

**UNIVERSITY OF TEXAS AT ARLINGTON**

**School of Social Work**

|  |
| --- |
| **Semester/Year:** Summer 2016  **Course Title:** Treatment of Children and Adolescents  **Course Prefix/Number/Section:** SOCW 6344-001 course code 54564  **Instructor Name:** Dr. Alexa Smith-Osborne, L.C.S.W.-S., A.C.S.W.  **Office Number:** 208A  **Phone Number:** No faculty telephones are available in faculty offices.  **Email Address:** alexaso@uta.edu  **Office Hours:** Tuesdays, 2-3 p.m.  **Day and Time (if applicable):** T/Th, 3:30-5:20 p.m.  **Location (Building/Classroom Number):** 115A  **Equipment: A laptop computer with wireless capability or equivalent is required for all SSW classes.**  **Blackboard:** [**https://elearn.uta.edu/webapps/login/**](https://elearn.uta.edu/webapps/login/) |

## **CSWE Educational Policy and Accreditation Standards (EPAS) Content for this Integrated Practice and Human Behavior and the Social Environment Course**

**EPAS core competencies and related advanced practice behaviors addressed in this course:**

**Educational Policy 2.1.1**—**Identify as a professional social worker and conduct oneself accordingly.**

1. Advanced practitioners practice in DPMHSA active self-reflection and continue to address personal bias and stereotypes to build knowledge and dispel myths regarding mental health and mental illness.
2. Advanced practitioners in DPMHSA develop an action plan for continued growth including use of continuing education, supervision, and consultation.

Recovery-oriented social workers understand how SAMHSA’s definition of mental health recovery and the 10 key components connect with social work ethics, history, and

practice. Practitioners should be aware of their own lived experiences of psychiatric

diagnoses, trauma, and/or substance abuse; cognizant of the effects of these

experiences on their own lives; and mindful of how those dynamics may influence their

work and their relationships. Recovery-oriented social workers

● identify as recovery-oriented social workers and behave accordingly;

● engage in self-care methods and seek support to develop awareness, insight,

and resiliency to more effectively manage the effects of trauma and retraumatization in their lives.

E**ducational Policy 2.1.2**—**Apply social work ethical principles to guide professional practice.**

1. Advanced practitioners in DPMHSA implement an effective decision-making strategy for deciphering ethical dilemmas in mental health treatment.
2. Recovery-oriented social workers apply thoughtful strategies of ethical reasoning to resolve dilemmas between individual self-determination and the ethical mandate to protect the client and others under the law.

**Educational Policy 2.1.3**—**Apply critical thinking to inform and communicate professional judgments.**

1. Advanced practitioners in DPMHSA evaluate, select and implement appropriate assessment and treatment approaches to the unique characteristics and needs of diverse clients.
2. Recovery-oriented social workers: use a recovery-oriented framework, engage in professional curiosity, and offer their expertise to support the client’s choices and preferences; analyze the medical/deficits model of assessment of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) with clients.

**Educational Policy 2.1.4**—**Engage diversity and difference in practice.**

Advanced practitioners in DPMHSA understand and can apply the relevant cultural, class, gender, race, age, disability, and other diversity issues that influence the prognosis and treatment of persons with severe and persistent mental illness and substance use disorders, persons with other mental health issues, and persons with psychiatric disabilities, and their families and communities. They can relate social work perspectives, the evidence base, and related theories to practice with these groups.

Recovery-oriented social workers attend to the potential for institutional bias in diagnosis by critically examining evidence of differences in diagnoses between and within groups (including race/ethnicity, gender, etc.)

**Educational Policy 2.1.5**—**Advance human rights and social and economic justice.**

1. Advanced practitioners in DPMHSA understand the range of physical and mental health disease course and recovery issues associated with social stigma and marginalization of persons with mental health diagnoses and psychiatric disabilities, and incorporate them in their assessment and intervention.
2. Recovery-oriented advanced practitioners in DPMHSA:

* Advocate within the profession and across the behavioral health system for recovery-oriented philosophy, progress, and practices;
* “Help individuals understand and act on their legal, civil, and human rights” (AHP,2011, p. 29), specifically those rights involving advance directives, informed consent and refusal for any particular mental health treatment, involuntary treatment, restraint and seclusion, and equal access to resources;
* Advocate for an improvement in individuals’ daily living conditions and address the inequitable distribution of power, money, and resources that results in disadvantage and injustice for their clients;
* Promote reduction and/or elimination of the use of physical and chemical restraints;
* Confront oppression and injustices and engage in efforts to minimize and overcome stigma and discrimination toward individuals with psychiatric conditions;
* Help professionals and others involved with individuals with lived experience of psychiatric diagnoses to replace demeaning, dehumanizing, and shame provoking language with recovery-oriented, strength-based, hope-building language and actions.

**Educational Policy 2.1.6**—**Engage in research-informed practice and practice-informed research.**

1. Advanced practitioners in DPMHSA use advanced strategies to search, appraise, and select for application the most up to date evidence and evolving practice guidelines in the assessment and intervention with influence persons with severe and persistent mental illness and substance use disorders, persons with other mental health issues, and persons with psychiatric disabilities, and their families and communities.
2. Recovery-oriented advanced practitioners in DPMHSA:
3. Critically examine the evidence for newly identified “evidence-based” practices and services for clients, particularly with regard to the inclusion of clients’ voices in intervention development and evaluation;
4. Stay informed about emerging and promising approaches to recovery-oriented practice, especially in regard to how it can be applied and/or customized to the individual, family, groups, organization, and communities;
5. Use quantitative, qualitative, participatory action research, and first person accounts to show that people can and do recover from psychiatric conditions;
6. Promote the inclusion of service users and their viewpoints at multiple levels of the research process including evaluating the relevance of outcomes when compared to their lived experience of psychiatric diagnoses.

**Educational Policy 2.1.7**—**Apply knowledge of human behavior and the social environment.**

1. Advanced practitioners in DPMHSA distinguish mental health, mental illness, and mental well-being across the life span.
2. Advanced practitioners in DPMHSA compare the various etiology and treatments for substance abuse and addiction.
3. Advanced practitioners in DPMHSA understand the relevant organizational world-views and culture that influence persons with severe and persistent mental illness and substance use disorders, persons with other mental health issues, and persons with psychiatric disabilities, and their families and communities. They can relate social work perspectives, the evidence base, and related theories to practice with these groups.
4. Advanced practitioners in DPMHSA understand system resources available to clients across the life course, and the unique issues facing them in gaining access to and utilizing these resources and reforming policy and delivery systems to address unmet needs.
5. Advanced practitioners in DPMHSA understand increased risk and protective factors related to bio-psycho-social-spiritual domains and incorporate them in their assessment and intervention, as well as a range of physical health and recovery issues associated with social stigma and marginalization of persons with mental health diagnoses and psychiatric disabilities.
6. Recovery-oriented advanced practitioners in DPMHSA critically analyze the various ways of understanding the multiple factors influencing an individual’s behavior.

**Educational Policy 2.1.9**—**Respond to contexts that shape practice.**

1. Advanced practitioners in DPMHSA assess social contexts.
2. They develop intervention plans to accomplish systemic change that is sustainable.
3. Recovery-oriented advanced practitioners in DPMHSA:

Practice with consideration for evolving contextual changes on macro and micro levels, innovations in science and technology, and nonlinear pathways to provide up-to-date services for persons with lived experience of psychiatric diagnoses.

**Educational Policy 2.1.10(a)–(d)**—**Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities.** Recovery-oriented advanced practitioners in DPMHSA are guided by the 10 components of recovery practice in their engagement, assessment, intervention, and evaluation activities. Above all, recovery-oriented practitioners hold hope for the individual’s recovery. They understand the interrelated connections among different aspects of wellness and mental health.

Recovery-oriented advanced practitioners in DPMHSA know how to work effectively in an integrated health/mental health setting with peer practitioners/specialists and representatives from other professional disciplines. Coordination continues throughout the process.

**Educational Policy 2.1.10(a)**—**Engagement:** Recovery-oriented advanced practitioners in DPMHSA recognize that individuals are much more than their diagnoses. Recovery-oriented mental health practitioners understand that each individual has a unique pathway to recovery, which should be recognized through shared decision-making and treatment-planning; these plans should remain flexible throughout the client’s nonlinear journey of recovery. They view their clients as individuals with unique histories, talents, resources, hopes, and dreams who are capable of self-determination and choice. Recovery-oriented advanced practitioners in DPMHSA learn from how individuals with mental health diagnoses have coped and support them to share their stories. They recognize that in some settings the value of the experience that peer specialists bring has far greater authenticity and resonates with service users in a way that is difficult for professional staff to replicate.

1. Advanced Practitioners in DPMHSA use strategies to establish a sense of safety for a collaborative therapeutic relationship.
2. They know how mental health concerns and mental illness influence the development of the helping relationship.
3. Recovery-oriented advanced practitioners in DPMHSA treat the voices of their clients with primacy, dignity, and value; construct a safe, trusting, and hope-building relationship with individuals and their families and significant others as appropriate by minimizing power differentials in relationships through respectful communication (e.g., avoiding jargon), transparency, partnership, and shared decision-making; assume the stance of learner instead of expert and help individuals with lived experience of psychiatric conditions to tell their stories, including their abilities to survive, overcome, and thrive; use a conversational approach while mining interactions for hidden or overt clues about the individual’s interests, strengths, and so forth; increase the individual’s ownership of the strengths assessment process; self-disclose to a level or degree that is comfortable for them, to engage with and meet the needs of the individual client; work with peer specialists within their professional settings to improve their ability to connect with people and the quality of treatment available to service users.

**Educational Policy 2.1.10(b)**—**Assessment:** Recovery-oriented advanced practitioners in DPMHSA assess client strengths and limitations from a holistic perspective that considers context, culture, and community norms alongside a clinical comprehension of psychiatric diagnoses. They have a critical understanding of the epidemiology of psychiatric diagnoses, the biopsychosocial causes of psychiatric conditions, and the role of culture in defining psychiatric diagnoses and responses to them. Recovery-oriented advanced practitioners in DPMHSA are aware of the established disparities in mental health diagnoses that have significant effects on service users’ courses of treatment and treatment outcomes. They are knowledgeable about the differences between strengths assessment and problem assessment. They recognize the importance of attending to trauma in assessment and take steps to mitigate or eliminate any retraumatization during the assessment process. Recovery-oriented advanced practitioners in DPMHSA:

● obtain an accurate description of the individual’s talents, skills, abilities and

aptitude, and resources (including social relations, present condition, and his or

her hopes for the future);

● search for multiple possible explanations of a person’s behavior by assessing the

biological, psychological, environmental, and social bases of the behavior;

● assess for trauma, co-occurring disorders, suicide risk, and physical health in

planning recovery activities and treatment;

● empower the individual to define meaningful personal goals and select his or her own pathways to goal attainment

● critically use diagnostic systems, including the DSM, as one way to understand

psychiatric conditions and to inform their understanding and treatment of clients;

● co-create an understanding about the client’s current situation as part of the

assessment so that the client can choose how he or she wishes to define his or

her life condition;

● work to ensure appropriate diagnosis and advocate for service users in this area.

1. Advanced practitioners in DPMHSA will be able to describe the structure of the DSM V and conduct an assessment using the DSM criteria and structure.
2. Advanced Practitioners in Children and Families use multidimensional bio-psycho-social-spiritual assessment tools.
3. They assess clients’ readiness for change and coping strategies.

**Educational Policy 2.1.10(c)**—**Intervention:** Recovery-oriented advanced practitioners in DPMHSA advocate for organizational change and transformation

to a recovery-based system. They promote individual recovery by advocating on behalf

of their clients to access resources and services that support their recovery pathways.

They understand that education and support for the family and significant others can be

key elements to supporting the individual’s own recovery process. They recognize that

peers “encourage and engage each other in recovery, often providing a vital sense of

belonging, supportive relationships, valued roles, and community” (AHP, 2011 p. 25).

They are knowledgeable about the importance of trauma-informed principles for

“[mitigating] the negative consequences of trauma…and minimization of coercive

practices in the process of recovery” (AHP, 2011, p. 27). They understand reputable

evidence-based practices for recovery and for whom they are applicable. Recoveryoriented Advanced practitioners in DPMHSA :

● practice or refer clients to family psychoeducation, supported employment,

wellness self-management, integrated treatment for co-occurring disorders, peer

support, supported education, and other well-established evidence-based

approaches;

● encourage and assist the client to identify and expand on social support networks

within the community, tap into existing resources, and create supports around

himself or herself (such as using peer support options);

● ensure that the client, with input from his or her family and significant others as

appropriate, is the central decision-maker;

● assist the individual in his or her quest for meaningful employment, education,

housing, or any other goal he or she might have;

● empower the client to assume leadership of his or her own well-being through

self-directed care, shared decision-making, and self-advocacy skills

development;

● communicate to assist the individual in decision-making about a range of

possible treatments, services, and options, sharing potential positive and

negative effects of these options with the individual;

● help individuals to identify nonpharmacological options for treatment, including a

broad range of social and individual wellness activities (i.e., personal medicine as

defined by Deegan, 2005);

● ensure plans are in place for psychiatric advance directives, wellness recovery

action plans (WRAP), and other preventative steps (to include identifying early

warning signs of symptoms, coping strategies, and personal medicine);

● develop and implement recovery plans and goals with clients that cross multiple

life domains (e.g., emotional, environmental, financial, intellectual, occupational,

physical, social, and spiritual dimensions), use natural community resources, and

promote community integration;

● help clients negotiate unique challenges or barriers to gain access to resources

and attain their goals by building relationships with resource holders and through

the use of a variety of advocacy strategies;

● know about current guidelines for use of medications to treat psychiatric

conditions and co-occurring disorders.

1. Advanced Practitioners in DPMHSA describe causes (empirically validated and theoretical), advanced assessment methods, and the most effective treatments for a variety of disorders: Mood, anxiety, cognitive, substance abuse, sexual, eating, psychotic disorders for adolescents, adults, and older adults.

2. Advanced practitioners in DPMHSA recognize the impact of illness phase-specific and treatment-phase-specific transitions and stressful life events throughout the individual’s and family’s life course; identify issues related to losses, stressors, changes, and transitions over their life cycle in designing theoretically based interventions and treatment.

**Educational Policy 2.1.10(d)**—**Evaluation:** Recovery-oriented advanced practitioners in DPMHSA evaluate the effects of services and interventions for

their consistency with the 10 components of recovery and individual goal achievement.

Recovery-oriented advanced practitioners in DPMHSA:

● monitor attainment of client established goals and outcomes;

● help clients access and interpret data to inform their decision-making regarding

services and supports;

● involve clients in service and program evaluation and quality improvement.

Social workers critically analyze, monitor, and evaluate interventions.

1. Advanced practitioners in DPMHSA contribute to the theoretical knowledge base in the area of mental health and mental illness through practice-based research, and use evaluation of the process and/or outcomes to develop best practices.

**UTA-School of Social Work: Definition of Evidence-Informed Practice:**

Evidence-informed practice (EIP) is a guiding principal for the UTA-SSW. This approach is guided by the philosophy espoused by Gambrill (2006) and others who discuss evidence-based practice (EBP). Though many definitions of EIP/EBP saturate the literature, we offer two definitions that most closely define our understanding of the concept and serve to explicate our vision of EIP for the UTA-SSW:

The use of the best available scientific knowledge derived from randomized, controlled outcome studies, and meta-analyses of existing outcome studies, as one basis for guiding professional interventions and effective therapies, combined with professional ethical standards, clinical judgment, and practice wisdom (Barker, 2003, p. 149).

…..the integration of the best research evidence with our clinical expertise and our patient’s unique values and circumstances (Strauss, et al. (2005).

The UTA SSW vision statement states that the “School’s vision is to promote social and economic justice in a diverse environment.”  Empowerment connects with the vision statement because, as Rees (1991) has pointed out, the very objective of empowerment is social justice.  Empowerment is a seminal vehicle by which social justice can be realized.  It could well be argued that true social justice cannot be realized without empowerment. Empowerment, anchored with a generalist base, directs social workers to address root causes at all levels and in all contexts, not simply “symptoms”.  This is not a static process but an ongoing, dynamic process, a process leading to a greater degree of social justice and equality.

**UTA-School of Social Work: Definition of Empowerment**

Empowerment is defined by Barker (2003:142) as follows:

In social work practice, the process of helping individuals, families, groups, and communities increase their personal, interpersonal, socioeconomic, and political strength and develop influence toward improving their circumstances.

**Graduate Catalog Course Description:**

Overview of the literature which describes physical, psychological, and cultural characteristics unique to childhood and adolescence. Attention then turned to treatment principles, and the specification of procedures for the amelioration of problems common to children and adolescents.

**Purpose of the Course**

This course focuses on direct social work practice with children and adolescents with mental health conditions. It follows the course SOCW6325 Advanced Micro Practice and SOCW 6336 Direct Practice with Mental Health Clients. While 6325 details a broad range of interventions and 6336 narrows the focus to adults with mental health concerns, this course addresses children and adolescents/youth with mental health concerns, including a focus on early onset of adult conditions described in the categorical system, DSM V, as well as infant, child, and adolescent conditions described in that system. Thus, the categorical system, DSM V, will be explored as it applies to this age group. The course addresses assessment and interventions for mental illness, substance abuse, and mental health disabilities. The current research literature on mental health is explored to determine the most reliable bases for contributing factors, assessment, and treatment. Particular mental health issues will include the fundamentals of mental well-being, problems-in-living, chronic and acute mental illnesses, and substance abuse.

The rationale for the course is that, in many settings, social workers are often the first, and sometimes the only, helping professionals available to provide services to troubled children. Social workers need a core foundation of assessment and intervention skills in order to work effectively with the unique challenges of working with children and adolescents. Assessment of children is examined in the context of human development, both of the individual child, their parent(s) and family, as well as the larger systems in their environment. An integrative bio-psycho-social framework for assessment and treatment of children and adolescents, drawing on ecological, systemic, cognitive, and behavioral theories, is used to assess and intervene with children's problems and difficulties with a strong emphasis on evidence-based interventions in children’s mental health. The current research literature on mental health is explored to determine the most reliable bases for contributing factors, assessment, and treatment. Wraparound philosophy and collaboration with other helping disciplines is emphasized.

Interventions are broadly defined to include both direct work with individual children, collaborative and/or conjoint work with parents and families, advocacy efforts and consultation. Specific techniques addressed in this course include behavioral contracting, cognitive-behavioral interventions and crisis intervention. Particular attention is given to understanding child development, assessment and intervention approaches with a culturally sensitive context, and through social work values and ethics. Content on interviewing children and families in a variety of settings is included. Collaboration with other helping professions is emphasized. Issues pertaining to social and economic justice are addressed through examining the impacts of poverty, health disparities, single-parent families and homelessness on children and families.

**II. Competency-Based Performance Outcome Objectives for Advanced Skills and Practice Behaviors:** Upon completion of this course, the participant will be able to:

1. Demonstrate an understanding of person-centered evidence-based practice that includes understanding recovery support systems, the person in the environment, human development, the neurological underpinnings of mental health conditions, and concepts of service user recovery and empowerment. EPAS 2.1.3, 2.1.6, 2.1.7, 2.1.9

2. Identify the potential risk factors, including biological underpinnings, that may increase children’s vulnerabilities for emotional, social and behavioral problems, as well as protective factors that promote resilience. Understand the social and economic context and forces impacting the development and well-being of children/adolescents. EPAS 2.1.3, 2.1.6, 2.1.7, 2.1.9

3. Describe the cultural context of development and epidemiology of prevalent mental health conditions in children and adolescents, including the roles played by race, ethnicity, gender and sexual orientation. EPAS 2.1.1, 2.1.2, 2.1.3, 2.1.4

4. Demonstrate skills in using valid diagnostic and assessment instruments and in the interviewing process, for diagnostic evaluation of early onset mental health conditions. EPAS 2.1.5, 2.1.6, 2.1.7, 2.1.10a-b

5. Demonstrate skills in the collaborative, ethical intervention process using the most appropriate evidence-based treatments with high fidelity. EPAS 2.1.5, 2.1.6, 2.1.7, 2.1.10c-e

Note: Course Syllabus Changes – The course instructor reserves the option to modify the course syllabus throughout the course offering by adding guest speakers, audio visual media, instructional technology, or supplemental materials and/or modify assignments or make substitutions so long as course objectives are met and the overall grading criteria are maintained.

**Requirements:**

Students are expected to participate actively in the teaching/learning process by asking questions, participating in discussions and actively voicing their views and opinions. Methods to be used include lectures, presentation, class exercises, videotaped role plays and live interview demonstrations, and exchange of ideas.

**C. *Required* Text(s) and Other Course Materials:**

Some class sessions will be done online using the BlackBoard site for this course to teach to teach literature search techniques and single subject design strategies for evaluating practice. *Clinical Evidence* and *Best Practice* e-databases:The developing evidentiary base on mental health interventions contained in the Central Library e-databases *BMJ* *Clinical Evidence* and *BMJ Best Practice* will serve as another set of required “texts” in this course. Major online references will include the Cochrane Library and the Campbell Collaboration Library within the Central Library e-databases. A program-oriented resource is [www.samhsa.gov/ebpWebguide](http://www.samhsa.gov/ebpWebguide).

American Psychological Association (2009). *Publication manual of the American Psychological Association* (6th Ed.)*.* Washington, D.C.: American Psychological Association. ISBN: 0-89042-025-4. **You may use the reference copy at the Central Library service desk if you have no copy.**

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* (5th ed.). Washington, DC: American Psychiatric Association ISBN: 978-0890425558 **You may use the reference hard copy at the Central Library service desk (24 hour checkout) if you have no copy. The Central Library also has an e-book copy available through E-book Library Collection in the STATREF resource:** <https://login.ezproxy.uta.edu/login?url=http://UTARL.eblib.com/patron/FullRecord.aspx?p=1811753>

Also available free online courtesy of the Central Library--**UTA web access for DSM V *Addiction Casebook*:** [**http://www.utarl.eblib.com.ezproxy.uta.edu/patron/SearchResults.aspx?q=DSM+casebook&t=quick**](http://www.utarl.eblib.com.ezproxy.uta.edu/patron/SearchResults.aspx?q=DSM+casebook&t=quick)

Johnson, H. (2014). *Behavioral neuroscience for the human services.* New York: Oxford University Press. ISBN: 978-0199794157

Galanter, C.A. & Jensen, P. S. (Eds.) (2016). *DSM-5 Casebook and Treatment Guide for*

*Child Mental Health.*  NY, NY: American Psychiatric Publishing. ISBN-13: 978-

1585624904 AVAILABLE 4TH WEEK OF JUNE

*Problem Solving Treatment for Primary Care Manual (PST-PC)*. This is an integrated behavioral health treatment protocol available along with therapy video clips at <http://pstnetwork.ucsf.edu/materials>.

*CHOOSE ONE EVIDENCE-BASED PRACTICE GUIDE:*

Guyatt, G. & Rennie, D. (Eds.). (2002). *Users*’ *guide to the medical literature:*

*essentials of evidence-based clinical practice*. Chicago: AMA Press; **OR**

Moore, R. A.& McQuay, H.(2006). *Bandolier's little book of making sense of the*

*evidence*. Oxford, U.K.: Oxford University Press; **OR**

Gambrill, E. (2006) Social work practice: A critical thinker’s guide. 2nd ed. New

York: Oxford.

**One clicker, available at the University Bookstore, and recording device** to use for recording your role plays in designated class exercises.

**D. Additional *Recommended* Text(s):**

Diamond, M.C., Scheibel, A.B., & Elson, L.M. (1985). *The human brain coloring book.*

Oakville, CA.: HarperPerennial.

Fischer, J. & Corcoran, K. (2007). *Measures for clinical practice*, Vol.1. Oxford: Oxford

University Press.

Galanter, C.A. & Jensen, P. S. (Eds.) (2009). *DSM-IV-TR Casebook and Treatment Guide for Child Mental Health.*  NY, NY: American Psychiatric Publishing.

Lezak, M.D. (1995). *Neuropsychological assessment.* (3rd ed.) Oxford: Oxford University

Press

Munson, C.E. (2000). *The mental health diagnostic desk reference: Visual guides and more for learning to use the Diagnostic and Statistical Manual (DSM-IV).*  New York: The Haworth Press, Inc.

Sadock, B.J. & Sadock, V.A. (2003). *Kaplan & Sadock’s Synopsis of psychiatry.* (9th

ed.). Baltimore: Lippincott Williams & Wilkins.

Spence, T.T., DiNitto, D.M., & Straussner, S.L. (Eds.). (2001). *Neurobiology of addictions: Implications for clinical practice.* New York: The Haworth Press, Inc.

Szuchman, L.T. & Thomlison, B. (2007). *Writing with style: APA style for social*

*work.* Belmont, CA.: Brooks/Cole.

**E. Major Course Assignments & Examinations:**

There are three exams, one paper or IBH training substitute, and class exercises (including some which are videotaped in class and some which are done through online discussion on the BlackBoard site for this course). **Follow the class agenda posted on the BlackBoard site for this course for online class sessions; you must arrange for computer/internet access for these class sessions.** All written assignments are in APA format and submitted in Word through the SafeAssign portal in BlackBoard.

Students will be asked to bring video cameras/phone cameras from home, if available, for social work skills lab exercises, reviewing and practice outside class.

**Major Course Assignments:** Objectives**: #** 1, 2, 3, 4, 5

Examinations.

There will be two closed book Examinations at the end of class during week 4 **(June 30)** and week 10 **(August 11)** and one “open book” examination due by week 11 **(i.e., before start of class on August 9)** in the form of a live diagnostic evaluation. Closed book examinations will be made up of a variety of multiple choice questions from IBH training, reading assignments, and lectures administered via the classroom electronic response system (clickers). The “open book” examination can be done at your convenience before August 9 and will require completion of one diagnostic evaluation (dx. eval.) of a child, adolescent, or young adult at your field placement or at the Center for Clinical Social Work; this examination will be documented by posting in the BlackBoard Discussion Board Diagnosis Forum a scanned copy of the completed age-appropriate structured interview guide and Diagnostic Evaluation Summary. The age-appropriate structured interview guide is posted in BlackBoard for you. If you choose to diagnose a CCSW participant, notify Ms. Silva at the CCSW at 817-272-2165 of your time availability to shadow a CCSW field intern doing a dx eval first and then to schedule you to do one yourself (you will be responsible to enter the progress note for the session; the original hard copy is to be filed in the case file of the participant and placed in the lower right hand drawer of the CCSW Project Office lateral file cabinet).

Writing Assignment.

A discussion essay attesting to completion of integrated behavioral health **(**IBH) treatment protocol (aka PST-PC) and videos (found at http://pstnetwork.ucsf.edu/materials) will before August 9**. The discussion essay attesting to completion of the integrated behavioral health online materials is to be submitted in BlackBoard on the Discussion Board IBH Forum.**

**IBH Essay:** Discuss the main principles of problem-solving therapy in primary care in the context of the integrated behavioral health for children, adolescents, and young adults based on the PST-PC treatment manual and treatment videos (Objectives 1-5). Use the following format:

1. Briefly describe the treatment method of problem-solving therapy including relevant empirical findings related to its use.

2. Describe assessment methodology including assessment measure appropriate for this intervention.

3. Identify methods to evaluate treatment efficacy of this treatment method.

**Grading: The essay will receive a maximum total of 25 points. Grading is on grammar and content. Poor grammar, spelling errors, etc. will lower essay score. Essay must be in your own words, not quoted, and will be around one page long. Use APA style throughout.**

**F. Grading Policy:**

All writing must be grammatically correct using APA style. Papers with many grammatical errors and misspellings will not receive a satisfactory grade.

There will be 3 examinations accounting for 75% of your final grade. Two exams will be closed book and one open book. One required IBH training completion essay will comprise 25% of your grade (25 points). The examination dates and written assignment due dates are noted on the course outline. The grade scale is as follows:

90 - 100 A

80 - 89 B

70 - 79 C

60 - 69 D

0 - 59 F

Examination 1 25 points

Examination 2 25 points

“Open book” exam: Completion of one dx eval 25 points

IBH essay 25 points

Grading Criteria:

1. Demonstrate an ability to integrate course readings, outside research, and lectures into papers and discussions
2. Demonstrate integration of independent and critical thinking into papers, class exercises and discussions
3. Papers are well organized and follow accurate use of grammar, spelling and language
4. Form and style of papers follow APA style.

**G. Make-Up Exam or Assignment Policy**:

Closed book examinations missed due to an excused absence for doctor-documented illness or military service will be made up during the class break of the class following the regularly scheduled exam or asap. The open book exam and essay can be submitted at student convenience at any time during the semester before start of class on August 9; therefore, make-up opportunities will not be necessary or allowed. Since this class is required as a condition of the HRSA stipend, no incompletes will be given for a final grade unless the student is withdrawing from the stipend program; in that case, work must be completed within one month of the end of the semester or the Incomplete will be converted to an F.

**H. Attendance Policy:**

At The University of Texas at Arlington, taking attendance is not required. Rather, each faculty member is free to develop his or her own methods of evaluating students’ academic performance, which includes establishing course-specific policies on attendance. For this course, here is the attendance policy:

It is expected that you attend class and participate in class discussion. Consequently, one missed class is a significant loss of instruction. It is expected that graduate students reschedule conflicting events and make prior arrangements for child care and alternate forms of transportation in the event of car problems/shared cars during scheduled face to face class times. Early and unexcused exits from class, tardiness, or inattention (e.g., using laptop/smart phone other than for recording skills exercises or lectures such as emailing/websurfing, falling asleep) will be counted as absence. The instructor must be notified prior to class if a student expects to be absent. The instructor may grant excused absences in the case of student illness documented with a medical note, attending a funeral due to the death of a first degree relative with documentation, or caring for the a dependent child who is ill with a medical note. Two points will be deducted from the total grade for each unexcused absence. In addition, one point will be deducted each time the student misses part of a class due to unexcused tardiness/partial absence or inattention.

**I. Course Schedule:**

As the instructor for this course, I reserve the right to adjust this schedule in any way that serves the educational needs of the students enrolled in this course. Should technical problems arise with course delivery, alternate but equivalent assignments may be given so long as the overall learning objectives, general time frame and grading structure for the course are sustained.

*Week 1*

**Topic: Introduction & Understanding Tx of Children/Adolescents**

**Readings/Lecture/Assignments:** Review Course Syllabus,

DSM system, Integrated Behavioral Health approach, Assessment Skills, Ethical

Issues, Recording, Neurobiology.

**Read:** PST-PC Manual, Ch, 1, Johnson, Part 1, online

training, structured diagnostic interview guides, and DSM intro

*Week 2: June 14 session is ONLINE BlackBoard*

**Topic: IBH Online Training and Evidence-**

**based Practice with Early Onset Mood Disorders in integrated behavioral**

**health care settings (e.g., primary care).**

**Readings/Lecture/Assignments:**  Literature search techniques,

techniques for evaluating the available evidence on best practices in mental

health; Mood/Anxiety Assessment,

Treatments –Problem Solving Treatment for depression and anxiety.

**Read:** Johnson, Parts 2 & 3, DSM sections on

Mood and Anxiety Disorders

*Week 3*

**Topic: Evaluating Clinical Evidence and Using**

**Practice Guidelines**

**Readings/Lecture/Assignments:**

**Read:** Johnson, Part 4, selected EBP text, continue DSM sections on Neurodevelopmental Disorders, Mood, and Anxiety, continue IBH.

###### Week 4

**Topic: The Assessment Interview and Clinical Interviewing Techniques, Elimination Disorders**

**Readings/Lecture/Assignments:** Practice assessment role plays/videotaping

**Read:** DSM sections and Manual; you should be 1/3 complete on online videos.

**June 30: Examination #1 in class using clickers. Casebook available.**

###### Week 5: July 5 session is ONLINE Blackboard

**Topic: Recovery-oriented mental health for Early Onset Severe and**

**Persistent Mental Illnesses**

**Readings/Lecture/Assignments:** Practice assessment role videotaping

**Read:** Begin Casebook; DSM sections on Psychotic Disorders, continue

Manual/online training. Online session: Use Second Life virtual registration process to “experience” entrance to a mental health agency and sign-in process first hand while experiencing hallucinations (University of California, Davis. Virtual Hallucinations -http://www.ucdmc.ucdavis.edu/ais/virtualhallucinations/); post on Discussion Board how long it took you and what you could do as a social worker to assist an older teen/young adult consumer having this experience, as well as their parent who may be accompanying them.

*Week 6: July 14 session is ONLINE Blackboard*

**Topic: Childhood onset anxiety and mood disorders, continued**.

**Readings/Lecture/Assignments:** Follow online agenda on Assessment and Treatment, Ethics, Racial, Ethnic, and Cultural Issues.

**Read:** Casebook,DSM section on OCD and related, continue Manual

and online training

###### Week 7

**Topic: Conduct Disorder/Oppositional Defiant Disorders, ADHD,**

**Intermittent Explosive Disorder, Substance Use Disorders and Substance**

**Misuse**

**Readings/Lecture/Assignments:** Assessment and Behavioral theory-based

Treatment, Racial, Ethnic, and Cultural Issues, Practice behavioral tx videotaping

**Read:** Casebook, DSM V *Addiction Casebook* (child cases)

<http://www.utarl.eblib.com.ezproxy.uta.edu/patron/SearchResults.aspx?q=DSM>+

casebook&t=quick; DSM section on disruptive disorders and substance use

disorders; you should be at least 2/3 done with online videos and Manual..

*Week 8*

**Topic: Behavioral symptoms and rare disorders (e.g., Gender Dysphoria,**

**Feeding and Eating Disorders, Early Aggressiveness and Violent Behaviors,**

**and Self-injurious Behaviors**

**Readings/Lecture/Assignments:** Behavioral Theory-based Treatment,

Racial, Ethnic, and Cultural Issues, general review of psychopharmacology

**Read:** Casebook, DSM sections on these disorders.

###### Week 9: both sessions are ONLINE Blackboard

**Topic: IBH Online Training and brief**

**intervention strategies**, **stress and trauma disorders.**

**Readings/Lecture/Assignments:** 1).Meet with/interview a peer specialist from an agency listed on the online agenda to find out about their work, their approach, and how to make referrals or attend self-help or peer support group for a relevant issue (e.g., NAMI, Overeaters Anonymous, PFLAG, etc.) and reflect on the experience on the Discussion Board. 2. Select a local agency that focuses on

psychosocial rehabilitation inclusive of youth/young adults. You may not select an agency or program where they are currently interning or where they have previously served as an intern or been employed. From their website, materials, and/or staff phone interview, gather and summarize information, and write a

critique of the agency in terms of the mission, goals, intervention model, and outcome monitoring within the context of the published literature for youth with mental disorders (if possible, focus on a selected diagnosis or diagnostic category to target the brief critique). Follow the rest on the online agenda on single subject design and other outcome measurement approaches for intervention effectiveness

**Read:** Casebook, Johnson, rest of book, DSM section on stress and trauma

Disorders. **Diagnostic evaluation and IBH essay due before 3:30 p.m. on 8/9.**

Week 10

**Topic: Play Therapy, Intervention Outcome Measurement,Intervening with**

**children with special concerns**

**Readings/Lecture/Assignments:**

**Read:** finish child sections of Casebook, finish DSM sections, finish Manual and

online training

**“Open book” Examination documentation and IBH essay**

**due in BlackBoard before class on August 9. August 11: Examination #2 in**

**class** **using clickers**

### Note*: Grades will be posted to the campus MyMav system at course completion and made available on the University Schedule for posting of grades. Grades cannot be given by email or individually by the instructor, per University Policy.*

**J. Expectations for Out-of-Class Study**:

Beyond the time required to attend each class meeting, students enrolled in this course should expect to spend at least an additional three hours (for each hour of class or lecture per week) of their own time in course-related activities, including reading required materials, completing assignments, preparing for assignments and exams, and reviewing online content, etc.

**K. Grade Grievance Policy**:

See BSW/MSW Program Manual.

**L. Student Support Services:**

UT Arlington provides a variety of resources and programs designed to help students develop academic skills, deal with personal situations, and better understand concepts and information related to their courses. Resources include tutoring, major-based learning centers, developmental education, advising and mentoring, personal counseling, and federally funded programs. For individualized referrals, students may visit or contact Ms. Jennifer Malone, Coordinator of the Office of Student Success and Academic Advising located on the third floor of Building a of the School of Social Work Complex. Dr. Chris Kilgore serves as a writing coach and resource as well and has posted an online writing clinic. Also, the Maverick Resource Hotline may be contacted at 817-272-6107, or send a message to [resources@uta.edu](mailto:resources@uta.edu), or view the information at [www.uta.edu/resources](http://www.uta.edu/resources).

**M. Librarian to Contact:**

The Social Sciences/Social Work Resource Librarian is John Dillard. His office is in the campus Central Library. He may also be contacted via E-mail: [dillard@uta.edu](mailto:dillard@uta.edu) or by Cell phone: **(817) 675-8962, b**elow are some commonly used resources needed by students in online or technology supported courses:

<http://www.uta.edu/library/services/distance.php>

The following is a list, with links, of commonly used library resources:

Library Home Page <http://www.uta.edu/library>

Subject Guides <http://libguides.uta.edu>

Subject Librarians <http://www-test.uta.edu/library/help/subject-librarians.php>

Database List <http://www-test.uta.edu/library/databases/index.php>

Course Reserves <http://pulse.uta.edu/vwebv/enterCourseReserve.do>

Library Catalog <http://discover.uta.edu/>

E-Journals <http://utalink.uta.edu:9003/UTAlink/az>

Library Tutorials <http://www.uta.edu/library/help/tutorials.php>

Connecting from Off- Campus <http://libguides.uta.edu/offcampus>

Ask a Librarian <http://ask.uta.edu>

**N. Emergency Exit Procedures:**

Should we experience an emergency event that requires us to vacate the building, students should exit the room and move toward the nearest exits, which are the stairwells located at either end of the adjacent hallway. When exiting the building during an emergency, one should never take an elevator but should use the stairwells. Faculty members and instructional staff will assist students in selecting the safest route for evacuation and will make arrangements to assist handicapped individuals.

**O. Drop Policy:**

Students may drop or swap (adding and dropping a class concurrently) classes through self-service in MyMav from the beginning of the registration period through the late registration period. After the late registration period, students must see their academic advisor to drop a class or withdraw. Undeclared students must see an advisor in the University Advising Center. Drops can continue through a point two-thirds of the way through the term or session. It is the student's responsibility to officially withdraw if they do not plan to attend after registering. **Students will not be automatically dropped for non-attendance**. Repayment of certain types of financial aid administered through the University may be required as the result of dropping classes or withdrawing. For more information, contact the Office of Financial Aid and Scholarships

(<http://wweb.uta.edu/aao/fao/>).

**P. Americans with Disabilities Act:**

The University of Texas at Arlington is on record as being committed to both the spirit and letter of all federal equal opportunity legislation, including the *Americans with Disabilities Act (ADA)*. All instructors at UT Arlington are required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Any student requiring an accommodation for this course must provide the instructor with official documentation in the form of a letter certified by the staff in the Office for Students with Disabilities, University Hall 102. Only those students who have officially documented a need for an accommodation will have their request honored. Information regarding diagnostic criteria and policies for obtaining disability-based academic accommodations can be found at [www.uta.edu/disability](http://www.uta.edu/disability) or by calling the Office for Students with Disabilities at (817) 272-3364.

**Q. Title IX:**

The University of Texas at Arlington is committed to upholding U.S. Federal Law “Title IX” such that no member of the UT Arlington community shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity. For more information, visit [www.uta.edu/titleIX](http://www.uta.edu/titleIX).

**R. Academic Integrity:**

Students enrolled all UT Arlington courses are expected to adhere to the UT Arlington Honor Code:

*I pledge, on my honor, to uphold UT Arlington’s tradition of academic integrity, a tradition that values hard work and honest effort in the pursuit of academic excellence. I promise that I will submit only work that I personally create or contribute to group collaborations, and I will appropriately reference any work from other sources. I will follow the highest standards of integrity and uphold the spirit of the Honor Code.*

UT Arlington faculty members may employ the Honor Code as they see fit in their courses, including (but not limited to) having students acknowledge the honor code as part of an examination or requiring students to incorporate the honor code into any work submitted. Per UT System *Regents’ Rule* 50101, §2.2, suspected violations of university’s standards for academic integrity (including the Honor Code) will be referred to the Office of Student Conduct. Violators will be disciplined in accordance with University policy, which may result in the student’s suspension or expulsion from the University.

**S. Electronic Communication:**

UT Arlington has adopted MavMail as its official means to communicate with students about important deadlines and events, as well as to transact university-related business regarding financial aid, tuition, grades, graduation, etc. All students are assigned a MavMail account and are responsible for checking the inbox regularly. There is no additional charge to students for using this account, which remains active even after graduation. Information about activating and using MavMail is available at <http://www.uta.edu/oit/cs/email/mavmail.php>.

**T. Student Feedback Survey:**

At the end of each term, students enrolled in classes categorized as “lecture,” “seminar,” or “laboratory” shall be directed to complete an online Student Feedback Survey (SFS). Instructions on how to access the SFS for this course will be sent directly to each student through MavMail approximately 10 days before the end of the term. Each student’s feedback enters the SFS database anonymously and is aggregated with that of other students enrolled in the course. UT Arlington’s effort to solicit, gather, tabulate, and publish student feedback is required by state law; students are strongly urged to participate. For more information, visit <http://www.uta.edu/sfs>.

**U. Final Review Week**:

This ONLY applies to courses administering a major or final examination scheduled in the week and locations designated for final examinations following last classes. A period of five class days prior to the first day of final examinations in the long sessions shall be designated as Final Review Week. The purpose of this week is to allow students sufficient time to prepare for final examinations. During this week, there shall be no scheduled activities such as required field trips or performances; and no instructor shall assign any themes, research problems or exercises of similar scope that have a completion date during or following this week *unless specified in the class syllabus*. During Final Review Week, an instructor shall not give any examinations constituting 10% or more of the final grade, except makeup tests and laboratory examinations. In addition, no instructor shall give any portion of the final examination during Final Review Week. During this week, classes are held as scheduled. In addition, instructors are not required to limit content to topics that have been previously covered; they may introduce new concepts as appropriate.

**V. School of Social Work - Definition of Evidence-Informed Practice:**

Evidence-informed practice (EIP) is a guiding principal for the UTA-SSW. This approach is guided by the philosophy espoused by Gambrill (2006) and others who discuss evidence-based practice (EBP). Though many definitions of EIP/EBP saturate the literature, we offer two definitions that most closely define our understanding of the concept and serve to explicate our vision of EIP for the UTA-SSW:

The use of the best available scientific knowledge derived from randomized, controlled outcome studies, and meta-analyses of existing outcome studies, as one basis for guiding professional interventions and effective therapies, combined with professional ethical standards, clinical judgment, and practice wisdom (Barker, 2003, p. 149). ...the integration of the best research evidence with our clinical expertise and our patient’s unique values and circumstances (Strauss, et al., 2005).

The University of Texas at Arlington School of Social Work vision statement states that the “School’s vision is to promote social and economic justice in a diverse Environment.”  Empowerment connects with the vision statement because, as Rees (1991) has pointed out, the very objective of empowerment is social justice.  Empowerment is a seminal vehicle by which social justice can be realized.  It could well be argued that true social justice cannot be realized without empowerment. Empowerment, anchored with a generalist base, directs social workers to address root causes at all levels and in all contexts, not simply “symptoms”.  This is not a static process but an ongoing, dynamic process, a process leading to a greater degree of social justice and equality.

University of Texas at Arlington-School of Social Work: Definition of Empowerment

Empowerment is defined by Barker (2003:142) as follows: In social work practice, the process of helping individuals, families, groups, and communities increase their personal, interpersonal, socioeconomic, and political strength and develop influence toward improving their circumstances.

*Note: Please also consider conserving paper by formatting and two-sided printing of syllabi with ½ inch margins. Please help our fragile environment by recycling all paper when finished, as well as plastic bottles, cans, etc., in the many recycling stations available in the Social Work Complex. Thank you.*

**Mental Health Recovery Bibliography**

Patrick Sullivan, Ph.D.

Indiana University School of Social Work

*The following bibliography was developed by Patrick Sullivan with some additions made by*

*Council on Social Work Education (CSWE) staff. The bibliography is separated into subsections*

*for different topics within mental health recovery. The sub-sections and starting page*

*number are outlined below. For additional resources on mental health recovery, visit the CSWE*

*website (www.cswe.org).*

*Bibliography Sub-sections*

- *Case management/Assertive Community Treatment 1*

- *Consumer Initiatives/ Self-Help 3*

- *Cultural Responsiveness and Diverse Populations 4*

- *Dual-Diagnosis 5*

- *Family Issues 6*

- *First-Person Accounts 7*

- *Future Directions/ Legal Issues 8*

- *Historical Context of Mental Health Services 10*

- *Housing Issues and Programs 10*

- *Mental Health Programs and Program Design 11*

- *Phenomenology of Severe Mental Illness 12*

- *Policy Issues 14*

- *Prognosis and Course of Severe Mental Illness 15*

- *Recreation and Leisure: Issues and Programs 16*

- *Supported Education 16*

- *Vocational Issues and Programs 17*

**Case Management/ Assertive Community Treatment**

Austin C. (1990). Case management: Myths and realities. *Families in Society, 71*(7), 398-405.

Austin, C. (1993). Case management: A systems perspective. *Families in Society, 74*(8), 451-

458.

Barry, K. L., Zeber, J., Blow, F., & Valenstein, M. (2003). Effect of strengths model versus

assertive community treatment model on participant outcomes and utilization: Two-year

follow-up. *Psychiatric Rehabilitation Journal, 26*(3), 268-277.

Mental Health Recovery Bibliography 2

Boyer, S., & Bond, G. (1999). Does assertive treatment reduce burnout? A comparison with

traditional case management. *Mental Health Services Research, 1*, 31-45.

Coffey, D. (2003). Connection and autonomy in the case management relationship. *Psychiatric*

*Rehabilitation Journal, 26*(4), 404-412.

Corrigan, P., McCraken, S., & Holmes, E. (2001). Motivational interviews as goal assessment

for persons with psychiatric disability. *Community Mental Health Journal, 37*(2), 113-122.

Cusak, K., Frueh, C., & Brady, K. (2004). Trauma history screening in a community mental

health center. *Psychiatric Services, 55*(2), 157-162.

Essock, S. M., Mueser, K. T., Drake, R. E., Covell, N. H., McHugo, G. J., Frisman, L. K., et al.

(2006). Comparison of ACT with standard case management for delivering integrated

treatment for co-occurring disorders. *Psychiatric Services, 57*(2), 185-196.

Greenley, J. R. (1995). Creation and implementation of the Program for Assertive Community

Treatment (PACT). In R. Schultz & J. R. Greenly (Eds.), *Innovating in community mental*

*health: International perspective* (pp. 83-96). Westport, CT: Praeger.

Marty, D., Rapp, C., & Carlson, L. (2001). The experts speak: The critical ingredients of

strengths model case management. *Psychiatric Rehabilitation Journal, 24*(3), 214-221.

McGrew, J., Pescosolido, B., & Wright, E. (2003). Case managers’ perspectives on critical

ingredients of assertive community treatment and on its implementation. *Psychiatric*

*Services, 54*(3), 370-376.

Miller, W., & Rollnick. S. (1991). *Teaching motivational interviewing.* New York, NY: Guilford

Press.

Moore, S. (1990). A social work practice model of case management: The case management

grid. *Social Work, 35*(8), 444-448.

Moore, S. (1992). Case management and the integration of services: How service delivery

systems shape case management. *Social Work, 37*(5), 418-423.

Raiff, N., & Shore, B. (1993). *Advanced case management: New strategies for the nineties.*

Newbury Park, CA: Sage.

Rapp, C. (1992). The strengths perspective of case management with persons suffering from

severe mental illness. In D. Saleebey (Ed.), *The strengths perspective in social work*

(pp. 45-58). New York, NY: Longman.

Rapp, C., & Chamberlain, R. (1989). The strengths model of case management: Results from

twelve demonstrations. *Psychosocial Rehabilitation Journal, 13*(1), 23-32.

Rapp, C., & Goscha, R. (2004). The principles of effective case management of mental health

services. *Psychiatric Rehabilitation Journal, 27*(4), 319-333.

Mental Health Recovery Bibliography 3

Rapp, C., & Goscha, R. (2012). *The Strengths Model* (3rd ed.)*.* New York, NY: Oxford University

Press.

Rapp, C., Saleebey, D., & Sullivan, W. P. (2005). The future of strengths-based social work.

*Advances in Social Work, 6*, 79-90.

Rose, S. (1992). Case management: An advocacy / empowerment design. In S. Rose (Ed.),

*Case management and social work practice* (pp. 271-297). New York, NY: Longman.

Rothman, J. (1994). *Practice with highly vulnerable clients*. Englewood Cliffs, NJ: Prentice Hall.

Salyers, M., Masterson, T., Kekete, D., Picone, J., & Bond, G. (1998). Transferring clients from

intensive case management: Impact on client functioning. *American Journal of*

*Orthopsychiatry, 68*, 233-245.

Samele, C., Gilvarry, C., Walsh, E., Manley, C., van Os, J., & Murray, R. (2002). Patients’

perceptions of intensive case management. *Psychiatric Services, 53*(11), 1432-1437.

Sullivan, W. P., Hasler, M. D., & Otis, A. (1993). Rural mental health practice: Voices from the

field. *Families in Society, 74*(8), 493-502.

Wolk, J., Sullivan, W. P., & Hartmann, D. (1994). The managerial nature of case management.

*Social Work, 39*(2), 152-159.

**Consumer Initiatives/ Self-Help**

Carlson, L. S., Rapp, C., & McDiarmid, D. (2001). Hiring consumer-providers: Barriers and

alternative solutions. *Community Mental Health Journal, 37*(3), 199-213.

Chamberlain, J. (1978). *On our own.* New York, NY: Hawthorne Books Inc.

Fisher, D. (1994). New vision of healing: A reasonable accommodation for consumer/survivors

working as mental health providers. *Psychosocial Rehabilitation Journal, 17*(3), 67-81.

Fisk, D., Rowe, M., Brooks, R., & Gildersleeve, D. (2000). Integrating consumer staff members

into a homeless outreach project: Critical issues and strategies. *Psychiatric*

*Rehabilitation Journal, 23*(3), 244-252.

Freund, P. (1993). Professional role(s) in the empowerment process: Working with mental

health consumers. *Psychosocial Rehabilitation Journal, 16*(3), 65-73.

Hodges, J., Hardiman, E., & Segal, S. (2003). Predictors of hope among members of mental

health self-help agencies. *Social Work in Mental Health, 2*(1), 1-16.

Kaufmann, C., Freund, P., & Wilson, J. (1989). Self-help in the mental health system: A model

for consumer-provider collaboration. *Psychosocial Rehabilitation Journal, 13*(1), 5-21.

Mental Health Recovery Bibliography 4

Linhorst, D., Eckert, A., Hamilton, G., & Young, G. (2001). The involvement of a consumer

council in organizational decision-making in a public psychiatric hospital. *The Journal of*

*Behavioral Health Services & Research, 28*(4), 427-438.

Moxley, D., & Freddolino, P. (1990). A model of advocacy for promoting client self-determination

in psychosocial rehabilitation. *Psychosocial Rehabilitation Journal, 14*(2), 69-82.

Paulson, R. (1991). Professional training for consumers and family members: One road to

empowerment. *Psychosocial Rehabilitation Journal, 15*(3), 69-80.

Petr, C., Holtquist, S., & Martin, J. (2000). Consumer-run organizations for youth. *Psychiatric*

*Rehabilitation Journal, 24*(2), 142-148.

Propst, R. (1992). Standards for clubhouse programs: Why and how they were developed.

*Psychosocial Rehabilitation Journal. 16*(2), 25-30.

Rappaport, J., Reischl, T., & Zimmerman, M. (1992). Mutual help mechanisms in the

empowerment of former mental patients. In D. Saleebey (Ed.), *The strengths*

*perspective in social work* (pp. 84-97). New York, NY: Longman.

Rivera, J., Sullivan, A., & Valenti, A. (2007). Adding consumer-providers to intensive case

management: Does it improve outcome? *Psychiatric Services, 58*(6), 802-809.

Salzer, M., & Shear, S. (2002). Identifying consumer-provider benefits in evaluations of

consumer-delivered services. *Psychiatric Rehabilitation Journal, 25*(3), 281-288.

Segal, S., & Silverman, C. (2002). Determinants of client outcomes in self-help agencies.

*Psychiatric Services, 53*(3), 304-309.

Solomon, P. (2004). Peer support/peer provided services: Underlying processes, benefits, &

critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.

Solomon, P., & Draine, J. (2001). The state of knowledge of the effectiveness of consumer

provided services. *Psychiatric Rehabilitation Journal, 25*(1), 20-27.

Tomes, N. (2006). The patient as a policy factor: A historical case study of the

consumer/survivor movement in mental health. *Health Affairs, 25*(3), 720-729.

Tower, K. (1994). Consumer-centered social work practice: Restoring client self-determination.

*Social Work, 39*(2), 191-196.

**Cultural Responsiveness and Diverse Populations**

Alverson, H., Drake, R., Carpenter-Song, E., Chu, E., Ritsema, M., & Smith, B. (2007).

Ethnocultural variations in mental illness discourse: Some implications for building

therapeutic alliances. *Psychiatric Services, 58*(12), 1541-1546.

Anglin, D., Link. B., & Phelan, J. (2006). Racial differences in stigmatizing attitudes toward

Mental Health Recovery Bibliography 5

people with mental illness. *Psychiatric Services, 57*(6), 857-862.

Bernstein, M., & Rose, D. (1991). Psychosocial programming for the elderly who are mentally ill.

*Psychosocial Rehabilitation Journal, 14*(3), 3-13.

Buckles, B., Brewer, E., Kerecman, J., Mildred, L., Ellis, A., & Ryan, J. (2008). Beyond stigma

and discrimination: Challenges for a social work practice in psychiatric rehabilitation and

recovery. *Journal of Social Work in Disability and Rehabilitation, 7*(3/4), 232-283.

Cook, B., McGuire, T., & Mirianda, J. (2007). Measuring trends in mental health care disparities,

2000-2004. *Psychiatric Services, 58*(12), 1533-1540.

Dallaire, B. (2009). Representations of elderly with mental health problems held by psychosocial

practitioners from community and institutional settings. *Social Work in Mental Health,*

*7*(1), 139-152.

Fearday, F., & Cape, A. (2004). A voice for traumatized women: Inclusion and mutual support.

*Psychiatric Rehabilitation Journal, 27*(3), 258-265.

Guarnaccia, P., Parra, P., Deschamps, A., Milstein, G., & Argiles, N. (1992). Si dios quiere:

Hispanic families’ experiences of caring for a seriously mentally ill family member.

*Culture, Medicine, & Psychiatry, 16*(2), 187-215.

Johnson, D., & Zoltnick, C. (2007). Utilization of mental health treatment and other services by

battered women in shelters. *Psychiatric Services, 58*(12), 1595-1597.

Mueser, K., & Taub, J. (2008). Trauma and PTSD among adolescents with severe emotional

disorders involved in multiple service systems. *Psychiatric Services, 59*(6), 627-634.

Nadeem, E., Lange, J., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma

keep poor young immigrant and U.S.-born Black and Latina women from seeking mental

health care? *Psychiatric Services, 58*(12), 1547-1554.

Whitley, R. (2007). Cultural competence, evidence-based medicine, and evidence-based

practices. *Psychiatric Services, 58*(12), 1588-1590.

**Dual-Diagnosis (Alcohol/Drug Abuse and Mental Illness)**

Burnam, M. A., & Watkins, K. (2006). Substance abuse with mental disorders: Specialized

public systems and integrated care. *Health Affairs, 25*(3), 648-658.

Carroll, K., & Rounsaville, B. (2003). Bridging the gap: A hybrid model to link efficacy and

effectiveness research in substance abuse treatment. *Psychiatric Services, 54*(3), 333-

339.

Clark, R., Samnaliev, M., & McGovern, M. (2007). Treatment for co-occurring mental and

substance use disorders in five State Medicaid programs. *Psychiatric Services, 58*(7),

942-948.

Mental Health Recovery Bibliography 6

Committee on Addictions of the Group for the Advancement of Psychiatry. (2002).

Responsibility and choice in addiction. *Psychiatric Services, 53*(6), 707-713.

Drake, R., Mueser, K., Burnette, M., McHugo, G. (2004). A review of treatments for people with

severe mental illnesses and co-occurring substance use disorders. *Psychiatric*

*Rehabilitation Journal, 27*(4), 360-374.

Fisher, W., Wolff, N., Grudzinskas, A. J., Jr., Roy-Bujnowski, K., Banks, S., & Clayfield, J.

(2007). Drug-related arrests in a cohort of public mental health service recipients.

*Psychiatric Services, 58*(11), 1448-1453.

Gagne, C., White, W., Anthony, W. (2007). Recovery: A common vision for the fields of mental

health and addictions. *Psychiatric Rehabilitation Journal, 31*(1), 32-36.

Gonzalez, G., & Rosenbeck, R. (2002). Outcomes and service use among homeless persons

with serious mental illness and substance abuse. *Psychiatric Services, 53*(4), 437-446.

Min, S. Y., Whitecraft, J., Rothbard, A., & Salzer, M. (2007). Peer support for persons with cooccurring

disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation*

*Journal, 30*(3), 207-213.

Ray, G. T., Weisner, C., & Mertens, J. (2005). Relationship between the use of psychiatric

services and five-year alcohol and drug treatment outcomes. *Psychiatric Services, 56*(2),

172-178.

Sullivan, W. P., & Mallony, P. (1992). Substance abuse and mental illness: Social work practice

with dual diagnosis clients. *Arete, 17*(2), 1-15.

Sullivan, W. P., Wolk, J., & Hartmann, D. (1992). Case management in alcohol and drug

treatment. *Families in Society, 73*(4), 195-203.

Wu, L. T., Ringwalt, C., & Williams, C. (2003). Use of substance abuse treatment services by

persons with mental health and substance abuse problems. *Psychiatric Services, 54*(3),

363-369.

Zweben, J., & Smith, D. (1989). Considerations in using psychotropic medication with dual

diagnosis patients in recovery. *Journal of Psychoactive Drugs, 21*(2), 221-228.

**Family Issues**

Cooring, D. (2002). Quality of life: Perspectives of people with mental illness and family

members. *Psychiatric Rehabilitation Journal, 25*(4), 350-358.

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Faloon, I., et al. (2001).

Evidence-based practices for services to families of people with psychiatric disabilities.

*Psychiatric Services, 52*(7), 903-910.

Fischer, E., Shumway, M., & Owen, R. (2002). Priorities of consumers, providers, and family

members in the treatment of schizophrenia. *Psychiatric Services, 53*(6), 724-729.

Mental Health Recovery Bibliography 7

Friedrich, R., Lively, S., & Rubenstein, L. (2008). Siblings’ coping strategies and mental health

services: A national study of siblings of persons with schizophrenia. *Psychiatric*

*Services, 59*(3), 261-267.

Gerace, L., Camilleri, D., & Ayeres, L. (1993). Sibling perspectives on schizophrenia and the

family. *Schizophrenia Bulletin, 19*(3), 637-647.

Goldman, C., Breen, R., Tichenor, M., Goldman, L., Bruner, T., & Hicks, P. (1993). Providing

respite for families of seriously mentally ill adults and training for mental health

professionals: A collaborative model. *Innovations and Research, 2*(4), 19-25.

Greenburg, J., Greenley, J., & Benedict, P. (1994). Contributions of persons with serious mental

illnesses to their families. *Hospital & Community Psychiatry, 45*(5), 475-480.

Hatfield, A. (1987). Families as caregivers: A historical perspective. In A. Hatfield & H. Lefley

(Eds.), *Families of the Mentally Ill* (pp. 3-30). New York, NY: Gilford Press.

Landeen, J., Whelton, C., Dermer, S., Cardamone, J., Munroe-Blum, H., & Thornton, J. (1992).

Needs of well siblings of persons with schizophrenia. *Hospital and Community*

*Psychiatry, 43*(3), 266-269.

Lefley, H. (1992). Expressed emotion: Conceptual, clinical, and social policy issues. *Hospital*

*and Community Psychiatry, 43*(6), 591-598.

Pickett-Schenk, S. A., Lippincott, R. C., Bennett, C., & Steigman, P. J. (2008). Improving

knowledge about mental illness through family-led education: The journey of hope.

*Psychiatric Services, 59*(1), 49-56.

Spaniol, L., Zipple, A., & Fitzgerald, S. (1984). How professionals can share power with families:

Practical approaches to working with families of the mentally ill. *Psychosocial*

*Rehabilitation Journal, 8*(2), 77-84.

Spaniol, L. Zipple, A., & Lockwood, D. (1993). The rise of the family in psychiatric rehabilitation.

*Innovations and Research, 2*(4), 27-33.

Stawar, T. (1992). Learning styles of adults with severe psychiatric disability: Implications for

psychoeducational programming. *Psychosocial Rehabilitation Journal, 15*(4), 69-76.

Styron, T., Pruett, M., McMahon, T., & Davidson, L. (2002). Fathers with serious mental illness:

A neglected group. *Psychiatric Rehabilitation Journal, 25*(3), 215-222.

**First-Person Accounts**

Burroughs, A. (2003). *Running with scissors: A memoir.* New York, NY: Picador.

Chamberlin, J. (2011). Confessions of a non-compliant patient. Lawrence, MA: National

Empowerment Center, Inc. Retrieved from

http://www.power2u.org/articles/recovery/confessions.html

Mental Health Recovery Bibliography 8

Cronkite, K., (1995). *On the edge of darkness: America’s most celebrated actors, journalists and*

*politicians chronicle their most arduous journey.* New York, NY: Dell Publishing.

Danquah, M. (1998). *Willow weep for me: A black woman’s journey through depression.* New

York, NY: The Ballantine Publishing Group.

Jamison, K. R. (1997). *An unquiet mind: A memoir of moods and madness.* New York, NY:

Vintage Books.

Lovelace, D. (2008). *Scattershot: My bipolar family.* New York, NY: Dutton.

Saks, E. R. (2007). *The center cannot hold: My journey through madness.* New York, NY:

Hyperion.

Thompson, T. (1996). *The beast: A journey through depression*. New York, NY: The Penguin

Group.

**Future Directions/ Legal Issues**

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health

system in the 1990's. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Donat, D. (2003). An analysis of successful efforts to reduce the use of seclusion and restraint

at a public psychiatric hospital. *Psychiatric Services, 54*(8), 1119-1124.

Draine, J., & Herman, D. (2007). Critical time intervention for reentry from prison for persons

with mental illness. *Psychiatric Services, 58*(12), 1577-1581.

Draine, J., Solomon, P., & Meyerson, A. (1994). Predictors of reincarceration among patients

who received psychiatric services in jail. *Hospital and Community Psychiatry, 45*(2), 163-

170.

Garret, B., & Posey. T. (1993). Community forensic initiatives in New York State. *Innovations &*

*Research, 2*(1), 39-41.

Hatfield, A. (1993). On being committed to treatment in the community. *Innovations & Research,*

*2*(1), 43-46.

Herr, S., Arons, S., & Wallace, R. (1983). *Legal rights and mental health care.* Lexington, MA:

Lexington Books.

Jordan, B. K., Federman, B., Burns, B., Schlenger, W., Fairbank, J., & Caddell, J. (2002).

Lifetime use of mental health and substance abuse treatment services by incarcerated

women felons. *Psychiatric Services, 53*(3), 317-325.

Kapp, M. (1994). Treatment and refusal rights in mental health: Therapeutic justice and clinical

accommodation. *American Journal of Orthopsychiatry, 64*(2), 223-234.

Lamb, R., Weinberger, L., Marsh, J., & Gross, B. (2007). Treatment prospects for persons with

severe mental illness in an urban country jail. *Psychiatric Services, 58*(6), 782-786.

Mental Health Recovery Bibliography 9

Lamberti, J. S. (2007). Understanding and preventing criminal recidivism among adults with

psychotic disorders. *Psychiatric Services, 58*(6), 773-781.

Lin, C. Y. (2003). Ethical exploration of the least restrictive alternative. *Psychiatric Services,*

*54*(6), 866-870.

Mechanic, D., & Bildner, S. (2004). Treating people with mental illness: A decade-long

perspective. *Health Affairs, 23*(4), 84-95.

Monahan, J., Bonnie, R. J., Appelbaum, P. S., Hyde, P. S., Steadman, H. J., & Swartz, M. S.

(2001). Mandated community treatment: Beyond outpatient commitment. *Psychiatric*

*Services, 52*(9), 1198-1205.

Monahan, J., & Shah, S. (1989). Dangerousness and commitment of the mentally disordered in

the United States. *Schizophrenia Bulletin, 15*(4), 541-553.

Morabito, M. (2007). Horizons of context: Understanding the police decision to arrest people

with mental illness. *Psychiatric Services, 58*(12), 1582-1587.

Mulvey, E. (1994). Assessing the evidence of a link between mental illness and violence.

*Hospital and Community Psychiatry, 45*(7), 663-668.

Perlin, M. (1993). Law and the delivery of mental health services in the community. *American*

*Journal of Orthopsychiatry, 64*(2), 194-208.

Petrila, J., & Ayers, K. (1994). Mental health law and mental health care: Introduction. *American*

*Journal of Orthopsychiatry, 64*(2), 172-179.

Roe, D., Weishut, D., Jaglom, M., & Rabinowitz, J. (2002). Patients’ and staff members’

attitudes about the rights of hospitalized psychiatric patients. *Psychiatric Services, 53*(1),

87-91.

Sales, B., & Shumna, D. (1994). Mental health law and mental health care: Introduction.

*American Journal of Orthopsychiatry, 64*(2), 172-179.

Scheid-Cook, T. (1991). Outpatient commitment as both social control and least restrictive

alternative. *The Sociological Quarterly, 32*(1), 43-60.

Scheyett, A., Kim, M., Swanson, J., & Swartz, M. (2007). Psychiatric advance directives: A tool

for consumer empowerment and recovery. *Psychiatric Rehabilitation Journal, 31*(1), 70-

75.

Slobogin, C. (1994). Involuntary community treatment of people who are violent and mentally ill:

A legal analysis. *Hospital and Community Psychiatry, 45*(7), 685-689.

Smith, S. (1994). Liability and mental health services. *American Journal of Orthopsychiatry,*

*64*(2), 235-251.

Smith-Bell, M., & Winslade, W. (1994). Privacy, confidentiality, and privilege in

psychotherapeutic relationships. *American Journal of Orthopsychiatry, 64*(2), 180-193.

Mental Health Recovery Bibliography 10

Solomon, P., Draine, J., & Meyerson, A. (1994). Jail recidivism and receipt of community mental

health services. *Hospital and Community Psychiatry, 45*(80), 793-797.

Srebnik, D., & Russo, J. (2007). Consistency of psychiatric care with advance directive

instructions. *Psychiatric Services, 58*(9), 1157-1163.

Sullivan, W. P., & Carpenter, J. (2010). Community-based mental health services: Is coercion

necessary? *Journal of Social Work in Disability and Rehabilitation, 9*, 148-167.

Theriot, M., & Segal, S. (2005). Involvement with the criminal justice system among new clients

at outpatient mental health agencies. *Psychiatric Services, 56*(2), 179-185.

Watson, A., & Angell, B. (2007). Applying procedural justice theory to law enforcement’s

response to persons with mental illness. *Psychiatric Services, 58*(6), 787-793.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the

complex issue of mentally ill offenders. *Psychiatric Services, 52*(4), 477-481

Wilder, C., Elbogen, E., Swartz, M., Swanson, J., & Van Dorn, R. (2007). Effect of patients’

reasons for refusing treatment on implementing psychiatric advance directives.

*Psychiatric Services, 58*(10), 1348-1350.

Wintersteen, R. (1986). Rehabilitating the chronically mentally ill: Social work’s claim to

leadership. *Social Work, 31*(5), 332-337.

**Historical Context of Mental Health Services**

Mechanic, D., & Rochefort, D. A. (1992). A policy of inclusion for the mentally ill. *Health Affairs,*

*11*(1), 128-150.

Sullivan, W. P. (1992). Reclaiming the community: The strengths perspective and

deinstitutionalization. *Social Work, 37*(3), 204-209.

**Housing Issues and Programs**

Carling, P. (1993). Housing and supports for persons with mental illness: Emerging approaches

to research and practice. *Hospital and Community Psychiatry, 44*(5), 439-449.

Deegan, P. (1992). The independent living movement and people with psychiatric disabilities:

Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*(3), 3-19.

Kloos, B., Zimmerman, S., Scrimenti, K., & Crusto, C. (2002). Landlords as partners for

promoting success in supported housing: “It takes more than a lease and a key”.

*Psychiatric Rehabilitation Journal, 25*(3), 235-244.

Knisely, M., & Fleming, M. (1993). Implementing supported housing in state and local mental

health systems, *Hospital and Community Psychiatry, 44*(5), 456-461.

O’Hara, A. (2007). Housing for people with mental illness: Update of a report to the President’s

New Freedom Commission. *Psychiatric Services, 58*(7), 907-913.

Mental Health Recovery Bibliography 11

Ridgway, P., & Zipple, A. (1990). The paradigm shift in residential services: From the continuum

to supported housing approaches. *Psychosocial Rehabilitation Journal, 13*(4), 11-31.

Rog, D. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal, 27*(4),

334-344.

Segal, S., & Liese, L. (1991). A ten-year perspective on three models of sheltered care. *Hospital*

*and Community Psychiatry, 42*(11), 1120-1124.

Stroul, B. (1988). Residential crisis services: A review. *Hospital and Community Psychiatry, 39*,

1095-1099.

Tice, C., & Shealy, M. (1992). Supported employment in a rural environment. *Human Services*

*in the Rural Environment, 16*(1), 11-14.

**Mental Health Programs and Program Design**

Bond, G., Salyers, M., Rollins, A., Rapp, C., & Zipple, A. (2004). How evidence-based practices

contribute to community integration. *Community Mental Health Journal, 40*(6), 569-588.

Clossey, L., & Rowlett, A. (2008). Effective organizational transformation in psychiatric

rehabilitation and recovery. *Journal of Social Work in Disability and Rehabilitation, 7*(3),

315-339.

Cnaan, R., Blankertz, L., Messinger, K., & Gardner, J. (1990). Expert’s assessment of

psychosocial rehabilitation principles. *Psychosocial Rehabilitation Journal, 13*(3), 59-73.

Corrigan, P. (2003). Towards an integrated, structural model of psychiatric rehabilitation.

*Psychiatric Rehabilitation Journal, 26*(4), 346-358.

Hardiman, E., & Hodges, J. (2008). Professional differences in attitudes toward and utilization of

psychiatric recovery. *Families in Society, 89*(2), 220-227.

Ragins, M. (n.d). Knowing a recovery culture when you see one: A guide for recovery-oriented

leaders. The Village Integrated Service Agency. Retrieved from http://www.villageisa.

org/Ragin's%20Papers/knowing\_a\_recovery\_culture\_when.htm

Solomon, P., & Stanhope, V. (2004). Recovery: Expanding the vision of evidence-based

practice. *Brief Treatment and Crisis Intervention, 4*(4), 311-321.

Starnino, V. (2009). An integral approach to mental health recovery: Implications for social work.

*Journal of Human Behavior in the Social Environment, 19*(7), 820-842.

Stromwall, L., & Hurdle, D. (2003). Psychiatric rehabilitation: An empowerment-based approach

to mental health services. *Health and Social Work, 28*(3), 206-213.

Sullivan, W. P. (1989). Developing community support programs in rural areas. *Human Services*

*in the Rural Environment, 12*(4), 19-24.

Mental Health Recovery Bibliography 12

Sullivan, W. P., Hasler, M. D., & Otis, A. (1993). Rural mental health practice: Voices from the

field. *Families in Society, 74*(8), 493-502.

Taylor, B., & Taylor, A. (1993). Wayfinding training for the severely mentally ill. *Families in*

*Society, 74*(7), 434-440.

Torrey, W., Rapp, C., Van Tosh, L., McNabb, C., & Ralph, R. (2005). Recovery principles and

evidence-based practice: Essential ingredients of service improvement. *Community*

*Mental Health Journal, 41*(1), 91-100.

Weiden, P., & Havens, L. (1994). Psychotherapeutic management techniques in the treatment

of outpatients with schizophrenia. *Hospital and Community Psychiatry, 45*(6), 549-555.

Wofensberger, W. (1972). *The principle of normalization in human services.* Toronto: National

Institute on Mental Retardation.

Young, J., Griffith, E., & Williams, D. (2003). The integral role of pastoral counseling by African-

American clergy in community mental health. *Psychiatric Service, 54*(5), 688-692.

Zipple, A., Selden, D., Spaniol, L., & Bycoff, S. (1993). Leading for the future: Essential

characteristics of successful psychosocial rehabilitation program managers.

*Psychosocial Rehabilitation Journal, 16*(4), 85-94.

**Phenomenology of Severe Mental Illness**

Amador, X., Strauss, D., Yale, S., & Gorman, J. (1991). Awareness of illness in schizophrenia.

*Schizophrenia Bulletin, 17*(1), 113-132.

Blanch, A., & Russinnova, Z. (2008). Special issue on spirituality and recovery. *Psychiatric*

*Rehabilitation Journal, 30*(4).

Bovet, P., & Parnas, J. (1993). Schizophrenic delusions: A phenomenological approach.

*Schizophrenia Bulletin, 19*(3), 57-597.

Brekke, J., Levin, S., Wolkon, G., Sobel, E., & Slade, E. (1993). Psychosocial functioning and

subjective experience in schizophrenia. *Schizophrenia Bulletin, 19*(3), 509-608.

Corin, E., & Lauzon, G. (1992). Positive withdrawal and the quest for meaning: The

reconstruction of experience among schizophrenics. *Psychiatry, 55*(3), 266-278.

Corrigan, P. (1997). How clinical diagnosis might exacerbate the stigma of mental illness. *Social*

*Work, 52*(1), 31-39.

Corrigan. P., Thompson, V., Lambert, D., Sangster, Y., Noel, J., & Campbell, J. (2003).

Perceptions of discrimination among persons with serious mental illness. *Psychiatric*

*Services, 54*(8), 1105-1110.

Davidson, L., Haglund, K., Stayner, D., Rakfeldt, J., Chinman, M., & Tebes, J. (2001). “I was just

realizing … that life wasn’t one big horror”: A qualitative study of supported socialization.

*Psychiatric Rehabilitation Journal, 24*, 275-292.

Mental Health Recovery Bibliography 13

Davidson, L., Stayner, D., Nickou, C., Styron, T., Rowe, M., & Chinman, M. (2001). “Simply to

be let in”: Inclusion as a basis for recovery. *Psychiatric Rehabilitation Journal, 24*(4),

375-388.

Davidson, L., Tondora, J., O’Connell, M., Kirk, T. Jr., Rockholz, P., & Evans, A. (2007). Creating

a recovery-oriented system of behavioral health care: Moving from concept to reality.

*Psychiatric Rehabilitation Journal, 31*(1), 23- 31.

Dickerson, F., Sommerville, J., Origoni, A., Ringel, N., & Parente, F. (2002). Experiences of

stigma among outpatients with schizophrenia. *Schizophrenia Bulletin, 28*(1), 143-155.

Estroff, S. (1981). *Making it crazy.* Berkeley, CA: University of California Press.

Estroff, S. (1989). Self, identity, and subjective experiences of schizophrenia: In search of the

subject. *Hospital and Community Psychiatry, 15*(2), 189-196.

Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives.

*Psychiatric Rehabilitation Journal, 24*(3), 248-256.

Longo, D., & Peterson, S. (2002). The role of spirituality in psychosocial rehabilitation.

*Psychiatric Rehabilitation Journal, 25*(4), 333-349.

Mehta, S., & Farina, A. (1997). Is being “sick” really better? Effect of the disease view of mental

disorder on stigma. *Journal of Social and Clinical Psychiatry, 63*, 108-116.

Miller, J. (2000). Personal consciousness integration: The next phase of recovery. *Psychiatric*

*Rehabilitation Journal, 23*(4), 342-352.

Ochocka, J., Nelson, G., & Jabzen, R. (2005). Moving forward: Negotiating self and external

circumstances in recovery. *Psychiatric Rehabilitation Journal, 28*(4), 315-322.

Onken, S., Craig, C., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions

and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal,*

*31*(1), 9-22.

Pettie, D., & Triolo, A. (1999). Illness as evolution: The search for identity and meaning in the

recovery process. *Psychiatric Rehabilitation Journal, 22*(3), 255-262.

Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery

narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335-343.

Ritsher, J., Luksted, A., Otlingham, P., & Grajales, M. (2004). Hearing voices: Explanations and

implications. *Psychiatric Rehabilitation Journal, 27*(3), 219-227.

Roe, D, Chopra, M., & Rudnick, A. (2004). Persons with psychosis as active agents interacting

with their disorder. *Psychiatric Rehabilitation Journal, 28*(2), 122-128.

Scheyett, A. (2005). The mark of madness: Stigma, serious mental illnesses, and social work.

*Social Work in Mental Health, 3*(4), 79-97.

Mental Health Recovery Bibliography 14

Schiff, A. (2004). Recovery and mental illness: Analysis and personal reflections. *Psychiatric*

*Rehabilitation Journal, 27*(3), 212-218.

Smith, M. (2000). Recovery from severe psychiatric disability: Findings of a qualitative study.

*Psychiatric Rehabilitation Journal, 24*(2), 149-158.

Strauss, J. (1989). Subjective experiences of schizophrenia: Toward a new dynamic psychiatric

rehabilitation. *British Journal of Clinical Psychology, 30,* 73-85.

Swarbrick, M. (2007). Consumer-operated self-help groups. *Psychiatric Rehabilitation Journal,*

*31*(1), 76-79.

Sullivan, W. P. (1993). “It helps me to be a whole person”: The role of spirituality among the

mentally challenged. *Psychosocial Rehabilitation Journal, 16*(3), 125-134.

Sullivan, W. P. (1994). A long and winding road: The process of recovery from mental illness.

*Innovations and Research, 3*(3), 19-27.

Sullivan, W. P. (1994). Recovery from schizophrenia: What we can learn from the developing

nations. *Innovations and Research, 3*(2), 7-15.

Sullivan, W. P. (1998). Recoiling, regrouping and recovering: First-person accounts of the role

of spirituality in the course of serious mental illness. In R. Fallot (Ed.), *Spirituality and*

*religion in recovery from mental illness*. San Francisco, CA: Jossey-Bass.

Young, S., & Ensing, D. (1999). Exploring recovery from the perspective of people with

disabilities. *Psychiatric Rehabilitation Journal, 22*(3), 219-231.

**Policy Issues**

Anthony, W. (2000). A recovery-oriented service system: Setting some system level standards.

*Psychiatric Rehabilitation Journal, 24*(2), 159-167.

Bollini, P., Pampallona, S., Nieddu, S., Bianco, M., Tibaldi, G., & Munizza, C. (2008). Indicators

of conformance with guidelines of schizophrenia treatment in mental health services.

*Psychiatric Services, 59*(7), 782-791.

Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health and*

*Social Work, 27*(2), 86-95.

Chamberlain, R., Rapp, C., Ridgway, P., Lee, R., & Boezio, C. (1999). Mental health reform in

Kansas: Cost containment and quality of life. *Psychiatric Rehabilitation Journal, 23*(2),

137-142.

Clark, C., & Krupa, T. (2002). Reflections on empowerment in community mental health: Giving

shape to an elusive idea. *Psychiatric Rehabilitation Journal, 25*(4), 341-349.

Cohen, C. (1993). Poverty and the course of schizophrenia: Implications for research and

policy. *Hospital and Community Psychiatry, 44*(10), 951-958.

Mental Health Recovery Bibliography 15

Corrigan, P., Steiner, L., McCracken, S., Blaser, B., & Barr. M. (2001). Strategies for

disseminating evidence-based practices to staff who treat people with serious mental

illness. *Psychiatric Services, 52*, 1598-1606.

Cunningham, D., Stephan, S., Paternite, C., Schan, S., Weist, M., Adelsheim, S., et al. (2007).

Stakeholders’ perspectives on the recommendations of the President’s New Freedom

Commission on Mental Health. *Psychiatric Services, 58*(10), 1344-1347.

Del Vecchio, P., & Fricks, L. (Eds.) (2007). Special issue on mental health recovery and system

transformation. *Psychiatric Rehabilitation Journal, 31*(1).

Isett, K., Burnam, M., Coleman-Beattie, B., Hyde, P., Morrissey, J., Magnabosco, J., et al.

(2007). The state policy context of implementation issues for evidence-based practices

in mental health. *Psychiatric Services, 58*(7), 914-921.

Jacobs, D., & Moxley, D. (1993). Anticipating managed mental health care: Implications for

psychosocial rehabilitation services. *Psychosocial Rehabilitation Journal, 17*(2), 5-14.

Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies

emerging from the states. *Psychiatric Rehabilitation Journal, 23*(4), 333-341.

Morrison, D. (2004). Real-world use of evidence-based treatments in community behavioral

health care. *Psychiatric Services, 55*(5), 485-487.

Onken, S., Dumont, J., Ridgway, P. Dornan. D., & Ralph, R. (2002). *Mental health recovery:*

*What helps and what hinders? A national research project for the development of*

*recovery facilitating performance indicators.* Alexandria, VA: National Association of

State Mental Health Program Directors.

Ware, N. (2008). A theory of social integration as quality of life. *Psychiatric Services, 59*(1), 27-

33.

Yoder, A. L. (2013). Corrections officers, not clinicians. Mad in America. Retrieved from

http://www.madinamerica.com/2013/01/corrections-officers-not-clinicians-2/

**Prognosis and Course of Severe Mental Illness**

Cohen, P., & Cohen, J. (1984). The clinician’s illusion. *Archives of General Psychiatry, 41*,

1178-1182.

Farone, D. (2006). Schizophrenia, community integration, and recovery. *Social Work in Mental*

*Health, 4*(4), 21-36.

Harding, C., Brooks, G., Ashikaga, T., Strauss, J., & Breier, A. (1987). The Vermont longitudinal

study of persons with severe mental illness I: Methodology, study sample, and overall

status 32 years later. *American Journal of Psychiatry, 144*(6), 718-726.

Harding, C., Zubin, J., & Strauss, J. (1987). Chronicity in schizophrenia: fact, partial fact, or

artifact? *Hospital and Community Psychiatry, 38*(5), 477-486.

Mental Health Recovery Bibliography 16

Kruger, A. (2000). Schizophrenia: Recovery and hope. *Psychiatric Rehabilitation Journal, 24*(1),

29-37.

Liberman, R., & Kopelowicz, A. (2005). Recovery from schizophrenia: A concept in search of

research. *Psychiatric Services, 56*(6), 735-741.

Resnick, S., Rosenheck, R., & Lehman, A. (2004). An exploratory analysis of correlates of

recovery. *Psychiatric Services, 55*(5), 540-547.

Romansky, J., Lyons, J., Lehner, R., & West, C. (2003). Factors related to psychiatric hospital

readmission among children and adolescents in state custody. *Psychiatric Services,*

*54*(3), 356-362.

Rund, B. (1990). Fully recovered schizophrenics: A retrospective study of some premorbid and

treatment factors. *Psychiatry, 53*(2), 127-139.

Sajatovic, M., Biswas, K., Kilbourne, A., Fenn, H., Williford, W., & Bauer, M. (2008). Factors

associated with prospective long-term treatment adherence among individuals with

bipolar disorder. *Psychiatric Services, 59*(7), 753-759.

van Gestel-Timmermans, H., Brouwers, E. P. M., van Assen, M. A. L. M., van Nieuwenhuizen,

C. (2012). Effects of a peer-run course on recovery from serious mental illness: A

randomized controlled trial. *Psychiatric Services, 63*(1), 54-60.

**Recreation and Leisure: Issues and Programs**

Gammonley, D., & Luken, K. (2001). Peer education and advocacy through recreation and

leadership. *Psychiatric Rehabilitation Journal, 25*(2), 170-178.

Hutchinson, D., Skrinar, G., & Cross, C. (1999). The role of improved physical fitness in

rehabilitation and recovery. *Psychiatric Rehabilitation Journal, 22*(4), 355-359.

Lloyd, C., King, R., Lampe, J., & McDougall, S. (2001). The leisure satisfaction of people with

psychiatric disabilities. *Psychiatric Rehabilitation Journal, 25*(2), 107-113.

Pyke, J., & Atcheson, V. (1993). Social recreation services: Issues from a case management

perspective. *Psychosocial Rehabilitation Journal, 17*(2), 121-130.

Richardson, C., Faulkner, G., McDevitt, J., Skrinar, G., Hutchinson, D., & Piette, J. (2005).

Integrating physical activity into mental health services for persons with serious mental

illness. *Psychiatric Services, 56*(3), 324-331.

Unger, K., Skrinar, G., Hutchinson, D., & Yelmokas, A. (1992). Fitness: A viable adjunct to

treatment for young adults with psychiatric disabilities. *Psychosocial Rehabilitation*

*Journal, 15*(3), 21-28.

**Supported Education**

Bernstein, R. (2006). A seat at the table: Trend or illusion? *Health Affairs, 25*(3), 730-733.

Mental Health Recovery Bibliography 17

Collins, M., Bybee, D., & Mowbray, C. (1998). Effectiveness of supported education for

individuals with psychiatric disabilities: Results from an experimental study. *Community*

*Mental Health Journal, 34*, 595-613.

Knis-Matthews, L., Bokara, J., DeMeo, L., Lepore, N., & Mavus, L. (2007). The meaning of

higher education for people diagnosed with a mental illness: Four students share their

experiences. *Psychiatric Rehabilitation Journal, 31*(2), 107-114.

Megivern, D., Pellerito, S., & Mowbray. C. (2003). Barriers to higher education for individuals

with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(3), 217-231.

Mowbray, C. (1999). The benefits and challenges of supported education: A personal

perspective. *Psychiatric Rehabilitation Journal, 22*(3), 248-254.

Mowbray, C., Moxley, D., Brown, K. (1993). A framework for initiating supported education

programs. *Psychosocial Rehabilitation Journal, 17*(1), 129-149.

Unger, K. (1993). Creating supported education programs utilizing existing community

resources. *Psychosocial Rehabilitation Journal, 17*(1), 11-23.

**Vocational Issues and Programs**

Anthony, W. (1994). Characteristics of people with psychiatric disabilities that are predictive of

entry into the rehabilitation process and successful employment outcomes. *Psychosocial*

*Rehabilitation Journal, 17*(3), 3-13.

Anthony, W., & Blanch, A. (1987). Supported employment for persons who are psychiatrically

disabled: An historical and conceptual perspective. *Psychosocial Rehabilitation Journal,*

*11*(2), 5-23.

Bond, G. (1998). Principles of the individual placement and support model: Empirical support.

*Psychiatric Rehabilitation Journal, 22*(1), 11-23.

Bond, G. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric*

*Rehabilitation Journal, 27*(4), 345-359.

Bond, G., Becker, D., Drake, R., & Vogler, K. (1997). A fidelity scale for the individual placement

and support model of supported employment. *Rehabilitation Counseling Bulletin, 40*(4),

265-284.

Bond, G., Drake, R., & Becker, D. (2008). An update on randomized controlled trials of

evidence-based supported employment. *Psychiatric Rehabilitation Journal, 31*(4), 280-

290.

Bond, G., Resnick, S. Drake, R., Xie, H., McHugo, G., & Bebout, R. (2001). Does competitive

employment improve nonvocational outcomes for people with severe mental illness?

*Journal of Consulting and Clinical Psychology, 69*, 489-501.

Mental Health Recovery Bibliography 18

Braitman, A., Counts, P., Davenport, R., Zurlinden, B., Rogers, M., Clauss, J., et al. (1995).

Comparison of barriers to employment for unemployed and employed clients in a case

management program: An exploratory study. *Psychiatric Rehabilitation Journal, 19*(1),

3-18.

Carlson, L., Smith, G., & Rapp, C. (2008). Evaluation of conceptual selling as a job development

process. *Psychiatric Rehabilitation Journal, 31*(3), 219-225.

Casper, E., & Carloni, C. (2007). Assessing the underutilization of supported employment

services. *Psychiatric Rehabilitation Journal, 30*(3), 182-188.

Clark, R. E. (1998). Supported employment and managed care: Can they coexist? *Psychiatric*

*Rehabilitation Journal, 22*(1), 62-68.

Frey, J. (1994). Long term support: The critical elements to sustaining competitive employment:

Where do we begin? *Psychosocial Rehabilitation Journal, 17*(3), 127-134.

Gold, L., Goldberg, R., McNary, S., Dixon, L., & Lehman, A. (2002). Cognitive correlates of job

tenure among patients with severe mental illness. *American Journal of Psychiatry,*

*159*(8), 1395-1402.

Gowdy, E., Carlson, L., & Rapp, C. (2003). Practices differentiating high-performing from lowperforming

supported employment programs. *Psychiatric Rehabilitation Journal, 26*(3),

232-239.

Harp, H. (1994). Empowerment of mental health consumers in vocational rehabilitation.

*Psychosocial Rehabilitation Journal, 17*(3), 83-89.

Huff, S., Rapp, C., & Campbell, S. (2008). “Every day is not always jell-o”: A qualitative study of

factors affecting job tenure. *Psychiatric Rehabilitation Journal, 31*(3), 211-218.

Kirsh, B. (2000). Factors associated with employment for mental health consumers. *Psychiatric*

*Rehabilitation Journal, 24*(1), 13-21.

Krupa, T. (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at

work. *Psychiatric Rehabilitation Journal, 28*(1), 8-15.

Mancuso, L. (1990). Reasonable accommodation for workers with psychiatric disabilities.

*Psychosocial Rehabilitation Journal, 14*(2), 3-19.

Maronne, J. (1993). Creating positive vocational outcomes for people with severe mental illness.

*Psychosocial Rehabilitation Journal, 17*(2), 43-62.

McGurron, M. (1994). An overview of the effectiveness of traditional vocational rehabilitation

services in the treatment of long term mental illness. *Psychosocial Rehabilitation*

*Services, 17*(3), 37-54.

Prince, J. (2007). Promoting consumer empowerment through entrepreneurship. *Psychiatric*

*Rehabilitation Journal, 30*(3), 223-225.

Mental Health Recovery Bibliography 19

Salyers, M., Becker, D., Drake, R., Torrey, W., & Wyzik, P. (2004). A ten-year follow up of a

supported employment program. *Psychiatric Services, 55*(3), 302-398.

Tilbury, D. (2002). *Working with mental illness: A community-based approach* (2nd ed.). New

York, NY: Palgrave.