Archives of Psychiatry and Psychotherapy, 2013; 3 : 49–56

Training and supervision of residential staff in Community-based Treatment Facilities

Andrzej Axer, Michael Donohue, David Moore, Tom Welch

Summary

Oregon's Public Mental Health System employs a large number of unlicensed personnel with limited formal mental health training, both in state hospitals and in residential treatment programs. These mental health paraprofessionals often have the most frequent and direct contact with seriously mentally ill individuals, and therefore have significant impact on their lives. The authors describe organization as well as clinical and administrative supervision of a mostly paraprofessional team working with severely and persistently mentally ill (SPMI) criminal offenders. The purpose of this article is to delineate the most important factors allowing for effective and safe utilization of the fairy unsophisticated personnel in the community based-secure treatment facility for individuals under criminal commitment, conditionally released from Oregon State Hospital.

staff training / supervision / residential treatment facility

OREGON'S COMMUNITY-BASED RESIDENTIAL SYSTEM

In Oregon, residential facilities typically provide the first point of entry to the community for mentally ill persons released from long-term inpatient treatment who continue to require a high level of care, treatment and supervision. According to patients' needs, Oregon's residential system is divided into secure (locked) and non-secure residential facilities for 6-16 patients, and residential treatment homes for up to five patients. The system is based on the assumption residents will be moving from higher to lower levels of care until they are ready to transition to independent or semi-independent living situations. Oregon has over one hundred fifty licensed residential programs, which are typically operated by private, non-profit mental health organizations like ColumbiaCare Services. Our organization runs seventeen residential treatment programs throughout Oregon at all levels of care.

Andrzej Axer[1], **Michael Donohue**[1], **David Moore**[1], **Tom Welch**[2]**:**
[1]Johnson Creek SRTF, Milwaukie,USA, [2]Columbia Care Services
Correspondence address: aaxer@columbiacare.org

The authors acknowledge that they have not been aided any grant.

PARAPROFESSIONAL STAFF IN RESIDENTIAL TREATMENT FACILITIES

By far, the largest group of personnel in hospital and community based residential programs in the United States consists of paraprofessionals with a bachelor's degree or less [1]. According to Oregon's Mental Health Standards, "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the supervision of a Master Level Mental Health Professional, and who meets the following minimum qualifications:

- (a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three

year's work, education, training or experience; and
- (b) Has the competencies necessary to:
  - (A) Communicate effectively;
  - (B) Understand mental health assessment, treatment and service terminology and to apply the concepts;
  - (C) Provide psychosocial skills development; and
  - (D) Implement interventions prescribed on a treatment plan [2]).

In reality, staff designated as QMHAs consist of a wide variety of individuals whose education encompasses bachelor's degrees in psychology, special education or criminal justice. These individuals may come to work straight from college or are persons with no high school diploma but with many years' experience in in the mental health field. Considering the fact such a diverse pool of employees with limited formal professional training plays such a critical role in providing residential treatment services, it is worth describing factors that allow them to function competently as members of the rehabilitation team. Empirical evidence shows effective teamwork is associated with less staff burnout, more optimistic attitudes about rehabilitation, and better clinical outcome [3]. Competent teams which individualize their services to the specific needs of each patient must develop mechanisms to support their overall mission, develop clear organizational structure, have strong leadership, define critical staff competencies, provide relevant training and positive supervision, encourage collaborative problem solving among team members, and monitor implementation of individualized treatment plans [4]. In the following segments, the authors will review these critical elements separately.

PROGRAM MISSION

Recovery-based residential treatment programs have a common mission of helping individuals with severe psychiatric disabilities achieve greater personal autonomy and improved social functioning. The overall goal is to gradually replace external control with patients' self-directed action, without jeopardizing patients' personal safety. Residential teams are charged with the task of creating and maintaining flexible and gently challenging learning environments where residents are encouraged to try new things that seemed to be out of their reach before.

ORGANIZATIONAL STRUCTURE

The program directed by the authors of this article provides a comfortable residence, psychiatric treatment and rehabilitation to eight individuals with severe mental illness under conditional release agreement from the Oregon State Hospital. The team leaders are an experienced psychiatrist, a doctoral-level professional psychologist, administrator with certification in psychiatric rehabilitation, and assistant administrator with several years of experience in both residential and acute inpatient psychiatric settings. The core team of residential staff consists of ten full time QMHAs and five QMHAs serving as extra help (to cover vacations and leave time of regular employees). The team provides intensive, structured rehabilitation programming for an average of twenty hours a week per each individual patient. The treatment schedule is highly predictable with designated times for group and individual interactions with residents. Skills training and therapy groups are conducted every weekday, always at the same time in the mid-morning and mid-afternoon. Consistency and predictability of group scheduling is a key factor allowing residents to show up on time. Each weekday, in the early afternoon, residents practice social skills in the community individually under the guidance and supervision of an assigned staff member. Evening hours are dedicated to recreation and physical exercises. Weekends are relaxed and include community based planned group activities.

Consistent structure is no less important for staff than it is for residents. There are always two QMHAs on each 8-12 hour shift. Daily routines for shift partners are listed in chronological order from the beginning to the end of their shift. This "Daily road map" includes signing in, checking out a key, reading messages, counting meds; walking through and greeting each resident; checking in with a shift partner to plan specific duties and break; working along with

residents to assist them with their tasks; sitting down by the table and socializing with residents during meals; administering all scheduled medications; reaching out to residents and engaging them in casual conversations; supporting and monitoring residents during community outings; debriefing community skills practice with each resident right after returning home; writing progress notes for activities consistent with treatment plans; taking a break; passing important information to the next shift; and saying "Good Bye" to residents before going home.

PROGRAM LEADERSHIP RESPONSIBILITIES

Roles of program leaders are clearly delineated so all QMHA team members know who is responsible for what. A program psychiatrist, who is also the company's medical director, provides medical oversight of the overall program and conducts regular medication management and therapy sessions with each resident. It is worth mentioning that unlike in many other community mental health agencies in Oregon, the psychiatrist treating residents of ColumbiaCare Services could be considered a model of a highly trained medical leader who seriously considers staff observations and asks for their opinions before making clinical decisions. The psychiatrist, board-certified in both general and forensic psychiatry, is not only permitted but encouraged by the executive leadership to utilize his full array of clinical skills, avoiding being associated solely with the prescription of medications.

The program psychiatrist also plays a significant role in modeling for staff botha collaborative approach and expressing genuine interest in residents. It must be emphasized that a program psychiatrist, who is highly respected by all staff, makes an important contribution to the team development and participates in staff meetings and training sessions. Periodically the psychiatrist facilitates a Balint-like group with the entire staff of the program to address any powerful emotional responses staff might have to their residents or to each other [5].

Aside from the program psychiatrist, other program leaders include the program administrator, the assistant administrator, and the clinical supervisor. The program administrator is responsible for maintaining the consistency of all daily operations with the program mission. His duties include protecting the physical and emotional safety of residents and staff, hiring new personnel, enforcing proper work habits, responding to residents' complaints, facilitating staff meetings, and approving program expenditures. The assistant administrator is responsible for maintaining adequate staff coverage, approving leave requests; coordinating staff initial orientation; keeping personnel files in order; and monitoring house expenditures. The clinical Supervisor designs treatment plans for each resident, conducts individual and group therapy sessions, and facilities monthly treatment plan reviews for each resident. He also provides regular clinical supervision of QMHA staff, giving them concrete written directions on how to assist residents in achieving specific objectives listed in their individualized treatment plans (Tab. 1).

Program leaders meet weekly to review outstanding clinical and operational issues. In all routine situations, program leaders obtain feedback from residential staff prior to making decisions and leave QMHAs some flexibility on how to complete their assignments. A more directive style of management is used only in time of crisis, in dealing with legal liabilities, and in most financial matters.

Table 1: Example of two treatment objectives and recommended interventions

Resident's Treatment Objective	Recommended interventions to be used by QMHA staff
Resident will use coping skills to reduce anxiety and suspiciousness as evidenced by anxiety and suspiciousness scores at or below point 2 on the BPRS scale [6].	Teach self-monitoring of symptoms; demonstrate and coach in using coping skills, including relaxation, yoga, etc.; teach how to use perception check; explore alternative explanations of events causing suspiciousness
Resident will express his thoughts coherently as evidenced by scores at point 2 on conceptual disorganization scale of the BPRS and at point 4 of MCAS Social Effectiveness Scale [7].	Paraphrase and check for understanding; encourage resident to break down complex thoughts in brief sentences; teach how to use correct words in a proper context; practice conversational skills in real life situations

QMHAS RESPONSIBILITIES

QMHA staff members in residential treatment programs function in two basic roles, as caregivers and as skills trainers. Caregiving functions are necessary to maintain residents' health, safety and basic comfort. One example is administering medications to residents who are not yet capable of doing so themselves. Shopping, preparing meals and housekeeping are also ultimately the responsibility of QMHAs, although residents are encouraged to assist them. Other tasks in this category include checking on residents at night, assisting with monthly fire drills, and transporting residents to the community for medical appointments or family visits. In addition, each QMHA is responsible for the implementation of the service plans which address specific care, safety and supervision needs of individual residents.

As skills trainers, instead of providing direct assistance, QMHAs train residents in those skills considered essential for transition to less structured living situations. Social skills training interventions correspond with each resident's goals for community living as part of their individualized treatment plans. Each QMHA must be able to support the implementation of these individualized treatment plans by encouraging residents to learn a particular new skill, and by providing demonstration, teaching problem-solving strategies, and coaching residents in practicing newly learned skill[s] both in a classroom environment and in real-life situations. It is important to mention that QMHAs must maintain a proper balance between teaching and caregiving functions depending on residents' changing physical and psychiatric conditions. However, all staff are expected to always look to maximize learning opportunities and avoid disempowering capable residents.

In order to create a safe and relaxed residential treatment environment, QMHAs are expected to treat residents attentively in a polite and adult manner. Use of humor, spontaneity and limited self-disclosure in the interest of resident needs are strongly encouraged. Each staff member must spend sufficient time with residents, keep promises, and seek reasonable compromises to avoid power struggles. Emphasizing safety, common sense and collaborative decision-making instead of enforcing compliance is a core principle for all staff.

QMHAs are matched with individual residents to serve as their "advocates"; they act like the spokespeople for residents to make sure their needs are not forgotten or discounted by the rest of the team. Staff advocates must know their resident's personal, medical and social needs in depth. They also facilitate contacts with family and friends. Residents are periodically surveyed about their satisfaction with the staff's attentiveness, clarity of communication, fairness, and politeness. Resident feedback is incorporated into clinical supervision whenever appropriate. In the absence of extensive professional training, QMHAs receive periodic reminders that they come to work to serve residents, must be aware of their own mood, motivation and demeanor; and they are encouraged to treat each other and supervisors directly and politely in order to model the same assertive behavior to residents.

HIRING AND SELECTION OF STAFF

Prospective employees who meet formal criteria for QMHA designation are invited for the initial meeting with the program administrator, his assistant and clinical supervisor. They first tour the facility, usually guided by one of the residents, then interview with the managers and, last but not least, are asked to introduce themselves to residents and respond to their questions. The primary purpose of this process is to assess a candidate's judgment, personal boundaries, unique interests and social skills.

Since each job interview is likely to produce performance anxiety, the management team always allows an interviewee to first inquire about the program. Interview questions probe candidates' styles of responding to real work situations in order to assess their natural clinical intuition and problem-solving skills. For example, interviewees are frequently asked how they would respond if a resident threw a plate out of frustration, scattering pieces of glass on the floor, and then went to his private bedroom cussing loudly. Candidates with good judgment usually say they would first clean the glass debris from the floor to prevent other residents from injur-

ing themselves and later check if the frustrated resident was able to calm down on his/her own. Candidates who lack good instincts frequently indicate that they would immediately follow a resident to diffuse his/her anger, which predictably would make things worse. Candidates who tend to be rigid inquire about what is our protocol instead of using their own gut feelings.

This initial interview, even with these projective questions, still leaves the management team with only a very preliminary understanding of a candidate's ability to handle real life situations. Much more informative is the interview with the residents, who quite eloquently ask prospective candidates about their educational background, professional experience, personal hobbies, cooking skills and interest in recreation. Interestingly enough, this process resembles more a conventional job interview than a problem-solving session with the managers. For residents, it is a natural opportunity to practice social skills, which additionally gives them a sense of involvement in choosing people who will take care of them. They also understand that the final hiring decision will always belong to the program administrator. Observing how prospective employees respond to such resident-led interviews always provides an extremely valuable source of information about their social skills. Some candidates appear very timid or are quite uncomfortable and give clients ambiguous or textbook answers. Others show natural warmth, clarity and genuine kindness in relating to people. This is by far the most real part of the hiring process. If selected, every hired staff receives intensive on-the-job training and supervision during a three month trial period, which gives the management team enough time to verify their first impression about a new employee's real abilities.

STAFF TRAINING

Oregon Administrative Rules require that all new residential staff, including QMHAs, receive at least 16 hours of pre-service orientation. The initial training must be completed within 30 days of hire and prior to staff being left alone with residents. The topics covered in the initial orientation include review of the facility's emergency procedures and house expectations, resident rights, basic understanding of symptoms of mental disorders, introduction to medication management, review of residents' treatment plans, crisis response procedures, incident reporting, rules concerning grievance procedures, protecting residents' privacy and confidentiality, and mandatory abuse reporting. The annual refresher follows initial training. Within the first year of employment, all residential staff are also trained in prevention and management of dangerous behavior, including violence and suicide prevention. In addition, bi-monthly team meetings provide a stage for training residential staff in response to current clinical or administrative issues. For example, on-going staff education in our program has covered several practical topics such as how to work well as a team, how to engage residents in skills training, how to respond calmly to challenging behaviors, how to eliminate medication administration errors, how to appropriately use personal self-disclosure and when it is inappropriate, and how to improve clinical documentation so it is more descriptive.

CLINICAL SUPERVISION

Regular clinical supervision sessions with each staff member are conducted at least once per month. In addition, the clinical supervisor observes and provides directions to QMHA staff in real time throughout the day. Review of clinical supervision notes from individual sessions with QMHAs staff between October 2012 and April 2013 revealed the following list of typical staff-resident relationship issues, which could not have been resolved without assistance of a professionally trained clinician.

- Over-involvement with specific residents resulting in burnout-out:

To deal with the stress of demanding residents, staff is encouraged to work as a team. When one is feeling overwhelmed some duties can be passed to the other or can intercept a resident to limit interactions. When the staff is engaging with a resident too much, the clinical supervisor can counsel them on teaching problem solving skills rather than solve a problem for the resident. A parental attitude (overprotective, all-

knowing, always right, and controlling) is discouraged, as it is a source of disappointment and burnout.

- Offering residents too many suggestions instead of allowing them to solve problems on their own:

This issue may result from a desire to protect residents from failure. Staff is taught problem solving strategies and work with the residents to learn those rather than provide repetitive responses or direct advice. This may initially cause more tension during interactions but the end result is change in resident ability to handle various difficulties by themselves.

- Avoiding "unpleasant" residents:

The most common finding is staff unpreparedness to respond effectively to defuse inappropriate behavior. Although disengagement is an option, seemingly spontaneous use of humor can often turn a situation for the better. Role play with the clinical supervisor helps staff to practice responses. Staff is then encouraged to look for an opportunity to use newly acquired skills and provide feedback to clinical supervisor on how it worked. Staff is cautioned against too great a reliance on this technique as a primary response to stop problematic behavior. The clinical supervisor identifies this as a tool to open a dialogue. Staff members are also encouraged to catch the resident doing something right and use this as another opportunity to have a dialogue based on positive interactions.

- Expressing personal frustration with residents who are "lacking of motivation" or "not making improvements:"

This is a common problem with newer staff who have unrealistic expectations of change. They are counseled to ignore any change occurring in the past month and focus on a minimum of 4 to 6 months for evidence of observable change. It is helpful to show newer staff historical treatment goals as evidence of gradual long term changes to address this concern. The clinical supervisor teaches staff how to shape changes incrementally and maintain existing skills of residents.

- Becoming triggered by emotionally reactive or intrusive residents:

A primary focus in supervision is on separation of personal feelings or experiences and the job. The first goal is to review professional self-awareness and clinical boundaries and then encourage staff to think of these episodes as training tools for the residents. The clinical supervisor often uses role-play with staff to formulate their responses to the triggering behaviors and seek alternative approaches. When staff take a similar approach with the resident after an intense situation they can frequently find a more successful way reframe the interaction in a more positive manner. Under no circumstances should the clinical supervisor engage in therapy with any staff.

- Feeling of betrayal by residents who violate house rules and lie about it:

This is an issue of staff personalizing resident behavior. Staff is engaged in training to understand the nature of resident's mental illness. This is intended to help staff to understand the difference between symptomatic and typical behaviors of mental illness. It also helps them understand that withholding or distorting information is also associated with addiction and may be expected.

- Responding to "delusional" talk without directly confronting it:

Staff are first instructed not to argue with residents, the clinical supervisor can instruct staff how to take a dual role in response. First they should not argue against a delusional belief as by definition it is not logical nor does it fit within socially accepted boundaries of understanding. Staff are expected to respond to emotions expressed and assist with processing stressors. Then staff are encouraged to look for the kernels of truth within the symptoms. Certain delusions can be expressed due to outside influences such as family stressors or in response to world events. The clinical supervisor encourages gentle probing to reveal clues to help in processing underlying needs. After becoming familiar with the delusions staff can use them to predict behaviors or watch for stressors. When a good rapport and trust are established with a resident, staff can gently inquire about other issues affecting the resident such as relationships or worries.

- Difficulty in building a relationship with distrustful or withdrawn residents:

Peripheral involvement can assist in engaging residents. The clinical supervisor teaches staff to approach the residents cautiously and respect their space. If the residents are outside enjoying the day or relaxing, staff are encouraged to go outside but not immediately approach them. The clinical supervisor suggests staff find a task to do, when residents are in the area, requiring some assistance, and then tell the residents you need help and ask politely. Thank them afterwards and express gratitude. Look for common interests; don't express hurt if they have a negative reaction, look for opportunities to compliment them. Don't personalize rejection as it may come from excessive internal stimulation, previous bad experiences, or lack of social skills.

- Apologizing for own distress caused by appropriate limit setting:

Staff is encouraged by the clinical supervisor to make simple statements such as, "I'm sorry, I know you really wanted to do X but this is a house rule" or, "I know this is upsetting to you but the doctor said X." If the resident is able, staff can teach problem solving for the specific issue.

In addition, the clinical supervisor reviews all QMHA progress notes and provides instant feedback to staff regarding the quantity and quality of their documentation. Clinical documentation of QMHA staff requires corrections for a variety of reasons, from spelling and syntax errors to more subtle issues, like separating factual observations from subjective opinions or assumptions regarding resident's motivation. Regular clinical oversight over the years has resulted in major improvements in clinical documentation. QMHAs staff are now able to write progress notes more concisely and descriptively, with better focus on specific interventions, and with more direct links to residents' treatment objectives.

ADMINISTRATIVE SUPERVISION

The program administrator and his assistant have an open door policy and interact with staff daily but their formal sessions with individual staff are scheduled every three months. Basic work expectations are clearly communicated in real time through direct feedback. Poor habits which require prompt corrective action include addressing residents in an abrupt manner, socializing with other staff excessively, talking about residents in public areas, ignoring safety precautions, coming to work late or not being able to complete assigned tasks within a scheduled time. One important message which an administrator frequently repeats to QMHA staff is that they must offer undivided attention to residents at all times without any distraction caused by their personal business, including reading a newspaper while supervising a resident in the kitchen.

Occasionally, one staff person requests an administrator's assistance in conflict resolution with another staff. However, the administrator gets involved in conflict between staff only as a last resort after both parties were unable to resolve the issue directly in spite of repeated attempts. More often, the administrator demonstrates to staff how to use assertive communication to give and receive feedback without getting into arguments. Interestingly enough, QMHAs sometimes have difficulties in being firm and polite with each other but they are able to use the same skills effectively with residents. For this reason, the administrator attempts to act like a coach for the staff rather than as an arbiter. The only exception to this rule would involve staff reporting alleged abuse of a resident by another staff member. Fortunately, there was no such case in the past three years.

SUMMARY

Based on the authors' experience, there are certain essential factors making it possible to utilize paraprofessional staff in the best interests of residents. These factors are:

- Program mission understood by all staff
- Fairly cohesive management team with clearly divided roles
- Residents involved in hiring of QMHA staff
- Staff kept accountable for their commitments and actions
- Schedules for both staff and residents consistent and predictable
- Concrete directions for QMHAs on how to implement treatment plans

- Treatment and documentation issues addressed in clinical supervision
- Staff performances issues addressed separately in administrative supervision

CONCLUSION

With proper training and supervision rooted in the clear program mission and clinical/organization structure, paraprofessional staff members without prior formal mental health training can effectively and safely work with the psychiatrically disabled individuals, treated under criminal commitment in the community-based secure residential setting.

REFERENCES

1. Liberman RP, Hilty DM, Drake RE and Tsand HW2001 Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation, Psychiatric Services 2001; 52(10).
2. Oregon Administrative Rules OAR 309-032-1505 (104): http://arcweb.sos.state.or.us/banners/rules.htm
3. Corrigan, PW, Giffort, DF (Eds). Building Teams and Programs for Effective Psychiatric Rehabilitation. New Directions in Mental Health Services 1998; (79).
4. Corrigan, PW, McCracken, SG. Training Teams to Deliver Better Psychiatric Rehabilitation Programs. Psychiatric Services 1999; 50(1).
5. Balint M. The doctor, his patient, and the illness. New York: International Universities Press, 1957.
6. Ventura J, Nuechterlein KH, Subotnik KL, Gutkind D, Gilbert EA. Symptom dimensions in recent-onset schizophrenia and mania: a principal components analysis of the 24-item Brief Psychiatric Rating Scale. Psychiatric Research 2000; 97(2).
7. Barker S, Barron N, McFarland BH, Bigelow DA. A community ability scale for chronically mentally ill consumers: Part I. Reliability and validity. Community Mental Health Journal 1994; 30(4).

ACKNOWLEDGMENT: The authors wish to thank Bob Beckett, President/Executive Director and Gary Mcconahay, PhD, Clinical Director of Columbia Care Services for carefully reviewing this article and for their helpful comments.