USC Suzanne Dworak-Peck
School of Social Work

Social Work 618

Systems of Recovery from Mental Illness in Adults

3 Units

Term Year

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I. Course Prerequisites

This advanced level practice course is open to any second year MSW student. If the student is not in a Field Education internship in which he/she is working with people with severe mental illness, a case can be provided by which to complete the required assignments.

II. Catalogue Description

This advanced mental health practice course focuses on the multi-level impact of mental illness on adults and families. Evidence-based interventions promoting increased quality of life and stability are emphasized.

III. Course Description

This advanced-level practice course offers evidence-based, strengths approaches to providing humane care for persons with mental illness, including those with substance abuse and severe socioeconomic disadvantages, who are commonly considered “difficult” to treat. Discrimination and social inequalities are considered throughout the course, including discrimination based on gender, race, ethnicity, socioeconomic status, sexual orientation, disability, and diagnosis. Many different etiological perspectives are included and readings draw from various theoretical approaches to treatment.

Required readings draw from classics in the field and are designed to give an historical perspective. In addition, readings from contemporary sources explore new research and practice in the field of the treatment of clients who have been diagnosed with severe mental illnesses. Readings are among the most recently available in the field.

This course includes content from policy, human behavior and the social environments, practice, and research. The integration of clinical field experience with theory is fostered by the inclusion of case material throughout the course, both provided by the instructor and also the students' clinical experiences. Students are helped to compare and critically analyze the theories and research methods used to understand and evaluate this population. The primary focus of the course is consistent with the Recovery Model emphasis and objectives.

IV. Course Objectives

Objective #	Objectives
1	Promote understanding of the major theories used to explain the causes and treatment of severe mental illness, so as to foster students' understanding of severe mental illness and its psychological and socioeconomic effects on clients and their families.
2	Facilitate advanced understanding of approaches to social work practice interventions with clients with severe mental illness, including neuroleptic management, residential and inpatient care, case management and community care, outreach as well as psychotherapy.
3	Enable students to acquire a fundamental knowledge base about diverse approaches to program planning and development, including advocacy, in the care of this population.
4	Help students acquire recovery-oriented knowledge, skills, and approaches.

V. Course format / Instructional Methods

The format of the course will consist of didactic instruction and experiential exercises. Case vignettes, videos, and role plays will also be used to facilitate the students' learning. These exercises may include the use of videotapes, role-play, or structured small group exercises. Material from the field will be used to illustrate class content and to provide integration between class and field. Confidentiality of material shared in class will be maintained. As class discussion is an integral part of the learning process, students are expected to come to class ready to discuss required reading and its application to theory and practice.

VI. Student Learning Outcomes

The following table lists the nine Social Work core competencies as defined by the Council on Social Work Education's 2015 Educational Policy and Accreditation Standards:

	Social Work Core Competencies
1	**Demonstrate Ethical and Professional Behavior ***
2	**Engage in Diversity and Difference in Practice ***
3	**Advance Human Rights and Social, Economic, and Environmental Justice ***
4	**Engage in Practice-informed Research and Research-informed Practice ***
5	**Engage in Policy Practice ***
6	**Engage with Individuals, Families, Groups, Organizations, and Communities ***
7	**Assess Individuals, Families, Groups, Organizations, and Communities ***
8	**Intervene with Individuals, Families, Groups, Organizations, and Communities ***
9	**Evaluate Practice with Individuals, Families, Groups, Organizations and Communities ***

* Highlighted in this course

The following table shows the competencies highlighted in this course, the related course objectives, student learning outcomes, and dimensions of each competency measured. The final column provides the location of course content related to the competency.

Competency	Objectives	Behaviors	Dimensions	Content
Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice Social workers understand that every individual, regardless of position in society, has fundamental rights such as freedom, safety, privacy, an adequate standard of living, healthcare and education. Social workers understand the global interconnections of oppression and human rights violations, and are knowledgeable about theories of human need, social justice and strategies to promote social and economic justice and human rights. Social workers practicing in health, behavioral health and integrated care settings understand the potentially challenging effects of economic, social and cultural factors in the lives of clients and client systems. They also understand stigma and shame on an individual, community and society-wide basis. Social workers use knowledge of the effects of oppression, discrimination, and historical trauma on client and client systems to guide treatment planning and intervention; and advocate at multiple levels for mental and physical healthcare parity and reduction of disparities for diverse populations.	Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels. Engage in practices that advance social, economic, and environmental justice.	**3a**. Understand how to integrate theory, research, and economic, social and cultural factors when engaging in advocacy strategies to promote social justice, economic justice and human rights.	Knowledge	Strengths-based Plan of Recovery Project Class Discussion
		3b. Use advocacy and policy analysis skills to inform advocacy efforts at multiple levels for mental and physical healthcare parity and reduction of parity and disparities for diverse populations.	Skills	

Competency	Objectives	Behaviors	Dimensions	Content
Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities Social workers understand that intervention is an ongoing component of the dynamic and interactive process of social work practice with and on behalf of diverse individuals, families and groups in health, behavioral health and integrated care settings. Social workers working with adults and older adults identify issues related to losses, changes, and transitions over their life cycle in designing intervention. Social workers understand methods of identifying, analyzing, modifying and implementing evidence-informed interventions to achieve client goals, taking into account influences such as cultural preferences, strengths and desires. Social workers in working with adults and older adults value and readily negotiate, mediate, and advocate for clients. Social workers value the importance of inter- professional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, inter-professional, and inter-organizational collaboration.	Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies. Apply knowledge of human behavior and the social environment, person in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies. Use inter-professional collaboration as appropriate to achieve beneficial practice outcomes Negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies. Facilitate effective transitions and endings that advance mutually agreed-on goals.	**8a**. Skillfully choose and implement culturally competent interventions to achieve practice goals and enhance capacities of clients.	Exercise of judgment	Brief Reaction Paper Crisis Intervention Demonstration Application Exercise of Brief Therapy Brief Therapy Demonstration Class Discussions
		8b. Are self-reflective in understanding transference and countertransference in client interactions as well as practice self-care in the face of disturbing personal reactions.	Reflection	

VII. COURSE ASSIGNMENTS, DUE DATES & GRADING

Assignment	Due Date	% of Final Grade
Class Participation	Each class session	10%
Article Presentation	Sign up for class session	10%
Strengths Based Plan for Recovery		75%
Section 1	1-Session 7	12.5%
Section 2	2-Session 7	12.5%
Section 3	3-Session 7	12.5%
Section 4	4-Session 10	12.5%
Section 5	5-6 Session 15	12.5%
Section 6		12.5%
Resource Drive	Session 15	5%

Each of the major assignments is described below.

Article Presentation – 10%

The student will choose an article from the syllabus and present the main conclusions to the class. Students will sign up on the first class session.

Due: Presentation will occur during the class session where article is listed on syllabus.

This assignment relates to student learning outcome 4, 7, 8, 9.

Strengths Based Plan for Recovery – 12.5 x 6 = 75%

Due: Parts 1, 2, & 3 are due on Session 7.

Part 4 is due on Session 10.

Part 5 & 6 are due on the last day of class.

- *THE STUDENT WILL SELECT A CLIENT TO WORK WITH FOR ALL 6 PARTS OF THIS PROJECT.*
- *THE CLIENT MUST BE SOMEONE WHO WILL WORK WITH THE STUDENT FOR THREE OR MORE SESSIONS.*
- *THE CLIENT MUST WANT HELP WITH SOMETHING, ANYTHING. (A mandated client who wants help with something is acceptable.)*
- *If the student is unable to select an appropriate client in the current field placement, a case is available.*

It is recommended that you include many quotations from the person with whom you are working.

*************Please use all the headings as listed below. All headings can be placed at the far left margin. Compare headings with assignment rubric. Some headings are placeholders. *************

Strengths-based Plan for Recovery

1) *Assessment (no text required for this heading)*
   - Brief Description of Person *(no text required for this heading)*
     - Demographics
     - What is the person requesting help with? *(THIS IS ONE OF THE MOST IMPORTANT QUESTIONS OF THIS ASSESSMENT.)*
     - Presenting symptoms
       - Identification, frequency, duration, intensity
     - Goals and Values of the Client (*not the clinician's goals and values*)

2) *Therapeutic Relationship (no text required for this heading)*
   - Plan for trusting relationship with this person *(no text required for this heading)*
     - Welcoming and engagement (How was this executed?)
     - Unique and ongoing dynamics (What is unique about YOUR work with THIS client? Countertransference?)
     - Appropriate self-disclosure (Yours with client)
     - Appropriate use of humor (Yours with client)
     - Appropriate sharing of emotions (Yours with client)
       - Sadness – tears
       - Excitement
       - Use of touching (hugging, etc.)
       - Other

3) *Shared Story of Illness (no text required for this heading)*
   - Contributing Factors *(no text required for this heading)*
     - Precipitating events (What has occurred in past two weeks – a month to cause person to come in and request services?)
     - Factors that increase stress and vulnerability (ongoing stressors)
     - Trauma and significant losses (any early or recent traumas)
   - Symptoms of illness
     - Diagnosis (list all as there may be more than one)
     - Differential Diagnoses
       - Justify all diagnoses
         - Example:
           - List DSM criteria
             - How client manifests this symptom.
           - List DSM criteria
             - How client manifests this symptom.
       - Remaining questions
         - What information are you seeking to rule out or rule in diagnoses? (Be sure to have a correct understanding of the term "Rule Out).
   - How are behaviors and symptoms obstacles to goals and values? (Be specific. Name goal / value and discuss impact of each.)
     - Goal
       - Obstacle

4) *Shared Plan of Recovery*
   - *(We know that high quality in these areas contribute to stability and increased quality of life. Use academic references to support your assertions.)*
   - *(Be sure that you are articulating the specific plans for the future of each area. Be sure to write out all headings*
   - *(In your paper, you may want to comment on past and present situations of each. However, the essence of this paper lies in planning for the increased quality of each*

area. Consider both very small and long term goals. Use references to assert that these areas are important in recovery.)

- Cut and paste idemographic information from Part 1.
- What does the person most want help with?
- Resources that will help to overcome illness and other obstacles. *(Heading placeholder.)*
- *(It is preferred to use all the headings, including subheadings and list all at far left margin.)*
- *(Use at least 4 references. May be from reading list.)*
- *(For each item, begin with a few assertions, with references, about how each area increases quality of life in people with mental illnesses.)*
- *IT IS NOT ENOUGH TO JUST LIST HISTORY IN ALL THESE AREAS. THE STUDENT WILL DEMONSTRATE THAT HE/SHE HAS HAD A MEANINGFUL CONVERSATION WITH THE CLIENT ABOUT EACH AREA. IT IS NOT ENOUGH TO SAY THAT CLIENT IS NOT INTERESTED. PEOPLE WITH MENTAL ILLNESSES ARE SOCIALIZED TO SETTLE FOR LOW STANDARDS. THE STUDENT WILL EDUCATE THE CLIENT ABOUT EACH AREA AND THE BENEFITS OF EACH AREA. EVEN HAVING THIS EDUCATIONAL CONVERSATION WILL INSTILL HOPE THAT THERE CAN BE A HIGHER QUALITY OF LIFE AND THAT THE CLIENT DESERVES THIS. THEN, THE STUDENT WILL WALK THE CLIENT THROUGH, STEP BY STEP, EACH AREA AND DEMONSTRATE A CONCRETE EXAMPLE OF MOVING FORWARD FOR EACH. THAT SAID, SOME CLIENTS, FOR EXAMPLE MAY HAVE COME FROM ABUSIVE FAMILIES AND DO NOT WANT TO HAVE ANY CONTACT WITH THEM. DO NOT PUSH IN AREAS IN WHICH THESE POINTS WILL CAUSE THE CLIENT ANY DISTRESS.*
  - Describe with as much detail as possible. *(These are areas that you and your client discuss together about the future. This is not intended to address the past. What are your client's ideas about each of these areas?)*
    - Areas to consider (Please use ALL headings in order)
      - Health (placeholder)
        - Physical (placeholder)
          - Body

            1) Literature statement about mental illness and this heading.
            2) History and current situation
            3) Specific plan for improved quality of life
          - Dental

            1) Literature statement about mental illness and this heading.
            2) History and current situation
            3) Specific plan for improved quality of life
        - Mental (placeholder)
          - Therapist

            1) Literature statement about mental illness and this heading.
            2) History and current situation
            3) Specific plan for improved quality of life
          - Psychiatrist

            1) Literature statement about mental illness and this heading.
            2) History and current situation
            3) Specific plan for improved quality of life
        - Social (placeholder)

- Friends

  1) Literature statement about mental illness and this heading.
  2) History and current situation
  3) Specific plan for improved quality of life

- Hobbies

  1) Literature statement about mental illness and this heading.
  2) History and current situation
  3) Specific plan for improved quality of life

- Housing

  1) Literature statement about mental illness and this heading.
  2) History and current situation
  3) Specific plan for improved quality of life

- Employment

  1) Literature statement about mental illness and this heading.
  2) History and current situation
  3) Specific plan for improved quality of life

- Family (placeholder)
  - Partner

    1) Literature statement about mental illness and this heading.
    2) History and current situation
    3) Specific plan for improved quality of life

  - Children

    1) Literature statement about mental illness and this heading.
    2) History and current situation
    3) Specific plan for improved quality of life

  - Parents

    1) Literature statement about mental illness and this heading.
    2) History and current situation
    3) Specific plan for improved quality of life

  - Siblings

    1) Literature statement about mental illness and this heading.
    2) History and current situation
    3) Specific plan for improved quality of life

- Education

1) Literature statement about mental illness and this heading.
2) History and current situation
3) Specific plan for improved quality of life

- Other

5) *Summary of Process*
   - Tell the story of your experience with this person in chronological time. *(Use the following headings.)*
     - Beginning
     - Middle
     - End
   - Within the above headings, include the following details. *(Bold or italicize each term so as to make it obvious. Use references.)*
     - Aspects of Recovery
       - Hope
       - Empowerment
       - Self-responsibility
       - Achieving meaningful roles
     - Essential Therapeutic Skills
       - Creating a trusting relationship
       - Constructing a shared story of how the person got into trouble
       - How symptoms and behaviors creates barriers to achieving goals and how to overcome them
       - In-vivo skill building
       - Creating a healing environment
       - Therapeutic boundaries

6) *Reflections of a Recovery Minded Social Workers (Use all the headings as listed below.)*
   - Tell 3 stories that I will most remember about working with this person.
   - What interventions did not work?
   - What resources were lacking that would have helped?
   - What do I know to be true about working with people who have been diagnosed with severe and persistent mental illnesses?

This assignment relates to student learning outcome 1-9.

Resource Drive – 5%

The student will present a useful resource for a service for people who have been diagnosed with mental illness. The student will bring handouts for classmates. The handout will have the following information.

- Name and brief description of resource.
- Contact information (address, phone, website address, name of person to contact, etc.)
- Requirements to receive service (diagnosis, catchment area, funding source, housing status, etc.)

Due: Session 15

This assignment relates to student learning outcome 2,3,4,8.

Class Participation (10% of Course Grade)

Student is expected to come to and remain in class (including field trips) for entire sessions. Student is expected to participate in class discussions. Texting and working on anything other than course material are considered not participating and participations points will be deducted accordingly.

Guidelines for Evaluating Class Participation

10: Outstanding Contributor: Contributions in class reflect exceptional preparation and participation is substantial. Ideas offered are always substantive, provides one or more major insights as well as direction for the class. Application to cases held is on target and on topic. Challenges are well substantiated, persuasively presented, and presented with excellent comportment. If this person were not a member of the class, the quality of discussion would be diminished markedly. Exemplary social work behavior in experiential exercises and demonstrating on target behavior in role-plays, small group discussions, and other activities.

9: Very Good Contributor: Contributions in class reflect thorough preparation and frequency of participation is high. Ideas offered are usually substantive and provide good insights and sometimes direction for the class. Application to cases held is usually on target and on topic. Challenges are well substantiated, often persuasive, and presented with excellent comportment. If this person were not a member of the class, the quality of discussion would be diminished. Good activity in experiential exercises demonstrating behavior that is usually on target in role-plays, small group discussions, and other activities.

8: Good Contributor: Contributions in class reflect solid preparation. Ideas offered are usually substantive and participation is very regular, provides generally useful insights but seldom offer a new direction for the discussion. Sometimes provides application of class material to cases held. Challenges are sometimes presented, fairly well substantiated, and are sometimes persuasive with good comportment. If this person were not a member of the class, the quality of discussion would be diminished somewhat. Behavior in experiential exercises demonstrates good understanding of methods in role-plays, small group discussions, and other activities.

7: Adequate Contributor: Contributions in class reflect some preparation. Ideas offered are somewhat substantive, provides some insights but seldom offers a new direction for the discussion. Participation is somewhat regular. Challenges are sometimes presented, and are sometimes persuasive with adequate comportment. If this person were not a member of the class, the quality of discussion would be diminished slightly. Occasionally applies class content to cases. Behavior in experiential exercises is occasionally sporadically on target demonstrating uneven understanding of methods in role-plays, small group discussions, and other activities.

6: Inadequate: This person says little in class. Hence, there is not an adequate basis for evaluation. If this person were not a member of the class, the quality of discussion would not be changed. Does not participate actively in exercises but sits almost silently and does not ever present material to the class from exercises. Does not appear to be engaged.

5: Non-Participant: Attends class only.

0: Unsatisfactory Contributor: Contributions in class reflect inadequate preparation. Ideas offered are seldom substantive; provides few if any insights and never a constructive direction for the class. Integrative comments and effective challenges are absent. Comportment is negative. If this person were not a member of the class, valuable airtime would be saved. Is unable to perform exercises and detracts from the experience.

Class grades will be based on the following:

Class Grades		Final Grade	
3.85 – 4	A	93 – 100	A
3.60 – 3.84	A-	90 – 92	A-
3.25 – 3.59	B+	87 – 89	B+
2.90 – 3.24	B	83 – 86	B
2.60 – 2.87	B-	80 – 82	B-
2.25 – 2.50	C+	77 – 79	C+
1.90 – 2.24	C	73 – 76	C
		70 – 72	C-

Within the School of Social Work, grades are determined in each class based on the following standards which have been established by the faculty of the School: (1) Grades of A or A- are reserved for student work which not only demonstrates very good mastery of content but which also shows that the student has undertaken a complex task, has applied critical thinking skills to the assignment, and/or has demonstrated creativity in her or his approach to the assignment. The difference between these two grades would be determined by the degree to which these skills have been demonstrated by the student. (2) A grade of B+ will be given to work which is judged to be very good. This grade denotes that a student has demonstrated a more-than-competent understanding of the material being tested in the assignment. (3) A grade of B will be given to student work which meets the basic requirements of the assignment. It denotes that the student has done adequate work on the assignment and meets basic course expectations. (4) A grade of B- will denote that a student's performance was less than adequate on an assignment, reflecting only moderate grasp of content and/or expectations. (5) A grade of C would reflect a minimal grasp of the assignments, poor organization of ideas and/or several significant areas requiring improvement. (6) Grades between C- and F will be applied to denote a failure to meet minimum standards, reflecting serious deficiencies in all aspects of a student's performance on the assignment.

VIII. REQUIRED AND SUPPLEMENTARY INSTRUCTIONAL MATERIALS & RESOURCES

Required Textbooks

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual – 5.* American Psychiatric Publishers. *(Pocket size edition is not acceptable as it contains errors. DSM 5 is available online free through the USC Library. Psychiatryonline.org)*

Benkhe, S., Preis, J., Bates. T. (1998). *The essentials of California mental health law.* W.W. Norton Publishers. Students who do not intend to practice in California may purchase a current mental health law book for your respective state.

Corrigan, P., Mueser, Kim., Bond, G., & Drake, R. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach*. The Guilford Press.

Saks, Elyn. (2008). *The center cannot hold: My journey through madness.* Hyperion.

Recommended Guidebook for APA Style Formatting

American Psychological Association (2009). *Publication manual of the American Psychological Association, 6th Edition.*

Note: Additional required and recommended readings may be assigned by the instructor throughout the course.

Course Overview

Unit	Topics	Assignments
1	■ Introduction ▸ Introduction to course ▸ Format, syllabus, assignments, objectives and overview of course material ▸ Choose article for presentation	
2	■ History of Mental Health Treatment Delivery in United States ▸ Stigma: Definitions, Impact, and Stigma Busters	
3	■ Introduction to the Philosophies of Mental Health Treatment Delivery ▸ Mental Health Treatment Delivery in the Medical Model ▸ Mental Health Treatment in the Recovery Philosophy ■ Levels of Care: Theories and Goals • Crisis Intervention • Inpatient Hospitalization ○ Voluntary vs. Involuntary treatment • Psychosocial Rehabilitation ○ Clubhouse Model ○ Day Programs • Vocational Programs • Case Management ○ Clinical Case Management ○ Assertive Case Management (ACT) • Residential Programs ○ Board and Care ○ Alternative Residential Programs: ▪ Soteria House ▪ R.D. Lang (Asylum) ▪ John Weir Perry Diabasis ▪ Work Farms ▪ Geel, Belgium • Self-help Groups • Psychotherapy	
4	Defining the Population from a Medical Perspective: Diagnosis, Etiology, Course of Illness, and Treatment Options, including Medication ▸ Psychotic Disorders ▼ Positive and Negative Psychotic Symptoms ▼ Schizophrenia, ▼ Schizoaffective Disorders ▸ Mood Disorders ▼ Depressive Disorders ▼ Bipolar Disorder ▸ Personality Disorders ▼ Cluster B: Borderline, Narcissistic, and Antisocial Personality Disorders ▸ The Impact of Trauma	

Unit	Topics	Assignments
5	■ Integrated Care for People with Co-Occurring Disorders › Scope and Dynamics of Co-morbidity between Mental Illness and Substance Abuse › Poverty and homelessness › Evidence Based Interventions with People with Co-occurring Disorders ▽ Motivational Interviewing ▽ Harm Reduction	
6	■ Recovery in Action: An Example › Visit to the Village of Long Beach › Supportive Employment › Member Panel	
7	■ Understanding and Communicating with a Person who is Experiencing Psychosis	*Strengths Based Plan For Recovery – Parts 1, 2, & 3.*
8	■ Symptom Management › Wellness Recovery and Action Plan (WRAP) › Illness Management and Recovery (IMR)	
9	■ Supportive Housing › Project 50 ■ Managing Crisis Situations: Risk for Suicide, Violence and Sociopathic Behaviors › Crisis Theory › Evidence- and Practice-based Methods for Managing Crisis Situations that include Risk for Suicide, Violence and Sociopathic Behaviors	
10	■ Culture, Class, Ethnicity, and Mental Illness › The Effects of Culture, Class and Ethnicity on Diagnosis and Treatment › Equal Access to High Quality Care › Cultural Sensitivity	*Strengths Based Plan For Recovery – Part 4.*
11	■ Mental Health Law and Advocacy	
12	■ Guest Speakers › Narratives	
13	■ Family Psycho-education › Impacts of Mental Illnesses on Family Members, including Children › Empathic Parenting with a Mental Illness: Evidence Based Interventions › Family Psycho-education and Advocacy ▽ Multi-Family Groups: An Evidence Based Intervention	

Unit	Topics	Assignments
14	■ Peer Support ➢ SAMSHA Packet	
15	■ Resource Drive ■ Wrap-Up ■ Course Evaluations	*Strengths Based Plan For Recovery – Parts 5 & 6.*
	STUDY DAYS / NO CLASSES	
	FINAL EXAMINATIONS	

Course Schedule—Detailed Description

Course Schedule

Unit 1:

Topics

- Introduction

Unit 2:

Topics

- History of Mental Health Treatment Delivery in United States
  - Introduction to the Philosophies of Mental Health Treatment Delivery
    - Mental Health Treatment Delivery in the Medical Model
    - Mental Health Treatment in the Recovery Philosophy
  - Stigma: Definitions, Impact, and Stigma Busters

Required Readings

Bellack, A.S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophrenia Bulletin*, *32*, 432–442.

Bond, G. R. (2004). How evidence-based practices contribute to community integration. C*ommunity Mental Health Journal, 40*(6).

Concurrent Disorders: Beyond the Label. An Educational Kit to Promote Awareness and Understanding of the Impact of Stigma on People Living with Concurrent Mental Health and Substance Use Problems. http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/beyond_the_label_toolkit05.pdf

Corrigan, P. (2009). Principles and practice of psychiatric rehabilitation: An empirical approach. Chapters 2, 3, 20, & 21.

Davidson, Larry. (2006). What happened to Civil Rights? *Psychiatric Rehabilitation Journal, 30*(1), 11-14.

Department of Health and Human Services. (2005). *Federal Action Agenda: Transforming mental health care in America.* Rockville, MS: Substance Abuse and Mental Health Services Administration

Drake, R. E., Bond, G. R., & Essock, S. M. (2009). Implementing evidence-based practices for people with schizophrenia. *Schizophrenia Bulletin*, *35*(4), 704 – 713.

Frese, J.F., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the Recovery Model. *Psychiatric Services, 52*(11), 1462-1468.

SAMHSA (2008). *Evidence-based practices: Shaping mental health services towards recovery*. http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/Fidelity/Introduction.asp.

Stanhope, V. & Solomon, P. (2007). Getting to the heart of recovery: Methods for studying recovery and their implications for evidence-based practice. *British Journal of Social Work, 38*(5), 885-899.

Recommended Readings

Corrigan, P.W. (Ed.) (2005). *On the stigma of mental illness: Practical strategies for research and*

social change. Washington, DC: American Psychological Association.

Deegan, P.E., Drake, R.H. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services,* 57(11): 1636-1639.

Fountain House: www.fountainhouse.org

Porter, R. (2002). Madness: A brief history. New York: Oxford University Press.

Ralph. R.O. & Corrigan, P.W. (Eds.) (2005). *Recovery in mental illness: Broadening our understanding of wellness.* Washington, DC: American Psychological Association.

Whitaker, R. (2003). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill.* Cambrdge, MA: Basic Books.

Unit 3:

Topics

- Introduction to the Philosophies of Mental Health Treatment Delivery
  - Mental Health Treatment Delivery in the Medical Model
  - Mental Health Treatment in the Recovery Philosophy
- Levels of Care: Theories and Goals
  - Crisis Intervention
  - Inpatient Hospitalization
    - Voluntary vs. Involuntary treatment
  - Psychosocial Rehabilitation
    - Clubhouse Model
    - Day Programs
  - Vocational Programs
  - Case Management
    - Clinical Case Management
    - Assertive Case Management (ACT)
  - Residential Programs
    - Board and Care
    - Alternative Residential Programs:
      - Soteria House
      - R.D. Lang (Asylum)
      - John Weir Perry Diabasis
      - Work Farms
      - Geel, Belgium
  - Self-help Groups
  - Psychotherapy

Required Readings

Amador, X. Poor insight in schizophrenia: Overview and impact on medication compliance. http://www.psychlaws.org/medicalresources/documents/AmadoronInsightforCNSReview.pdf

Brekke, J.S., Hoe, M., & Long, J. & Green, M.F. (2007). How neurocognition and social cognition influence functional change during community-based psychosocial rehabilitation for individuals with schizophrenia. *Schizophrenia Bulletin, 33*(5), 1247-1256.

Chamberlin, J. (2008). Confessions of a non-compliant patient. National Empowerment Center. http://www.power2u.org/articles/recovery/confessions.html

Corrigan, P. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach*. Chapters 5, 6, 13 & 18.

Fenton,W. (2000). Evolving perspectives on individual psychotherapy for schizophrenia. *Schizophrenia Bulletin. 26*(1): 47-72.

Laura's Law (2002). A Guide to Laura's Law, California's Law for Assisted Outpatient Treatment. http://www.psychlaws.org/stateactivity/California/Guide-Lauras-Law-AB1421.htm

Salyers, M. P., & Tsemberis, S. (2007). ACT and recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams. *Community Mental Health Journal, 43*, 619–641.

Torrey, E.F. & Chaberlin, J. (2008) Should Forced Medication be a Treatment Option in Patients with Schizophrenia? National Empowerment Center. http://www.power2u.org/debate.html

Recommended Readings

Amador, X. (2007). "It's not about denial." http://www.xavieramador.com/wordpress/wp-content/uploads/schiz-digest-winter-07.pdf

Amador, X. (2009). Why we should listen, yet don't. http://www.xavieramador.com/wordpress/wp-content/uploads/schiz-digest-winter-09.pdf

Flannery, M., & Glickman, M. (1996). *Fountain House*: *Portraits of lives reclaimed from mental illness*. Center City, MN: Hazelden. (classic).

Jackson, R.L. (2001). *The club house model: Empowering application of theory to generalist practice.*

Unit 4:

Topics

- Defining the Population from a Medical Perspective: Diagnosis, Etiology, Course of Illness, and Treatment Options, including Medication
  - Psychotic Disorders
    - Positive and Negative Psychotic Symptoms
    - Schizophrenia,
    - Schizoaffective Disorders
  - Mood Disorders
    - Depressive Disorders
    - Bipolar Disorder
  - Personality Disorders
    - Cluster B: Borderline, Narcissistic, and Antisocial Personality Disorders
  - The Impact of Trauma

Required Readings

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual – 5.* American Psychiatric Publishers.

Bola, J.R. (2006). Psychosocial acute treatment in early-episode schizophrenia disorders. *Research on Social Work Practice, 16*(3),263-275.

Buchanan, R. W., Kreyenbuhl, J., Kelly, D. L., Noel, J. M., Boggs, D. L., Fischer, B. A., et al. (2010). The

2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements.*Schizophrenia Bulletin, 36*(1), 71-93.

Corrigan, P. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach*. Chapters 1,4, & 7.

Davidson, L. (2010). PORT through a recovery lens. *Schizophrenia Bulletin, 36*(1), 107-108.

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin, 36*(1), 48-70.

Morrison, A. & Larkin, W. (2015). Trauma and psychosis: New directions for theory and therapy. Routledge.

Read, J. (2006). Breaking the Silence: Learning Why, When, and How to Ask about Trauma, and How to Respond to Disclosures. *Trauma and Psychosis: New Directions for Theory and Therapy*. Warren Larking and Anthony P. Morrison (eds.) Routledge.

Read, J., Perry, B., Moskowitz, & Connolly,J.(2001). The contribution of early traumatic events to schizophrenia in some patients: A tramagenic neurodevelopmental model. *Psychiatry*. 64(4), 319-345.

Ronson, J. (2011). Bipolar kids: Victims of the 'madness industry'?" New Scientist. June 8.

Wilson, J.P. & Friedman, M.J. (*Eds.)* (2004). Treatment of PTSD in persons with severe mental illness. Chapter 14. by Kim Mueser & Stanley Rosenberg. *In Treating Psychological Trauma and PTSD*. New York: The Guilford Press.

Recommended Readings

Carey, B. (2006). Revising schizophrenia? Are drugs always needed? *New York Times*.

Davidson, L., Schmutte, T., Dinzeo, T., & Andres-Hyman, R. (2008). Remission and recovery in schizophrenia: patient and practitioner perspectives. *Schizophrenia Bulletin*, *34*, 5–8.

Silverstein, S.M., Bellack, A.S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review,* 28: 1108-1124.

Foa, El, Keane, Tl, & Friendman, M. (2000). Guidelines for treatment of PTSD*. Journal of Traumatic Stress, 13*(4), 539-588.

Harrow, M. & Jobe, T.H. (2007). Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: A 15-year multifollow-up study. *The Journal of Nervous and Mental Disease, 195*(5), 406-414.

Hogan, M. (2010). Updated schizophrenia PORT treatment recommendations: A commentary. *Schizophrenia Bulletin, 36*(1), 104-106.

Lehman, A.F., Kreyenbuhl, R.W., Buchanan, F.B., Dixon, L.B., Goldberg, R., Green-Paden, L.D., Tenhula, W.N., Boerescu, D., Tek, C., Sandson, N., & Steinwachs, D.M. (2004). The schizophrenia patient outcomes research team (PORT): Updated treatment recommendations 2003. *Schizophrenia Bulletin, 30*(2), 193-217.

Milkowitz, D.J. (2006). A review of evidence-based psychosocial interventions for bipolar disorder. *Journal of Clinical Psychiatry, 67(*11), 28-33.

Mueser, K.T. & Jeste, D.V. (2008). *Clinical Handbook of Schizophrenia*. New York: The Guilford Press.

Pincus, H. A. (2010). Commentary: from PORT to policy to patient outcomes: Crossing the quality chasm. *Schizophrenia Bulletin, 36*(1), 109-111.

Rothschild, B. (2000). *The body remembers*. *The* psychophysiology *of trauma and trauma treatment.* New York: W. W. Norton & Company.

Unit 5:

Topics

- Integrated Care for People with Co-Occurring Disorders
  - Scope and Dynamics of Co-morbidity between Mental Illness and Substance Abuse
  - Poverty and homelessness
  - Evidence Based Interventions with People with Co-occurring Disorders
    - Motivational Interviewing
    - Harm Reduction

Required Readings

Brunette, M. F., Asher, D., Whitley, R., Lutz, W. J., Wieder, B. L., Jones, A. M., & McHugo G.J. (2008). Implementation of integrated dual disorders treatment: A qualitative analysis of facilitators and barriers**,** *Psychiatric Services, 59*(9), 989 - 995.

Carey, Kate. (1996). Substance use reduction in the context of outpatient psychiatric treatment: A collaborative, motivational, harm reduction approach. *Community Mental Health Journal, 32*(3), p. 291-306.

Corrigan, P.W. (2005). Motivational interviewing of people with schizophrenia. *Medscape Psychiatry & Mental Health, 10*(2). http://www.medscape.com/viewarticle/515818_1.

Corrigan, P. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach*. Chapters 14 &15.

Draine, J., & Herman, D. B. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services, 58*, 1577-1581.

Recommended Readings

Denning, P. (2004). Practicing Harm Reduction psychotherapy: An alternative approach to addictions. Guilford Press.

Kavanagh, D.J. (2008). Management of co-occurring substance use disorders. In K.T. Mueser & D.V. Jeste (Eds). *Clinical Handbook of Schizophrenia*. New York: The Guilford Press.

Miller, W. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* (2nd ed.). New York: Guilford press.

Mueser, K., Drake, R., Clark, R., McHugo, G., Mercer-McFadden, C., & Ackerson, T. (1995). *Toolkit: Evaluating substance abuse in persons with severe mental illness.* The Evaluation Center @ HRSI

White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Wilson, J.P. & Friedman, M.J. (*Eds.)* (2004). Dual diagnosis and treatment of PTSD. Chapter 10. By Kim Mueser & Stanley Rosenberg. *In Treating Psychological Trauma and PTSD*. New York: The Guilford Press.

Unit 6:

Topics

- Recovery in Action: An Example
  - Visit to the Village of Long Beach
  - Supportive Employment
  - Member Panel

Required Readings

Becker, D.R. & Drake, R.E. (2004). Supported employment for people with severe mental illness. Behavioral Health Recovery Management Project. http://www.bhrm.org/guidelines/Supported%20Employment%20for%20People%20with%20Severe%20Mental%20Illness.pdf

Corrigan, P. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach*. Chapter 9 &10.

Gowdy, E., Carlson, L., Rapp, C. (2004). Organizational factors differentiating high performing from low performing supported employment programs. *Psychiatric Rehabilitation Journal, 28*(2), 150-156.

Hopper, K. & Wanderling, J. (2000). Revisiting the developing country distinction n course and outcome in schizophrenia: Results from ISoS, the WHO collaborative follow-up project. *Schizophrenia Bulletin, 26*(4), 835-846.

Marrone, J. & Golowka, E. (2005). If work makes people with mental illness sick, what do unemployment, poverty, and social isolation cause? In *Recovery from severe mental illnesses: Research evidence and implications for practice,* Vol 1 Davidson, L., Harding, C., Spaniol L. Boston, MA: Center for Psychiatric Rehabilitation / Boston University, pp 451-463.

Rosenheck, R. A., & Mares, A. S. (2007). Implementation of supported employment for homeless veterans with psychiatric or addiction disorders: Two-year outcomes. *Psychiatric Services, 58*(3), 325 - 333.

Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). (2003) *Supported employment workbook.* http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/16.SE_workbook.pdf

Recommended Readings

U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Mental Health Services. (2003). *Work as a priority: A resource for employing people who have serious mental illness and who are homeless.* www.mentalhealth.samhsa.gov

Becker, D.R. & Drake, R. (2003*). A working life for people with severe mental illness*. Oxford University Press. www.oup-usa/psychweb.

Unit 7:

Topics

- Understanding and Communicating with a Person who is Experiencing Psychosis

Required Readings

Cullberg, J. (2006). *Psychosis: An integrative perspective.* Chapter 15. Routledge.

Mueser, K & Berenbaum, H. (2009). Psychodynamic treatment of schizophrenia: Is there a future? *Psychological Medicine,* 20, Issue 02, July.

Saks, E. (2008). The center cannot hold: My journey through madness. Hyperion.

Recommended Readings

Frith, C. (1995). *The cognitive neuropsychology of schizophrenia.* Hove, UK: Lawrence Erlbaum Associates.

Fromm-Reichmann, F. (1954). Psychotherapy of schizophrenia. *The American Journal of Psychiatry*. 11(6) 410. (Classic)

Fromm-Reichmann, F. (1960). *Principles of intensive psychotherapy.* The University of Chicago Press. (Classic)

Goldstein, K. (1943). The significance of psychological research in schizophrenia, *Journal of Nervous and Mental Disease, 97,* 261-279.

Grof, S. & Groff, C. (1989). *Spiritual emergency: When personal transformation becomes a crisis.* Jeramy P. Tarcher / Putnam. Penguin Putnam, Inc.

Jackson, M. (1994). *Unimaginable storms. A search for meaning in psychosis.* London, Karnac.

Laing, R.D. & Esterson, A. (1964). *Sanity, madness, and the family.* London: Tavistock.

Perry, J.W. (1999). *Trials of the visionary mind.* State University of New York Press.

Rasmussen, B. & Angus, L. (1996). Metaphor in psychodynamic psychotherapy with borderline clients: A qualitative analysis. *Psychotherapy, 33*, 4, 521-530.

Robinson, P. (1972). *Asylum.* King Video.

Searles, H. (1979). *Collected papers on schizophrenia and related subjects.* London: Hogarth Press.

Sullivan, H.S. (1953). The interpersonal theory of psychiatry. (Eds. Helen Swick Perry and Mary Ladd Gawel). Norton & Company.

Sullivan, HS. (1954). The psychiatric interview. (Eds. Helen Swick Perry and Mary Ladd Gawel). New York: W.W. Norton & Company.

Walant, K. (1995). *Creating the capacity for attachment.* Rowman & Littlefield Publishers, Inc.

Unit 8:

Topics

- Symptom Management
  - Wellness Recovery and Action Plan (WRAP)
  - Illness Management and Recovery (IMR)

Required Readings

Mueser, K., Meyer, Pll, Penn, D., Clancy, R., Clancy, D., & Salyers, M. (2006). The Illness Management and Recovery Program: Rationale, development, and preliminary finding. *Schizophrenia Bulletin, 32,* 32-43.

Vreeland, B., Minsky, S., Yanos, P. T., Menza, M., Gara, M., Kim, E., et al. (2006). Efficacy of the team solutions program for educating patients about illness management and treatment. *Psychiatric Services*, *57*(6), 822 - 828.

Whitley, R., Gingerich, S., Lutz, W. J., & Mueser, K. T. (2009). Implementing the illness management and Recovery program in community mental health settings: facilitators and barriers. *Psychiatric Service, 60*, 202–209.

Recommended Readings

Copeland, Mary Ellen. (2002). *Facilitator training manual Wellness Recovery Action Planning Curriculum.* Dummerston , VT :Peach Press.

Unit 9:

Topics

- Supportive Housing
  - Project 50
- Managing Crisis Situations: Risk for Suicide, Violence and Sociopathic Behaviors
  - Crisis Theory
  - Evidence- and Practice-based Methods for Managing Crisis Situations that include Risk for Suicide, Violence and Sociopathic Behaviors

Required Readings

Bellack, A.S., Silverstein, S.M. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review,* 28: 1108-1124.

Corporation for Supportive Housing. http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageID=42&nodeID=81

Corrigan, P. (2009). Principles and practice of psychiatric rehabilitation: An empirical approach. Chapters 8.

Gladwell, M. (Feb 13, 2006). Million Dollar Murray. Why problems like homelessness is easier to solve than to manage. www.gladwell.com/pdf/murray.pdf

Yanos, P. T., Barrow, S. M., & Tsemberis, S. (2004). Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: successes and challenges. *Community Mental Health Journal, 40* (2), 133-150.

Unit 10:

Topics

- Culture, Class, Ethnicity, and Mental Illness
  - The Effects of Culture, Class and Ethnicity on Diagnosis and Treatment
  - Equal Access to High Quality Care
  - Cultural Sensitivity

Required Readings

Alegría, M., Chatterji, P., Wells, K., et al. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*, 1264–1272.

Cohen, A., Patel, V., Thara, R., & Gureje, O. (2008). Questioning an axiom: Better prognosis for schizophrenia in the developing world? *Schizophrenia Bulletin, 34*, 229–244.

Corrigan, P. (2009*). Principles and practice of psychiatric rehabilitation: An empirical approach*. Chapter 20.

DelBello, M. (2002). Effects of ethnicity on psychiatric diagnosis: A developmental perspective. *Psychiatric Times. 19(*3).

Fattot, R. D. (2007). Spirituality and religion in recovery: Some current issues. *Psychiatric Rehabilitation Journal*, 30 (4), 261-270.

Lakes, K., Lopez, S., & Garro, L.C. (2006). Cultural Competence and Psychotherapy: Applying Anthropologically Informed Conceptions of culture. *Psychotherapy: Theory, Research, Practice, 43* (4), 380–396

Lopez, S. (2002). Teaching culturally informed psychological assessment: Conceptual issues and demonstrations. *Journal of Personality Assessment, 79*(2), 226-234.

Lopez, S.R., Kopelowicz, A. & Canive, J.M. (2001). Strategies in developing culturally congruent family interventions for schizophrenia: The case of Hispanics. In D.L. Johnson & H.P. Lefley (Eds.), *Family Interventions in Mental Illness.* Greenwood Publishing Group.

Lopez, S.R., Melson, H.K., Polo, A.J., Jenkins, J.H., Karno, M., Vaughn, C. & Snyder, K.S. (2004). Ethnicity, expressed emotion, attributions, and course of schizophrenia: family warmth matters. Journal of Abnormal Psychology, 113(3), 428-39.

Read, J. & Ross, C. (2003). Psychological trauma and psychosis: Another reason why people diagnosed Schizophrenic must be offered psychological therapy. *Journal of the American Association of Psychoanalysis and Dynamic Psychiatry. 31* (1).

Wong-McDonald, A. (2007). Spirituality and psychosocial rehabilitation: Empowering persons with serious psychiatric disabilities at an inner-city community program. *Psychiatric Rehabilitation Journal, 30 (1),* 295-300.

Yamada, A.-M., & Brekke, J. S. (2008). Addressing mental health disparities through clinical competence not just cultural competence: The need for assessment of sociocultural issues in the delivery of evidence-based psychosocial rehabilitation services. *Clinical Psychology Review, 28*, 1386–1399.

Recommended Readings

Blake, W. (1973). The influence of race on diagnosis. *Smith College Studies.* 43 Pp. 184-193. (classic).

Starkowski, S., Flaum, M., Amador, X., Bracha, H., Pandurangi, A., Robinson, D., & Tohen, M. (1996). Racial differences in the diagnosis of psychosis. *Schizophrenia Research. 21*, 117-124.

Trierweiler, S., Murdoff, Jackson, J., Neighbors, H., & Munday, C. (2005). Clinician race, situational and diagnosis of mood versus schizophrenia disorders, *Culture, Diversity and Ethnic Minority Psychology, 11*(4).

Unit 11:

Topics

- Mental Health Law and Advocacy

Required Readings

Benkhe, S., Preis, J., Bates. T. (1998). *The essentials of California mental health law.* W.W. Norton Publishers. (PACE YOURSELF.)

Unit 12:

Topics

- Guest Speakers
  - Narratives

Unit 13:

Topics

- Family Psycho-education
  - Impacts of Mental Illnesses on Family Members, including Children
  - Empathic Parenting with a Mental Illness: Evidence Based Interventions
  - Family Psycho-education and Advocacy
  - Multi-Family Groups: An Evidence Based Intervention

Required Readings

Corrigan, P. (2009). Principles and practice of psychiatric rehabilitation: An empirical approach. Chapter 11.

Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin, 26*(1), 5-20.

McFarlane, W.R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29*(2), 223-245.

Murray-Swank, A.B. & Dixon, L. (2004). Family psychoeducation as an evidence-based practice. *CNS Spectrum, 9*(12), 905-912.

Recommended Readings

Borrowclough, C. & Lobban, F. (2008). Family Intervention. In K.T. Mueser & D.V. Jeste (Eds). *Clinical Handbook of Schizophrenia*. New York: The Guilford Press.

McFarlane, W. (2004). *Multifamily groups in the treatment of severe psychiatric disorders.* The Guilford Press.

Mueser, K. & Glynn, S. (1999). *Behavioral family therapy for psychiatric disorders, 2nd ed.* New Harbinger Publications, Inc.

Unit 1

Topics

- Peer Support

Required Readings

Corrigan, P. (2009). *Principles and practice of psychiatric rehabilitation: An empirical approach.* Chapter 17.

Davidson, L., Chinman, M., Shells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3), 443–450.

Mead, S. & MacNeil, C. (2006). Peer support: What makes it unique? *International Journal of Psychosocial*
Rehabilitation Journal, 25(2), 134-141.

Tools for Transformation Series: Peer Culture / Peer Support / Peer Leadership. DBHMRS. http://www.nattc.org/userfiles/Tools%20for%20Transformation%20Peer%20Support.pdf

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients.
Psychiatric Rehabilitation Journal, 27(4), 392-400.

Recommended Readings

Alderman, T. & Marshall, K. (1998). *Amongst ourselves: A self-help guide to living with Dissociative Identity Disorder.* Oakland CA: New Harbinger Publications, Inc.

Caris, Silvia. www.peoplewho.org

Campbell, Jean

Copeland, M.E. (2002*). The depression workbook*, 2nd edition. West Dummerston, Vermont: Peach Press.

Fundamentals of co-counseling manual. Seattle, WA: Rational Island Publishers.

White, Barbara & Madara, Edward. (Eds) (2002). The self-help sourcebook: Finding and forming mutual and self-help groups. 7th ed. Denfille, NJ. American Self-help Cleaninghouse. (Chapter 5, “A Review of Research on Self-Help Mutual Aid Groups,”) Elaina M. Kyrouz, et al.)

Unit 15:

Topics

- Resource Drive
- Wrap-Up
- Course Evaluations

STUDY DAYS / NO CLASSES

FINAL EXAMINATIONS

University Policies and Guidelines

IX. Attendance Policy

Students are expected to attend every class and to remain in class for the duration of the unit. Failure to attend class or arriving late may impact your ability to achieve course objectives which could affect your course grade. Students are expected to notify the instructor by email (xxx@usc.edu) of any anticipated absence or reason for tardiness.

University of Southern California policy permits students to be excused from class for the observance of religious holy days. This policy also covers scheduled final examinations which conflict with students' observance of a holy day. Students must make arrangements *in advance* to complete class work which will be missed, or to reschedule an examination, due to holy days observance.

Please refer to Scampus and to the USC School of Social Work Student Handbook for additional information on attendance policies.

X. Academic Conduct

Plagiarism – presenting someone else's ideas as your own, either verbatim or recast in your own words – is a serious academic offense with serious consequences. Please familiarize yourself with the discussion of plagiarism in *SCampus* in Part B, Section 11, "Behavior Violating University Standards" https://policy.usc.edu/scampus-part-b/. Other forms of academic dishonesty are equally unacceptable. See additional information in *SCampus* and university policies on scientific misconduct, http://policy.usc.edu/scientific-misconduct.

XI. Support Systems

Student Counseling Services (SCS) - (213) 740-7711 – 24/7 on call

Free and confidential mental health treatment for students, including short-term psychotherapy, group counseling, stress fitness workshops, and crisis intervention. https://engemannshc.usc.edu/counseling/

National Suicide Prevention Lifeline - 1-800-273-8255

Provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. http://www.suicidepreventionlifeline.org

Relationship & Sexual Violence Prevention Services (RSVP) - (213) 740-4900 - 24/7 on call

Free and confidential therapy services, workshops, and training for situations related to gender-based harm. https://engemannshc.usc.edu/rsvp/

Sexual Assault Resource Center

For more information about how to get help or help a survivor, rights, reporting options, and additional resources, visit the website: http://sarc.usc.edu/

Office of Equity and Diversity (OED)/Title IX compliance – (213) 740-5086 Works with faculty, staff, visitors, applicants, and students around issues of protected class. https://equity.usc.edu/

Bias Assessment Response and Support

Incidents of bias, hate crimes and microaggressions need to be reported allowing for appropriate investigation and response. https://studentaffairs.usc.edu/bias-assessment-response-support/

Student Support & Advocacy – (213) 821-4710

Assists students and families in resolving complex issues adversely affecting their success as a student EX: personal, financial, and academic. https://studentaffairs.usc.edu/ssa/

Diversity at USC – https://diversity.usc.edu/

Tabs for Events, Programs and Training, Task Force (including representatives for each school), Chronology, Participate, Resources for Students

XII. STATEMENT ABOUT INCOMPLETES

The Grade of Incomplete (IN) can be assigned only if there is work not completed because of a documented illness or some other emergency occurring after the 12th week of the semester. Students must NOT assume that the instructor will agree to the grade of IN. Removal of the grade of IN must be instituted by the student and agreed to be the instructor and reported on the official "Incomplete Completion Form."

XIII. POLICY ON LATE OR MAKE-UP WORK

Papers are due on the day and time specified. Extensions will be granted only for extenuating circumstances. If the paper is late without permission, the grade will be affected.

XIV. POLICY ON CHANGES TO THE SYLLABUS AND/OR COURSE REQUIREMENTS

It may be necessary to make some adjustments in the syllabus during the semester in order to respond to unforeseen or extenuating circumstances. Adjustments that are made will be communicated to students both verbally and in writing.

XV. CODE OF ETHICS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (OPTIONAL)

Approved by the 1996 NASW Delegate Assembly and revised by the 2008 NASW Delegate Assembly [http://www.socialworkers.org/pubs/Code/code.asp]

Preamble

The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of

people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

XVI. COMPLAINTS

If you have a complaint or concern about the course or the instructor, please discuss it first with the instructor. If you feel cannot discuss it with the instructor, contact the chair of the [xxx]. If you do not receive a satisfactory response or solution, contact your advisor and/or Associate Dean and MSW Chair Dr. Leslie Wind for further guidance.

XVII. TIPS FOR MAXIMIZING YOUR LEARNING EXPERIENCE IN THIS COURSE (OPTIONAL)

- ✓ Be mindful of getting proper nutrition, exercise, rest and sleep!
- ✓ Come to class.
- ✓ Complete required readings and assignments BEFORE coming to class.
- ✓ BEFORE coming to class, review the materials from the previous Unit AND the current Unit, AND scan the topics to be covered in the next Unit.
- ✓ Come to class prepared to ask any questions you might have.
- ✓ Participate in class discussions.
- ✓ AFTER you leave class, review the materials assigned for that Unit again, along with your notes from that Unit.
- ✓ If you don't understand something, ask questions! Ask questions in class, during office hours, and/or through email!
- ✓ Keep up with the assigned readings.

Don't procrastinate or postpone working on assignments.