of you
- offer to help the person with a particular task if you think it would be appreciated

Even window-shopping with another person can be good, especially if there is a theme, even humorous, like "I'm going to find something in the window I could wear to a Halloween party." A woman in the focus group said she went window-shopping with a friend. They tried on lots of clothes that they'd buy if they had the money, and it was great fun. Test the waters by proceeding slowly. As you both enjoy each other more, the friendship deepens. Notice how you feel about yourself when you are with the other person. If you feel good about yourself, you may be on the road to a fulfilling friendship.

# Life Skills for Vocational Success

## ([www.workshopsinc.com](http://www.workshopsinc.com))

### Who is this site for?

- Educators, counselors, job coaches, and other professionals working to increase the employability of people with disabilities.
- Professionals working in Welfare Reform training centers.
- Anyone interested in teaching people life skills as a means to increasing the chance of vocational success.

### What is contained in this site?

- Over 60 lesson plans to teach people life skills.
- Links to other rehabilitation and disability related sites.
- Links to companies that sell life skills training materials.

### Why was this site developed?

The purpose of this site is twofold. First, to disseminate quality training resources over the Internet to professionals who work in vocational rehabilitation settings. Second, to advertise the manual from which all of this valuable information came. The curriculum, *Life Skills for Vocational Success*, was developed through a grant from the [Alabama Department of Rehabilitation Services](#). The grant was obtained by Jim Crim, Executive Director of [Workshops, Inc.](#), and Milton Moats, Facility Coordinator for the Alabama Department of Rehabilitation Services. [Bart Trench](#) was hired to write the manual in September, 1997. With the assistance of [many people](#), the manual was completed on June 1, 1998.

### How do I use this site?

Navigate through the manual using the links contained on this page. The table of contents will help you navigate through the various lesson plans and other resource information. Print out lesson plans and other materials as needed. If you would like all of the materials contained in the manual (all of the information could not be included on the Internet) and save some ink in your printer cartridge, manuals can be purchased at the low price of \$35.

## OVERVIEW OF THE CURRICULUM

The first unit, *Social Skills*, provides training on standard social skills such as communication skills, anger management, and conflict resolution. In addition, lessons are available on making friends and getting along with co-workers and roommates. Much of the training in this unit relies on practicing the skills to help a person become more socially competent.

The second unit, *Decision-Making Skills*, is short, but important. Problem-solving and decision-making skills are probably the most important skills a person can develop. Making good decisions and the ability to solve problems can make up for a lot of skill deficits. For example, a person may not know how to ride a bus to work, but the ability to solve problems may help him figure out who he needs to talk to in order to make sure he gets to work each day. This unit provides three different problem solving techniques.

Unit three, *Employability*, covers a wide range of skills that are necessary to retain a job. Because there are extensive resources on job readiness and job seeking available in print and on the Internet, trainers will find little information on obtaining a job. Lessons on getting to work on time, understanding standard procedures during the first few days on the job, and wearing proper attire can assist students in getting off on the right foot on the job. A lesson on sexual behavior in the workplace provides training in the areas of sexual harassment and

dating co-workers. Other lessons in the unit provide an overview of standard expectations of employers regarding safety, productivity, attitude, and acting appropriately.

Unit four, *Money Management*, has a little more complicated material due to the nature of the skills. As mentioned earlier, basic money handling skills will not be covered. The material has been simplified as much as possible while keeping enough information in the lesson to provide comprehensive training. Standard money management topics are included such as understanding the benefits of the job, budgeting, using a bank, and using credit. Additional topics include protecting your money and staying out of debt.

*Transportation* is the fifth unit. Transportation covers a wide range of skills, from teaching someone to ride a bus in a step-by-step sequence to teaching someone about the process of buying a car. This unit addresses the fact that people in vocational rehabilitation settings have different skills and different financial means. A person who has limited financial resources and does not have the ability to drive would not be appropriate for training on owning a car. Training on using public transportation would be more appropriate. This unit provides an excellent example of how the training can be used to fit the needs of each individual. Unit six, *Health*, provides training on maintaining a healthy lifestyle. There is a wealth of information on staying healthy. This unit gives students information that will help them avoid getting sick and perform well at work. Topics include fitness, nutrition, the problems of drug and alcohol use related to the job, and accessing and using medical services appropriately. The unit contains a lesson on how to use sick leave benefits appropriately.

Unit seven, *Family Responsibilities*, provides necessary information about pregnancy, securing child care and how to balance working with the responsibilities of caring for a sick, elderly, or disabled family member.

*Basic Understanding of the Law* is unit eight. This unit covers information that many students need to stay out of trouble at work and in society. The unit also contains information about hiring a lawyer. A final area of focus is understanding and using the laws of the Americans with Disabilities Act to receive necessary accommodations at work, in public buildings, and while using public transportation.

The last unit, *Telephone Skills*, provides basic training on obtaining phone numbers, getting information over the phone, and using proper phone manners when looking for a job and while on the job. There is also a lesson on making long distance phone calls.

The appendices contain information in four basic areas. First, there are several appendices that contain government documents used in the training. All of these documents are public domain and available on the Internet. Instead of the actual documents, links to the sites to obtain these forms are provided.

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second, appendix H contains reviews of educational materials on the market. Due to the cost of ordering preview copies, a few products from each company were ordered to get a sampling of the overall quality of the products. Any product that was received was reviewed, and a summary and recommendation for use can be found in this section. Due to the enormous cost of some of these products, it is impractical for any one agency to purchase the materials necessary to put together a well-rounded curriculum. There are some comprehensive life skill packages available, but they tend to be very expensive. Some materials cost \$1,000 or more. The resource directory is intended to provide the reader a review of the materials so he/she can make a more informed decision.

Third, appendix I includes companies that sell life skills training products. Although this list is not comprehensive, it will provide trainers a list of companies to contact if they are interested in obtaining a catalog to purchase life skill educational materials.

Finally, appendix J contains links to WEB pages related to vocational rehabilitation, disability, and life skill training materials.

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