



Mental Health Specialty Training

Recommendations for Improvement
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1 | Introduction

The State of Washington Department of Social and Health Services, within one of its functions, licenses and monitors the state's Assisted Living Facilities and Adult Family Homes. Within that network of care, three care specialties exist which require caregivers to receive specialty training: dementia, mental health, and developmental disabilities. These three specialties have established training curricula and requirements that are detailed in the Washington Administrative Code (WAC), Chapter 388-112—Residential Long-Term Care Services.

Beginning in January of 2014, DSHS retained the services of Coraggio Group to assist them in implementing sections of SSB 5630 that enact recommendations of the Adult Family Home Quality Assurance Panel and relate to improvement of and expansion of specialty training for Adult Family Homes and Assisted Living Facilities. As a first step, DSHS and Coraggio Group undertook a statewide Stakeholder Outreach tour to:



- › Solicit feedback on the current specialty trainings and requirements,
- › Identify opportunities to improve the trainings,
- › Identify needs for additional specialty trainings, and
- › Identify opportunities for the revision of relevant portions of the WAC.

Planning for the Stakeholder Outreach effort began with identification of target stakeholder groups, assessment of geographic distribution of homes, and development of discussion guides to ensure that the conversations generated consistent categories of feedback. Forty meetings were held, including individual interviews, focus groups, public meetings, telephone interviews, and telephone focus groups. An online survey was also employed to gather feedback. The Stakeholder Outreach effort concluded in mid-June, 2014 and ultimately included nearly 400 individuals sharing their perspectives about the specialty trainings.

A research effort followed this gathering of stakeholder input, where the content, instructional quality, and program design of the specialty training was reviewed against current research in care and adult education, as well as trends among other states and international care programs.

Compared to Dementia and Developmental Disabilities, even fewer states have training programs developed specifically for Mental Health caregivers. The National Alliance on Mental Illness (NAMI) has a program called NAMI Basics, which provides caregiver training through their state affiliates, and this may fill in training gaps in some states. We found many areas where current thinking and research points to ways in which the Mental Health specialty training can be made better, and we heard from many stakeholders what they would like to see in future versions of the training. This research effort also included visits to Adult Family Homes and interviews with caregivers and providers.

Based on this combination of stakeholder input and research, we have formulated the recommendations contained in this report. Many of these recommendations are “common sense” and will be relatively easy to adopt. Others will pose a challenge for DSHS to implement, and will likely require a phasing plan in order to prioritize the most important changes.

2 | Summary of Stakeholder Input

The pages that follow compile many of the key themes heard during stakeholder outreach that took place between January and June 2014. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training.

NOTE: For a full report of all collected comments related to the Mental Health Specialty Training, please see the appendix to the DSHS Specialty Training Stakeholder Outreach Report. This report is available for download on the DSHS website at:

[https://www.dshs.wa.gov/sites/default/files/AL TSA/stakeholders/documents/specialtytraining/DSHS Outreach Report.pdf](https://www.dshs.wa.gov/sites/default/files/AL TSA/stakeholders/documents/specialtytraining/DSHS%20Outreach%20Report.pdf)



Key Stakeholder Comments Related to Content of Mental Health Specialty Training

A key mental healthcare skill that should be better supported by the specialty training is crisis management.

Many stakeholders, including Ombuds, observed that caregivers are all too often unprepared for crises with their mental health residents. This includes behavior management skills, but also includes crisis planning—often the plans are not used properly, if they exist at all. It was suggested many times that these portions of the training should be bolstered.

- › “More on crisis training - exists in curriculum, but weak. (And mental health support system is very broken, so people will need to handle crises on their own.)”
- › “I don't think there is much training about de-escalating residents. It seems like what I see is that even when there is a lower-level crisis, even if that is a part of their baseline, the caregivers kind of are paralyzed and don't know, and are trying to figure it out as they go. Is there a crisis plan in place?”
- › “I have observed that often the crisis plan is there, but they haven't been trained on it, and they don't access or use it.”
- › “Caregivers should know who to call if a situation escalates - when to call mental health crisis teams vs. 911. They should also be trained on how to react in such a situation - and how to protect themselves and other residents.”

Caregivers should be able to identify signs and symptoms of mental illnesses, and know how to track behaviors so they are aware of changes.

With mental health clients, many caregivers don't seem to have an understanding of how to document behavior on an ongoing basis, or what behaviors they should be watching for that may indicate decompensation. This creates situations where a resident's mental health may begin to decline and—because their behavior is not being compared to an established baseline—the decline isn't noted until it has become a crisis. Stakeholders felt that instruction around documentation of behavior needs to be stronger in the training.

- › “Documentation is important. The residents are in a state of change, so it needs to be written that we could see the change when they are living with us.”
- › “[Caregivers should understand] signs of decompensation in mental health patients.”
- › “Do they know the baseline and what to do when they see signs and symptoms?”

2 | Summary of Stakeholder Input

- › “We don't care if somebody diagnoses mental health, because that is not their job, but they should recognize signs and symptoms. Sometimes, depression might manifest as staying in their room, and no AFH is going to report that.”
- › “We don't want diagnostic clarity, but we want them to share information and want them to notice these things as potential signs of mental illness.”

The training should better prepare caregivers to advocate for their clients medically and to access community mental health resources on behalf of their clients.

It seems to be an accepted fact that there are challenges and gaps within the mental health system. However, even when services are available, many caregivers do not know they exist, or do not know how to access them. Better preparing caregivers with ways to access community mental health resources, and with an understanding of what is available and when to use it, will likely improve outcomes for clients.

- › “How does a provider take notes and document changes that they see so they can advocate with medical personnel, and can communicate with the social workers and families.”
- › “More information on... resources available to us.”
- › “[Caregivers should know about] resources that are available (or not – emergency response may be limited); e.g. RSN (Regional Support Network).”
- › “How do caregivers handle a situation they can't address? How do you access resources? Who do you go to?”

Personality disorders are not covered in the training, yet are some of the most difficult to manage in a care setting.

In the existing specialty training manual, personality disorders are noted only to mention that they are not covered by the training. Many stakeholders feel that this omission is inappropriate, because many of the most challenging mental health clients have one of the various personality disorders.

- › “I don't see personality disorders [in the training] - borderline, narcissistic, dissociative. Those are the really challenging behavior components to work with as well.”
- › “Add personality disorders to module 1.”
- › “I don't see personality disorder classifications (borderline, narcissistic, etc.) in the Mental Health training outline – can be most challenging in ALF settings.”
- › “I think the biggest population we see out there is personality disorders, and that is not covered by the book... Those are what our main audience is, and the book does not touch on them at all.”

The cultural sensitivity module needs to be refreshed.

We heard from stakeholders that there is a very real need to have cultural sensitivity built into the training. However, many of them feel that the current module, though well-intended, could be improved. Suggestions were made that the topic should also be intentionally included throughout the manual, and not only in the specific module.

- › “The cultural sensitivity section is not very well-done at all. I see what they are trying to do, but it wasn't done very appropriately. When you are from this culture, you can write a cultural sensitivity module and miss a lot.”
- › “Cultural section is written by somebody who knows all the right steps from the book.”
- › “Cultural training is more textbook and less relevant to what is needed.”

The specialty training should provide caregivers with a better understanding of psychotropic medications.

Because medications are so central to the care of mental health patients, and because this is an ever-changing part of the care, a great number of stakeholders felt that the training information about medications should be updated and expanded. They felt that many caregivers don't understand the importance of proper dosing, how to watch for side effects, or what other factors may influence the effectiveness of medications.

- › “I would expect staff members to know more about medications related to mental health, and understand the importance of compliance with medications.[In] the community setting - clients tend to not want to take medications. I would want the staff to understand the importance of anti-psychotics and/or antidepressants.”
- › “I would want them to know that this person needs to be on medication to remain stable.”

- › “Understand medications and side effects.”

Providers should come out of the mental health specialty training with a clear understanding of the complexities of caring for mental health clients.

Stakeholders expressed concerns that many homes begin taking in mental health clients without fully understanding how it will affect the other residents in their homes, or without being fully prepared to handle the complex nature of caring for these clients. While building this understanding is important for every caregiver, it is especially important for providers and managers to understand, pointing to a possibility that this could be somehow covered in more depth in the manager training.

- › “In licensing, the homes I saw get in over their heads were the ones trying to take in this population. They didn't understand what they were getting into.”
- › “The desperate homes who take in a MH resident, and then they realize that they are over their heads and that they should have done a better job assessing.”

Key Stakeholder Comments Related to Instruction for Mental Health Specialty Training

The materials are in need of an update to incorporate the latest thinking around mental health care.

A great many stakeholders feel that it is time to update the specialty training curriculum for mental health, especially in light of how rapidly the field is changing—new models of care and new medications being two updates recommended specifically. Additionally, many stakeholders felt that the current training is based in a “medical model” and that more current thinking would indicate a curriculum based in a “person-centered” care model.

- › “Curriculum was pretty good at the time, but is not current and evidence-based.”
- › “There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma informed and be more experiential vs. medical.”
- › “The person-centered approach should be the focus of the training model, not the medical model.”

Adding video resources to the training materials would help students to understand what behaviors look like.

Unlike the dementia specialty training, the mental health specialty training does not have a set of videos that accompany the written training manual. Stakeholders believe that the addition of a video element to this training would better prepare caregivers for behaviors they are likely to encounter in the care setting, and could demonstrate useful principles of care.

- › “[The training should include] DVDs of what mental illness symptoms look like.”
- › “Provide video of experts interacting with mental health clients.”
- › “A supporting video would be nice as long as it a quality video with examples and demonstrations of various mental disorders.”

Role-playing is a strong tool for building an understanding of skills, yet some are uncomfortable with it as a training technique.

Opinions were somewhat split on the inclusion of role-playing in the delivery of mental health specialty training. Some stakeholders felt that role-playing is a critical tool for building an understanding of how interactions with clients will go, and for practicing useful care tools. They also felt that the role-playing may help with comprehension in students who are less proficient in English. Other stakeholders felt that the role-playing is an uncomfortable part of the training, may cause students to disengage from the learning, and may cause frustration in ESL learners.

- › “Do more real life scenarios and role playing.”
- › “The role-playing, for me, was the most effective part. It's kind of hard - for somebody who has experience in the field, that perspective is different than somebody who is fresh.”

2 | Summary of Stakeholder Input

- › “Struggle with role-playing exercises, particularly with ESL. Hard to explain and get through with various individuals in the class. And [the] process itself is uncomfortable.”

Key Stakeholder Comments Related to Mental Health Specialty Training Requirements and Testing

There is too much content to be covered in four hours of training.

While recognizing that a longer training will put a cost burden on facilities, there was broad consensus that the current time requirement for mental health specialty training is insufficient for the amount of information that should be conveyed.

- › “The timeframe is way too short. If you are just teaching the mental health book, it's four hours - that is not enough time to cover the topics in here. We originally dedicated eight hours, and got it chopped back to four.”
- › “Limited material or time given to the material, as I recall.”
- › “Need to match requirements with [the] time allowed.”
- › “It's a lot to take in within a short amount of time. And they have expressed that they wish there was a follow-up class.”
- › “[The training needs to allow for] more time to work on real life scenarios [of] hallucinations and delusions.”

The test does not measure the desired skills, and does not measure skill application.

Stakeholders felt that the test given with the training is too focused on testing the rote memorization of technical information from the manual, and not focused enough on assessing whether caregivers understand and are able to apply care principles and skills. Many stakeholders questioned whether a true competency assessment can be done in a written test.

- › “[The test] seemed to emphasize lingo more than practical skills.”
- › “Need to verify skills. How do you know they can apply them?”
- › “I agree we have to have an objective, concrete, written tool. In my experience the test is poorly written.”
- › “Where is the ongoing assessment of skill sets after the training?”

Having the option of adding modules that go into depth within certain mental illnesses would help caregivers zero in on the skills and understanding they need most.

Because the mental health specialty training is—necessarily—generalized, many stakeholders indicated that it would be advantageous for caregivers to be able to add deeper training that is more specific to the population they will serve.

- › “Current training is very basic preparation. Adequate starting place, but needs to continue.”
- › “Consider a more modular approach.”
- › “I think it's a good introductory to what is out there - for people who have never experienced mental health, and maybe they can use that to help a resident in a crisis situation. But it's really just an introduction.”

Key Stakeholder Comments Related to Instruction for All Current Specialty Trainings

Many stakeholders questioned whether manager training shouldn't be given a greater differentiation from the standard caregiver training.

The current training practice is that managers receive the same training as the caregivers, but receive a short additional segment of training, and are also given a separate exam. Stakeholders wished for more clarity around the differentiation, and possibly a complete separation.

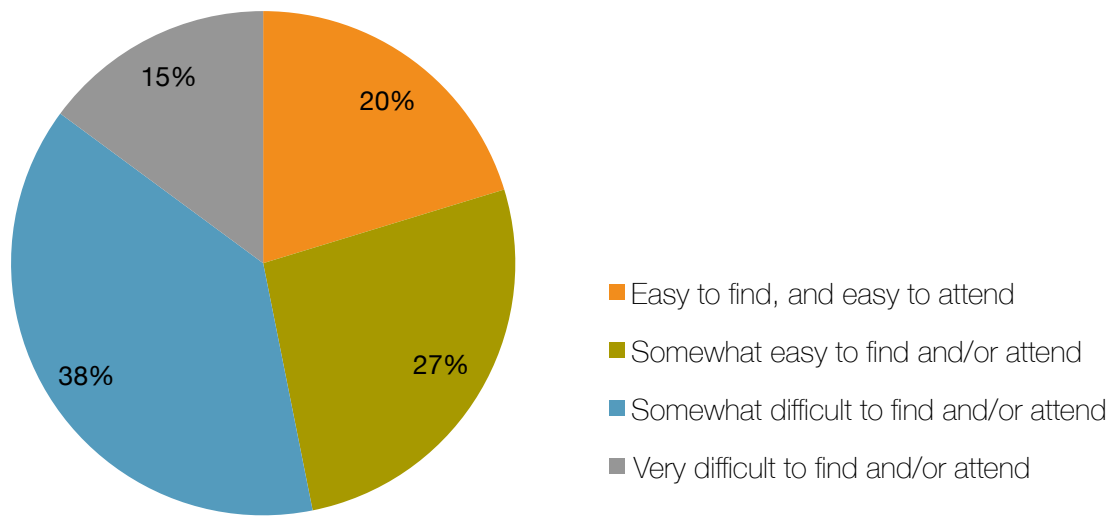
- › “I have heard that we should break out the manager training... a lot of what is in the training for the caregivers...”
- › “What skills should managers have? Should there be different training? It seems to me that maybe something around leadership and quality - how to evaluate and how to be a good manager. How to follow through. Seems like those would be good manager training. A lot of time people get hired, but they don't get the training that goes with the title.”
- › “It is also difficult to train managers in the same class as others. I think they should be offered as different classes. Everyone else had to stay an extra hour and a half while the managers were going through the extra training and skills testing.”
- › “[DSSH needs to] clarify [the] intended difference between manager and caregiver skills and training.”

There is a desire for the specialty trainings to be more accessible in terms of frequency, location, and audience.

Stakeholders are eager to have greater access to trainings. The need is especially acute in rural areas, where traveling to trainings adds additional cost burdens for caregivers and providers. A desire for family members to have access to these trainings was also noted.

- › “Improved access. Content is fine.”
- › “The classes aren't accessible enough.”
- › “Classes need to be more frequent and more local – staff cannot work in an AFH unsupervised until they have completed this class and sometimes staff need to wait anywhere between 4-8 weeks to get [into] a class.”
- › “Some of my AFH providers say there used to be online training that was accessible.”
- › “I think specialty training should be opened up to family members.”

The following chart represents how survey respondents answered a question about how easy to find and/or attend specialty training is:



Key Stakeholder Comments Related to Requirements and Testing of All Current Specialty Trainings

DSHS should look at ensuring consistent delivery of trainings and examinations across the state.

While recognizing that the specialty trainings will likely never be perfectly consistent, stakeholders believe that there is room for improvement, and that new delivery methods or requirements may ensure a greater consistency in the delivery of training.

- › “[It would be] helpful if training were more consistent - so that home owners or administrators can rely on what people have learned, regardless of where they were trained.”
- › “The level of training is not consistent across the state of Washington.”
- › “Training is not consistent. Trainers are human [and they have] different approaches, expertise, [and] and knowledge. Sometimes managers teaching the classes don't really grasp the material themselves, [and] may just be reading/following [the] structure or showing video, vs. adding own experience, real-life scenarios.”
- › “Consider a better 'train-the-trainer' model that ensures more consistent delivery and skills.”

DSHS should carefully consider how to address language differences, and their effects on training and care.

It is likely that there will continue to be a significant number of caregivers for whom English is not their first language. There are trade-offs to be identified and discussed between current requirements for a basic level of English to be spoken and the desire to create opportunities for highly skilled and empathetic caregivers to succeed—regardless of their English proficiency. As specialty trainings and WAC requirements are reviewed or updated, this is a topic that a great many caregivers identified as a critical one to address, although there was a plurality of opinions as to how these trade-offs should be handled.

- › “Currently, training is one-size-fits-all. If we are moving into the 21 century, we could look at translating training documents into the 5 main core languages and offer training done in English and translated into the 5 core languages.”
- › “Maybe even provide a test on communication as a prerequisite before taking the class. If students do not pass, then they must take a class until they pass the examination on communication. It is not about their deficiency in the English language but they must be able to communicate clearly to a population who are already vulnerable due to their cognitive impairments.”
- › “Many of the medical terms will be difficult for those who are less fluent in English, while the concepts will not. Find ways to adapt training so that there are alternative paths to understanding, or different ways for the provider to communicate the concepts to the caregivers if they are giving the training.”
- › “Language in the test makes it unnecessarily difficult for people who are not native English speakers. Uses words like 'may' 'inheritance' 'heredity' 'strengths' ' meaningful' that are not clear and/or familiar. Test-takers don't want to speak up.”
- › “We need to have greater access to teaching English as a second language to help empower our staffs.”
- › “If I have dementia and English is a second language for the caregiver, it is hard to have good communication.”
- › “Caregivers who are not clear in English have more difficulty communicating with residents, receiving training, and comprehending the test. [They were] able to demonstrate that they understood in person, but couldn't pass the test.”
- › “[It] could be helpful to translate the materials. The Home Care Aid exam is translated into 12 languages [but these specialty trainings are] only in English. [This] may eliminate people who could be very effective.”

Stakeholders felt that the system would benefit if the Ombuds and DSHS staff were required to take the specialty trainings, so that they have the same understanding as caregivers.

Many stakeholders observed that their interactions with DSHS staff members and Ombuds are sometimes challenged because these individuals don't always have a full understanding of how caregivers are trained and what best practices for care may be.

- › “Training for Ombudsman – [they] may come in to interview/assess [specialty] residents, but the ombudsman doesn't have appropriate skills for working with a person with [specialty], and causes new problems.”
- › “I think bringing the ombudsmen into the training would be very helpful and valuable.”
- › “We would like it if the licensors had to take the training. They would better understand what we are doing and why. Case managers too—so they understand how much time it takes to deliver this care.”
- › “Ombudsman should be trained also—they need to know how to interact with the residents.”
- › “The licensors should also be trained or informed of the training requirements.”

3 | State and International Trends

In order to assess how Washington's curriculum compares to the curriculum required or provided by other jurisdictions, we structured a research effort that looked at a cohort of other states, as well as a handful of English-speaking countries. Private sector training materials proved difficult to gain access to without signing up for the training programs themselves.

To determine a cohort that would provide a good baseline to compare Washington against, we began with research promoted by AARP, the Commonwealth Fund, and the Scan Foundation: the *2014 Long Term Scorecard*. (Reinhard, Kassner, Houser, Ujvari, Mollica, and Hendrickson, 2014) Thinking about impact in terms of care outcomes, we began with the data category of "Quality of Care and Quality of Life", from which we identified the top five states:



1. Minnesota
2. Alaska
3. North Dakota
4. Iowa
5. South Dakota

Through online investigation and telephone conversations with state agency representatives, we learned that there was little correlation between states that were top performers in this category and rigorous training requirements for caregivers. In most of these states, there is no requirement whatsoever for specialized training. It appears as though other factors are driving the successful outcomes in these states, possibly including rural settings with deeper community connections, higher caregiver retention based on limited availability of jobs, and a regional culture of care (note that four of these five states are adjacent to one another).

In looking at the training requirements for Developmental Disabilities and Dementia, we utilized a second cohort that included 11 states that require 40 hours or more of training for caregivers (Washington requires 75), and five which have specific skills and curriculum provided by the state. Overlap in these two lists left us with a 13-state cohort for which we conducted additional research to learn their general requirements for caregiver training. However, we found that this cohort had minimal requirements for mental health specialty training. Those states that have some specific requirements for mental health caregiver training are listed below:

Colorado

Staff shall be given on-the-job training or have related experience in the job assigned to them. Prior to providing direct care, the facility must provide adequate training on specific needs of the population served (e.g., residents in secured environments, severely and persistently mentally ill, frail elderly, AIDS, Alzheimer's disease, diabetics, dietary restrictions, and bedfast)

3 | State and International Trends

Idaho

A facility admitting and retaining residents with a diagnosis of dementia, mental illness, developmental disability, or traumatic brain injury must train staff to meet the specialized needs of these residents. For mental illness, staff are to be trained in the following areas: overview of mental illness; symptoms and behaviors specific to mental illness; resident's adjustment to the new living environment; behavior management; communication; integration with rehabilitation services; ADLs; and stress reduction for facility personnel and residents.

Maryland

Staff whose duties include personal care must complete a state-approved, five hours of training on cognitive impairment and mental illness within the first 90 days of employment. Staff whose job duties do not involve the provision of personal care services shall receive a minimum of two hours of training on cognitive impairment and mental illness within the first 90 days of employment.

Michigan

[Caregivers must have] an introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home. Training shall be obtained from individuals or training organizations that use a curriculum that has been reviewed and approved by the department.

Missouri

For residential care facilities, prior to or on the first day that a new employee works in a facility, he/she shall receive orientation of at least one hour appropriate to job function. The orientation shall include but not be limited to: job responsibilities, emergency response procedures, infection control, confidentiality of resident information, preservation of resident dignity, information regarding what constitutes abuse/neglect and how to report abuse/neglect, information regarding the Employee Disqualification List, instruction regarding the rights of residents and protection of property, and instruction regarding working with residents with mental illness.

Ohio

The initial training required for providing care for special populations of residents (late-stage cognitive impairment, increased emotional needs or presenting behaviors, or serious mental illness) must be conducted by a qualified instructor for the topic covered.

Pennsylvania

Assisted living residence direct care staff may not provide unsupervised assisted living services until completion of 18 hours of training including a demonstration of job duties, followed by supervised practice, and successful completion and passing the licensing agency approved direct care training course and passing of the competency test. Initial direct care staff training includes safe management techniques; assisting with ADLs and IADLs; personal hygiene; care of residents with mental illness, neurological impairments, mental retardation, and other mental disabilities; the normal aging-cognitive, psychological, and functional abilities of individuals who are older; implementation of the initial assessment, annual assessment, and support plan; nutrition, food handling, and sanitation; recreation, socialization, community resources, social services, and activities in the community; gerontology; staff person supervision; and other specified elements.

3 | State and International Trends

We were able to analyze two state-designed mental health care trainings (Michigan and Pennsylvania), as well as one designed by the National Alliance on Mental Illness (NAMI), to compare them with Washington's in terms of content. The table below summarizes which modules are included in each of these trainings. In the interest of comparison, reasonable efforts were made to collate similar topics with the same title. The three highlighted rows represent topics that have been included by two or more of the reviewed trainings. In every case, these are also included in the Washington training curriculum.

Count of Module Titles in State and Non-Profit Mental Health Caregiver Trainings

Modules	MI	PA	WA	NAMI	Total
Advocacy, Review, Sharing and Evaluation				1	1
Care for Residents with Dementia/Mental Illness/Mental Retardation		1			1
Approaches and Techniques For Dealing With Challenging Behavior	1		1		2
Culturally Compassionate Care			1		1
Decompensation and Relapse Planning			1		1
Environmental Emergencies: Preventing, Preparing, and Responding	1				1
Getting Help and Self Care			1		1
Introduction to Community Residential Services/Your Role as Direct Care Staff	1				1
Introduction to Mental Disorders			1	1	2
Medications and Mental Health	2		1		3
Nutrition and Food Service	1			1	2
Objective and Subjective Family Burden				1	1
Respectful Communications			1		1
Suicide Prevention			1		1
The Biology of Mental Illness: Getting an Accurate Diagnosis				1	1
The Rights of Individuals Receiving Mental Health Services	1				1
The Systems Involved With Your Child and the Importance of Record Keeping				1	1
Treatment Works				1	1

The table on the following page details the percentage of the total training material devoted to each topic within these four training manuals, as a way to measure how each state prioritizes particular topics. Because medications are such a complex part of mental health care, it is not surprising that Michigan has devoted such a large portion of its curriculum to them. What is perhaps surprising, based on what we learned from the stakeholders we surveyed, is that behavior and communication don't rank as a major portion of any of the four curricula reviewed.

Topics, As Percentage of Overall Training Content in State and Non-Profit Mental Health Caregiver Trainings

State	Topic	Percent
Michigan	Introduction to Community Residential Services/Your Role as Direct Care Staff	10%
Michigan	The Rights of Individuals Receiving Mental Health Services	3%
Michigan	Basic Health and Medications	24%
Michigan	Nutrition and Food Service	13%
Michigan	Environmental Emergencies: Preventing, Preparing, and Responding	11%
Michigan	Working with People: Positive Techniques to Address Challenging Behavior	10%
Michigan	Advanced Health and Medications	29%
Washington	Introduction to Mental Disorders	17%
Washington	Culturally Compassionate Care	8%
Washington	Respectful Communications	12%
Washington	Creative Approaches to Challenging Behavior	14%
Washington	Decompensation and Relapse Planning	23%
Washington	Suicide Prevention	8%
Washington	Medications and Mental Health	10%
Washington	Getting Help and Self Care	7%
Pennsylvania	Care for Residents with Dementia/Mental Illness/Mental Retardation	N/A
NAMI	Introduction: It's Not Your Fault; Mental Illnesses are Brain Disorders	16%
NAMI	The Biology of Mental Illness: Getting an Accurate Diagnosis	16%
NAMI	Treatment Works	16%
NAMI	Objective and Subjective Family Burden	16%
NAMI	The Systems Involved With Your Child and the Importance of Record Keeping	16%
NAMI	Advocacy, Review, Sharing and Evaluation	16%

Based on our comparative assessment and our stakeholder outreach, Washington's current training requirements and curriculum are not optimized, and significant extensions, inclusions, and revisions are necessary in order to have the greatest positive influence on care outcomes possible. The following chapters detail our recommendations for updates to the design of the mental health caregiver training program, improvements in instructional quality, and updates and improvements to the content of the curriculum, as well as the changes these updates imply for the Washington Administrative Code.

4 | Recommendations: Content

The recommendations in this section call for doubling the length of time that caregivers will spend learning about the mental health specialty. In part, this is to bring the three existing specialty trainings closer together in terms of time requirements, but it is also a reaction to what we heard from stakeholders—namely, that the current mental health specialty training does not sufficiently prepare new caregivers on topics specifically related to care of those with mental illnesses.

In our analysis of DSHS data, we found a correlation between certain client needs and frequency of moves from one facility to another. We also identified a correlation between some behaviors and frequency of client moves. Some of these client needs and behaviors (symptoms) are topics that can be addressed in the training content, such as: medication management, delusions, and hallucinations.

We believe that if Washington takes special care in redesigning the curriculum to bolster understanding around these and other key client needs, it will positively affect not only the number of moves that clients endure, but also may have positive impacts on caregiver engagement and retention.

We have also included recommendations for Washington to begin to include new ways of thinking about care delivery, and to continue its role as a leader in the field.

Key Recommendations

The following six recommendations are, among all changes considered, those that were most requested by stakeholders, most indicated through our research, or most urgently in need of updating:

- › Expand the basic mental health training to 12 hours – approximately half online, half in-person
- › Create online learning modules that will total approximately 6.5 hours of instruction:
 - Module 1: Introduction to Mental Disorders
 - Module 2: Caregiving for Mental Health
- › Redesign the instructor-led training materials to total approximately 5.5 hours of instruction, including:
 - Module 3: Respectful Communication
 - Module 4: Creative Approaches to Challenging Behaviors
 - Module 5: Suicide Prevention
- › Include Trauma-Informed Care (TIC) as a topic in the *Caregiving for Mental Health* module.
- › Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of mental illness, other reference material, and contact information that becomes a tool for caregiver use.
- › Update the look and feel of the training materials to reflect the importance of the topics.



Expand the basic mental health training to 12 hours – approximately half online, half in-person

We heard from many caregivers that the current four-hour training is not sufficient to prepare a caregiver to begin working with residents who have mental illness:

- › “The timeframe is way too short. If you are just teaching the mental health book, it's four hours - that is not enough time to cover the topics in here. We originally dedicated eight hours, and got it chopped back to four.”
- › “It's a lot to take in within a short amount of time. And they have expressed that they wish there was a follow-up class.”
- › “[The training needs to allow for] more time to work on real life scenarios [of] hallucinations and delusions.”

Considering the quantity of material that is implied by the required learning objectives, and the length of the current manual, it is clear that caregivers would benefit greatly from a training curriculum that goes into more depth, while also being less rushed.

Access to training was also expressed as a concern by many stakeholders, particularly those in less-populated portions of the state. Our recommendation that only portions of the training be in-person allows that the instructor-led training will still be delivered within one day, while the online portions would allow for more flexible scheduling of training. While this may not improve access overall, per se, this arrangement will not exacerbate the issue.

Create online learning modules that will total approximately 6.5 hours of instruction

There is a significant amount of technical and background material in the mental health specialty training that we believe will be best delivered via multimedia online training. This will allow learners to self-pace on complicated materials, and will also allow for translation of technical materials into caregivers' native languages (see translation recommendation on page 28).

- › “I would expect staff members to know more about medications related to mental health, and understand the importance of compliance with medications.[In] the community setting - clients tend to not want to take medications. I would want the staff to understand the importance of anti-psychotics and/or antidepressants.”
- › “There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma informed and be more experiential vs. medical.”

We also believe that adding an online portion to the training addresses, in part, the access challenge that was cited by stakeholders. In fact, many stakeholders specifically called for online training:

- › “Online training would be helpful for rural areas.”
- › “Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information. (Could have a blend of both online and in-person.)”
- › “I would like to see interactive ONLINE training.”

We recommend the following topics be included within the two online modules:

- › Module 1: Introduction to Mental Disorders
- › Module 2: Caregiving for Mental Health
 - Culturally Compassionate Care
 - Trauma-Informed Care
 - Decompensation and Relapse Planning

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- Medications and Mental Health
- Medical Advocacy
- Getting Help and Self-Care

Of special note is the inclusion of the module on Trauma-Informed Care, which represents a current way of thinking about caregiving that was not included in the last version of the curriculum. The extended length of the training will allow for these important topics to be addressed in greater depth, and the understanding of the technical background from these online portions will prepare the learners with the context and vocabulary to have the conversations necessary in the instructor-led portion of the training.

Redesign the instructor-led training materials to total approximately 5.5 hours of instruction

While the online portions of the training will allow for more technical information to be conveyed at a custom pace, and in select languages, we believe the balance of the training should be instructor-led, should include practice activities and role-playing, and should be conducted in English in order to best simulate conditions in the care facility. Accordingly, these two modules deal with the interactive elements of caregiving:

- › Module 3: Respectful Communication
- › Module 4: Creative Approaches to Challenging Behaviors
 - Crisis Management
- › Module 5: Suicide Prevention

It is worth noting that the *Creative Approaches to Challenging Behaviors* module we propose is nearly as long at the entirety of the current training. We believe that providing caregivers with a solid foundation in managing behaviors may help decrease caregiver turnover and may also help decrease the frequency with which clients are moved from one facility to another. DSHS client data supports this assertion: we analyzed a sample of 3,705 client moves, and the assessments most proximate to each move. This data sample included instances of clients who moved one to five times. Because the sample size for the four- and five-move clients was too small to be statistically significant, we discarded that portion of the data for our analysis. Within the 38 identified “current behaviors”, we found that 24 of these behaviors were correlated with a higher incidence of client movement. That is, a client who moved three times within the sample window was more likely to have one of these 24 behaviors than a client who had moved once or twice. In the table below, these behaviors correlated with move frequency are highlighted:

Current Behaviors	One Move	Two Moves	Three Moves
Accuses other of stealing	6%	7%	4%
Assaultive	5%	5%	8%
Breaks-throws items	5%	7%	3%
Combative during personal care	7%	7%	9%
Crying tearfulness	22%	25%	25%
Delusions	14%	14%	19%
Disrobes in public	2%	2%	5%
Easily irritable/agitated	48%	52%	52%
Eats non edible substances	1%	1%	2%
Fire setting behavior	0%	0%	0%
Hallucinations	14%	14%	18%
Hiding items	5%	5%	4%
Hoarding/collecting	7%	8%	7%

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Inappropriate toileting/menses activity	8%	10%	14%
Inappropriate verbal noises	4%	4%	1%
Injures self	4%	3%	5%
Intimidating/threatening	6%	7%	8%

Left home and gotten lost	1%	1%	1%
Manic symptoms	2%	1%	2%
Mood swings	17%	22%	22%
Obsessive re health/body functions	9%	12%	4%
Repetitive complaints/questions	26%	26%	33%
Repetitive movement/pacing	14%	16%	19%
Resistive to care	31%	32%	43%
Rummages/takes belongings	4%	3%	9%

Current Behaviors	One Move	Two Moves	Three Moves
Seeks vulnerable sexual partner	0%	0%	2%
Sexual acting out	3%	2%	4%
Spitting	1%	2%	3%
Unrealistic fears or suspicions	15%	16%	18%
Unsafe cooking	0%	0%	0%
Unsafe smoking	1%	1%	2%
Up at night/requires intervention	16%	15%	18%
Uses foul language	12%	13%	12%
Verbally abusive	10%	11%	13%
Wanders/exit seeking	6%	6%	7%
Wanders/not exit seeking	4%	3%	4%
Yelling/screaming	17%	22%	13%

Include Trauma-Informed Care (TIC) as a topic in the *Caregiving for Mental Health* module

Trauma-Informed care presents an alternative to traditional care techniques by focusing on increasing function rather than curing conditions. The principles of TIC are: safety, trustworthiness, choice, collaboration, and empowerment. Through these principles, facilities can improve not only quality of care, but also quality of life for its clients (Keesler, 2014). While it will be impossible to fully instruct caregivers in TIC during the specialty training, an introduction to the topic will go a long way toward building awareness and understanding of factors that may influence the interactions of the caregivers and residents.

It is worth noting that Trauma-Informed Care is not highly prevalent in training materials of other states, and is a relatively recent addition to the field. In this sense, the inclusion of TIC in Washington's mental health specialty training materials will be a demonstration of Washington's leadership in preparing caregivers.

According to Jennings (2007), an appropriate curriculum should cover:

1. The Prevalence and Impact of Trauma
2. Dynamics of Traumatization
 - a. How some caregiving actions can potentially mimic traumatic experiences

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b. Avoidance of retraumatization

3. Impact of culture, race, ethnicity, gender, age etc. can have on perceptions of trauma and healing mechanisms

“Cultural issues affect not only those who seek help but also those who provide services. Each group of providers embodies a culture of shared beliefs, norms, values, and patterns of communication. They may perceive mental health, social support, diagnosis, assessment, and intervention for disorders in ways that are both different from one another and different from the culture of the person seeking help.” (President’s New Freedom Commission on Mental Health Final Report, 2003)

4. Trauma-informed understanding of difficult behaviors
5. Maintenance of professional boundaries
6. Vicarious traumatization / Self-care

As one stakeholder put it, “There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. [A home or facility providing] long-term care is a person’s home and should focus on maximizing independence and help people live out their life. Training should be more trauma-informed and be more experiential vs. medical.”

Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of mental illness, other reference material, and contact information that becomes a tool for caregiver use.

Two consistent themes we heard from stakeholders—the desire to reduce the technical detail in the training materials, and the need for caregivers to have easy access to resources, contacts, and information—combine to form this recommendation. We recommend that DSHS design a stand-alone resource guide that will be distributed with the training materials, and will provide the caregiver a “cheat sheet” for resources specific to the specialty (in this case mental health), and if possible specific to geographies. This may take many forms, but it should be simple, portable, and durable:

“Could we develop a “student guide” that would be more useful to caregivers working in the field? Something they could have after the training that would give them quick access to the most critical information.”

“To have a resource available to call 24/7 when situations arise. This is after basic training of course. I think a 24/7 resource is important. A pocket guide would also be good.”

“We need to provide resources so caregivers know who to go to in the event of these crises.”

The current Resources module is largely comprised of internet links, and it would be possible to list all of these links on one centralized webpage that could be referenced on the Resource card. In addition to the current resources listed, a redesigned Resource Card may include contact information for local or regional advocacy, informational, or service organizations. Providing a way for caregivers to customize the cards for their residents is also desirable. For instance, having a space to add phone numbers for specific social workers may be helpful. Such a card would allow the caregiver to have a single “go-to” source if they needed to reach out for information or assistance.

Update the look and feel of the training materials to reflect the importance of the topics.

We recommend that updates to training materials receive a graphic treatment that is crisp and professional, and that the materials be illustrated with informational graphics and include photographs of caregivers interacting with clients. Such photographs would allow caregivers to envision themselves in the role of caregiver to clients with mental illness. Among the principles of andragogy (adult education) stated by Malcolm Knowles, the use of photographs would support both “need to know” – the need to understand the reason for learning something, and

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“readiness” – the principle that adult learners better attend to subjects that they perceive as having direct relevance to their work.

Further, Dual Coding Theory (DCT), first proposed by Allan Paivio in 1971, supports the inclusion of photographs and diagrams within the learning materials. DCT holds that human beings process information through parallel intellectual paths—one for language-based information and the other for non-verbal stimuli, such as visual imagery. When the two modalities are engaged simultaneously, retention and recall of the subject matter is heightened, and this effect has been demonstrated by many studies that have tested this theory over the past four decades. In a *Change Magazine* article, entitled *Applying the Science of Learning to the University and Beyond*, Diane F. Halperin and Milton D. Hakel state:

A given piece of information can be organized and “stored” in memory in either or both of these representational systems. According to dual-coding theory, information that is represented in both formats is more likely to be recalled than information that is stored in either format alone. Learning and recall are thus enhanced when learners integrate information from both verbal and visiospatial representations. (Halperin and Hakel, 2003)

Use of photographs should be judicious and respectful, and should also reflect the diversity of both caregivers and those they care for.

5 | Recommendations: Instructional Quality

The Mental Health specialty training is offered by a wide variety of trainers across the state, and is often taught by providers, supervisors, and corporate trainers within care facilities. Because the WAC defines detailed instructor qualifications for community instructors, yet only defines minimal requirements for providers, supervisors, and corporate trainers who may deliver the training within the facilities, it is likely that the training is delivered at different levels, and is possible that in some cases the training may not be delivered at all. Many stakeholders expressed concern about this variation in training quality:



“Training is not consistent. Trainers are human [and they have] different approaches, expertise, [and] knowledge. Sometimes managers teaching the classes don't really grasp the material themselves, [and] may just be reading/following [the] structure or showing video, vs. adding [their] own experience, [and] real-life scenarios.”

Our recommendations related to instructional quality for the Mental Health specialty training are to update the trainer requirements, and to apply more rigor to the preparation, validation, and ongoing evaluation of those offering training:

- › Enforce validation of subject matter expert (SME) qualifications for instructors
- › Verify and enforce adult education qualifications for instructors
- › Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.

Enforce validation of subject matter expert (SME) qualifications for instructors

Instructors who have experience working with people with mental illness bring their experience into the classroom to enrich the learning experience. In light of this, we recommend that DSHS develop a consistent set of instructor requirements, applying the same standard to both community trainers and in-facility trainers.

“Overall knowledge of the particular condition. Many people who work in the system do not have a fundamental understating of the illness.”

“There needs to be a higher-level requirement for training. The minimum is not working.”

The current requirements are detailed in WAC 388-112-0385:

- (1) The minimum qualifications for instructors for **manager mental health specialty**, in addition to the general qualifications in WAC 388-112-0380 (1) and (2) include:
 - (a) The instructor must be experienced in mental health caregiving practices and capable of demonstrating competency in the entire course content;
 - (b) Education:
 - (i) Bachelor's degree, registered nurse, or mental health specialist, with at least one year of education in seminars, conferences, continuing education, or in college classes, in

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subjects directly related to mental health, such as, but not limited to, psychology. (One year of education equals twenty-four semester hours, thirty-six quarter hours, or at least one hundred ninety-two hours of seminars, conferences, and continuing education.)

(ii) If required by WAC 388-112-0160, successful completion of the mental health specialty training, prior to beginning to train others.

(c) Work experience - Two years full-time equivalent direct work experience with people who have a mental illness; and

(d) Teaching experience:

(i) Two hundred hours experience teaching mental health or closely related subjects; and

(ii) Successful completion of an adult education class:

(A) For instructors teaching alternate curriculums, a class in adult education that meets the requirements of WAC 388-112-0400.

(iii) For instructors teaching mental health specialty training, successful completion of the DSHS instructor qualification/demonstration process:

(iv) And has been approved and contracted by the department as a community instructor.

(e) Instructors who will administer tests must have experience or training in assessment and competency testing.

(2) Instructors for long-term care worker mental health specialty training:

(a) Long-term care worker mental health specialty may be taught by an assisted living facility administrator (or designee), adult family home provider (or designee), or corporate trainer, who has successfully completed the manager mental health specialty training. A qualified instructor under this subsection may teach specialty to long-term care workers employed at other home(s) licensed by the same licensee.

(3) Long-term care worker mental health specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for manager mental health specialty in subsection (1).

It is recommended that active review and enforcement of these requirements be implemented.

Verify and enforce adult education qualifications for instructors

Instructors who understand how adults learn are more able to meet learners where they are, based on their learning styles, and ensure all students achieve the learning outcomes and objectives for training. Currently, adult education is woven through the curriculum, the trainer preparation, and reflected in the DSHS Training Guide.

We recommend that DSHS actively enforce the adult education qualifications that are currently in place, and ensure that these are enforced for both community instructors and in-facility instructors. In accordance with the WAC 388-112-0385, the minimum requirements for instructors include the successful completion of an adult education class. In accordance with WAC 388-112-0400, an adult education class must include adult education theory and practice, facilitation techniques, learning activities for adults, competency testing, and working with adults with special training needs (e.g. ESL). We have also recommended the development of a two-hour online adult education course that would fulfill this requirement (see page 30). We recommend that anybody wishing to offer this training should meet these requirements, whether they are providers, supervisors, corporate trainers, or community trainers.

- › “During the training - lets talk about if this work is for you, who you are comfortable supporting, how do you spend your working time, how do you handle people who challenge you? (From a trainer perspective) Some people welcome this; others decide it is not what they want to do after all. Some people come and

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do not understand the concepts and not getting the message [to determine if the job is appropriate for them and their capabilities]. Sometimes they cannot visualize what the job entails.”

- › “Communication style of the trainer has to be flexible, so that all cultures can learn the information”
- › “Consider a better ‘train-the-trainer’ model that ensures more consistent delivery and skills.”

Adult learner-centered training is also characterized by its focus on the competencies that trainees need to perform well on the job. It takes into consideration their concrete, immediate needs and builds on the knowledge, attitudes, and skills that trainees have gained through their life experiences. The varied experiences of participants enrich the learning environment and bolster participants’ confidence in learning new material. (PHI, 2008)

Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.

Continuous improvement is an important part of any training program. By actively seeking and receiving feedback instructors take an active role in the intentional learning process ensuring that course content, materials, and activities are continually refreshed and up to date.

We recommend the DSHS create a course evaluation form and process that is similar to, if not the same as, the Service Alternatives evaluation form in use with the Developmental Disabilities Specialty Training.

Specific questions that may be added to the evaluation include:

- › Did the instructor actively involve you in the learning process?
- › Did the instructor draw out the learners’ own experiences and knowledge that is relevant to the topic?
- › Did the instructor explicitly tell the learners how and when they will be able to use/apply what they are learning?
- › Did the instruction include a variety of visual, auditory, read/write, and motion-based activities?

In addition to the ongoing collection of these assessments, we recommend that DSHS institute a regular process for ongoing in-person observations of trainers, perhaps on an annual basis, to monitor quality of instruction.

“It would be great if an outside party would come in assess our trainers and provide feedback to make it better and more consistent. We want caregivers to walk out of training being wowed.”

“Some instructors just play the video and don’t interact much. Consider monitoring/observing how training is delivered to ensure that trainers are competent.”

6 | Recommendations: Program Design

A guiding principle of our analysis has been to keep an eye on how changes are likely to affect outcomes in terms of care delivery. Affecting care outcomes means that information must be delivered to caregivers easily and in ways that will best support their learning. Of the changes recommended in this section, those that indicate the most radical change are in support of greater accessibility, both in terms of physical/location access, and in terms of cognitive access. This includes a doubling of the length of the training.



The following recommendations suggest changes we believe would increase access, support greater understanding of training materials, and add greater rigor and accountability to the existing system:

- › Expand training to 12 hours, and split it into 2 parts:
 - 6.5-hour competency-based online training
 - 5.5-hour in-person skills training
- › Update language options for trainings:
 - Online training available in English, plus the five most commonly-spoken languages in care settings
 - In-person training in English only
- › Bear the cost of basic mental health caregiver training directly through ALTSA, rather than indirectly through the daily rate.
- › Training validation: online training validated automatically by the training system; in-person training validated by the trainer
- › Develop a two-hour online manager training for managers and supervisors in care settings where residents have mental illness, and require both online and in-person assessment of managers.
- › Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in any of the three caregiver specialties.
- › Require active demonstration of training competency for managers or supervisors who wish to train their employees.
- › Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.
- › Rename the training, and develop additional levels of training in order to achieve “specialty” designation
- › Open online and/or in-person training to families and others

Expand training to 12 hours, and split it into 2 parts: a 5.5-hour competency-based online training, and a 6.5-hour in-person skills training

As stated in the Content section, we recommend that the training for the Mental Health specialty be expanded to approximately 12 hours of instruction, approximately half online and half in-person. This would make the length of the training consistent with our recommendations for the other specialties.

The online training should be competency-based, whereby learners can learn at their own pace, can “test out” of portions they already have knowledge of, and move forward to new competency sections upon completion of a previous section. Learners should not be expected to “sit through” training if the material is already known to them, as this likely does nothing to improve care outcomes and has the potential to cause learners to disengage from the material. To the degree possible, learners should be provided with an opportunity to connect with other learners online. This may take the form of online forums, video chats, or other options. This connectivity should be accommodated within the Learning Management System (LMS), if possible. We recognize, however, that the creation of such a system will have a fiscal impact to DSHS.

The in-person portions of the training would continue to be taught by approved instructors, and would focus on interactive learning experiences around behaviors and communication. This is where learners would get the chance to try out care approaches in a safe space with other learners.

A 2010 US Department of Education meta-analysis looked at how online learning compared to in-person learning, and found that studies generally indicated an advantage for online training:

Learning outcomes for students who engaged in online learning exceeded those of students receiving face-to-face instruction, with an average effect size of +0.20 favoring online conditions. (Means, Toyama, Murphy, Bakia, and Jones, 2010)

The analysis, focused primarily on adult learners learning job-related information, found that different methods of online instruction did not lead to significant changes in learning quality, with one exception—when online learning was combined with in-person learning, learning was enhanced. The study’s authors were careful to point out that this may have more to do with other factors such as additional learning time, and may not be related, per se, to the combination of online and in-person learning. Nevertheless, this provides validation that the split we are recommending between in-person and online training will not be likely to diminish learning outcomes.

An additional factor that may prove to be useful in the design of future specialty training curriculum is the use of learner reflection:

...manipulations that trigger learner activity or learner reflection and self-monitoring of understanding are effective when students pursue online learning as individuals. (Means, Toyama, Murphy, Bakia, and Jones, 2010)

To the extent that any future online curriculum is developed for the Mental Health Specialty Training, this finding suggests that the incorporation of “break points” within the training—especially the online portions—that engage the learner in reflection and self-assessment of learning may enhance reception and retention of information.

Update language options for trainings: create an online training available in English, plus the five most commonly-spoken languages in care settings; redesign the remainder of the training as an in-person training in English only

As indicated in the Content section of this report, we recommend that the proposed online portion of the specialty training be made available not only in English, but also in up to five of the most commonly-spoken languages in care settings. These languages should be identified based on an analysis of the native languages of caregivers throughout the system, and not based on the languages spoken by clients or the state’s population at large. Because of the unique demographics of caregivers, there are languages spoken by groups of caregivers that may not be among the most common languages in Washington.

The portions of the training we recommend translating are those that require comprehension and retention of technical information, which we believe will be more effectively learned in the caregiver’s native language, regardless

of whether that language is used in the care setting. These modules are coincident with those modules that we are recommending for the online portion of the training, so that the in-person portions of the training—particularly those parts that require role-playing of care scenarios—would still be conducted in English.

Those modules which would be translated include:

Module 1: Introduction to Mental Disorders

Module 2: Caregiving for Mental Health

- › Culturally Compassionate Care
- › Trauma-Informed Care
- › Decompensation and Relapse Planning
- › Medications and Mental Health
- › Medical Advocacy
- › Getting Help and Self-Care

We recognize that the creation of translated online training that may include some video and interactive elements will be a significant challenge for DSHS, but we also believe that the potential for improvement of care outcomes is great, and warrants this change.

Bear the cost of basic mental health caregiver training directly through ALTSA, rather than indirectly through the daily rate.

Currently, providers have the option of training caregivers themselves, or paying to have their caregivers trained by a community trainer. This cost is offset by DSHS through an addition to the daily rate, though our outreach highlighted that few providers understand this arrangement.

One would expect that the contribution to the daily rate would encourage providers to secure high-quality community trainings for their caregivers. However, the system has created a “perverse incentive” where the most financially advantageous thing for a provider to do is to pocket the additional daily rate, and train the caregiver themselves at no additional out-of-pocket cost.

Because the money comes to the provider through the daily rate, it feels as if it is part of their compensation. The behavioral economics hypothesis of the “endowment effect”, which has demonstrated that people value more highly that which they already possess, explains why this happens: once the money is in their hands, they feel as if they own it, and therefore paying for training feels like an additional expense.

By contrast, Developmental Disabilities specialty training is paid for directly by DDA, and although there are also provisions that allow for providers to train their own staff, that option is rarely exercised.

We recommend that ALTSA re-design the compensation system for mental health specialty training to directly cover training costs, in the interest of encouraging the best available training for all caregivers.

Training validation: online training should be validated automatically by the training system; the trainer should validate in-person training

If our recommendation to split the training into online and in-person segments is adopted, it has the potential to cause some additional clerical burden for DSHS in keeping track of when caregivers have successfully completed training sections. Splitting the training in two effectively doubles the number of validations that must take place.

Therefore, if possible, the online training system/learning management system should provide an automatic update to a DSHS database when learners complete the online portion of the training, and should also allow the learner to download a certificate of completion that could be presented to a trainer in order to demonstrate completion of the

pre-requisite for the in-person portion of the training. In-person training would continue to be validated by the trainer, with details submitted to DSHS.

Develop a two-hour online manager training for managers and supervisors in care settings where residents have mental illness, and require both online and in-person assessment of managers.

Caregiver turnover is most often associated with poor supervision practices (Larson, Lakin, and Bruininks, 1998). When a caregiver leaves, a replacement will start the training cycle over again, and the new caregiver will need to learn all the intricacies of the specific care environment. For these reasons, among others, it is desirable to retain caregivers to provide continuity and quality of care to residents. This means having sufficiently trained supervisors who can create engaging work environments. Currently, the manager training for the Mental Health specialty is an add-on to the existing four-hour course, with a separate assessment.

“[There should be] caregiver, manager and instructor levels for the test. I would like instructors to have teaching experience, but also more intensive training.”

We propose a standalone online manager training be developed that would supplement the caregiver training for those who will be supervising other caregivers. This training would be the equivalent of approximately two hours of in-person training. Much of the content could be standardized for all specialties, and could cover topics related to the additional challenges for homes caring for residents with special needs. The balance of the training could be customized to mental health-specific materials.

Many other states having specific caregiver supervisor trainings require far greater than a two-hour training, but we believe that a few basics can be communicated in this short training module. Some topics may include:

1. Resident assessment, admission, retention, specific to mental health specialty
2. Laws and regulations, specific to mental health specialty
3. Use and misuse of medication, specific to mental health specialty
4. Employee engagement, general
5. Washington state requirements, general

Currently, providers and their designated supervisors are required to meet many requirements, but demonstrated managerial knowledge and skills are not among them. We propose a much more rigorous process that would require managers to be assessed not only within the online training module, but also through an in-person competency evaluation conducted by DSHS. We recognize that this recommendation adds considerable complexity for both DSHS and for providers. However, the potential for enhanced leadership skills to positively impact employee engagement and retention could offer significant improvement for care outcomes and for the bottom line of facilities, as recruitment and training are more expensive than retention. Additionally, no amount of training can replace the skills and knowledge gained providing direct care. With that in mind, the shortest path to improved care outcomes is to retain good managers and caregivers, rather than better training for new ones.

Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in any of the three caregiver specialties.

Currently, providers and managers may train their own staff in the mental health specialty. In the spirit of maintaining accessibility for the training, we recommend that this option remain, with the condition that the provider or manager has received both the manager training (specified above) and an additional two-hour equivalent “train the trainer” course that would provide instruction in adult learning principles and best practices for instruction of the material. This training module could be developed in such a way that it would be universal for all current and future specialties, including Developmental Disabilities, Dementia, and Mental Health.

Specific topics of this training may include:

1. Actively involving learners in the learning process.
2. Drawing out learners' experience and knowledge relevant to the topic.
3. Providing clear course goals and objectives.

6 | Recommendations: Program Design

4. Describing explicitly how and when the learners will be able to use/apply what they are learning
5. Using tones, gestures, eye contact and language to communicate respect for the learner
6. Addressing VARK preferences in each class: visual, auditory, read/write and kinesthetic

Many of these themes would be actively reviewed for each trainer in the additional training evaluation questions we recommend on page 25.

Require active demonstration of training competency for managers or supervisors who wish to train their employees.

Given the importance of the information to be conveyed, we recommend the highest rigor in the screening of managers who wish to train their staff, requiring documentation of all requirements, and no longer allowing for self-attestation on any items. Active demonstration of training competency should also be required upon completion of the two-hour adult education training, as described on page 30.

Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.

Currently, the WAC (388-112-0115) allows that a caregiver working in a care setting where multiple specialties are present (e.g. a home where one or more clients have both developmental disabilities and dementia) may choose one specialty to train in, and is not required to train in the other specialt(ies). Presumably, this is to avoid placing an onerous burden on providers and caregivers, but we believe it is a loophole that is not in the best interest of clients, and does not contribute to best possible care outcomes.

We recommend that, moving forward, new caregivers are required to receive specialty training for all specialties present in their care environment, when and if those specialties become present. The state may wish to mitigate this change by allowing secondary or tertiary specialty trainings to occur over a longer timeframe, in order to distribute the burden over time.

Rename the training, and develop additional levels of training in order to achieve “professional” designation

The current training, while designated as “specialty” training, does not truly create specialists in the care of individuals with mental illness. This was expressed many times by stakeholders, and applied to all three current specialty trainings:

“Calling it specialty training is misleading—it doesn’t make people specialists... it’s a misnomer when we say a home is now a specialized provider [when their caregivers have taken this training].”

At the same time, we heard from many stakeholders that they would be very open to the notion of tiered training that would allow caregivers to gain increasingly specialized training and designation over time. This may take the form of additional training modules that are additive to the revised introductory training, and taken as part of continuing education. A caregiver would gain higher designations only after completing these additional tiers of training, and completing a certain number of hours of direct caregiving.

A model that we would recommend, developed by DSHS’s curriculum specialist, includes the following:

For individuals whose primary job responsibilities include providing long-term support for populations with mental illness, a three (3) tier education approach is offered within Washington State. To be awarded a certificate for each level, all workshops and additional requirements must be completed:

6 | Recommendations: Program Design

1. Basic Mental Health Caregiver, Level 1
2. Mental Health Caregiver, Level 2
3. Mental Health Caregiver, Level 3

The table below illustrates the levels of training and their prerequisites:

Mental Health Caregiver Trainings	Requirements				
		Hrs	Level 1	Level 2	Level 3
Basic Mental Health Technical Training (Level 1)	O	5.5	x	x	x
Basic Mental Health Skills Training (Level 1)	IL	6.5	x	x	x
Mental Health Caregiver Level 2 Training	O; IL	12		x	x
Mental Health Caregiver Level 3 Training	O; IL	12			x
Manager and Trainer Classes					
Care Manager Training	O	2	n/a	n/a	n/a
Adult Education Training*	O	2	*	*	*
Active Demonstration of Trainer Competency	IL	?	n/a	n/a	n/a
*Trainers are subject to additional requirements, per WAC 388-112-0385					

O = Online Learning, IL = Instructor Led, D = Documentation

Basic Mental Health Caregiver (Level 1)

Complete a combination of 12 hours of training in each population category (6.5 hours technical training online as prerequisite to 5.5 hours skills training, instructor led). Once you have completed both workshops for a total of 12 hours, you will receive your Basic Mental Health Caregiver Level 1 Certification:

Basic Mental Health Technical Training

- › Module 1: Introduction to Mental Disorders
- › Module 2: Caregiving for Mental Health
 - Culturally Compassionate Care
 - Trauma-Informed Care
 - Decompensation and Relapse Planning
 - Medications and Mental Health
 - Medical Advocacy
 - Getting Help and Self-Care

Basic Mental Health Skills Training

- › Module 3: Respectful Communication
- › Module 4: Creative Approaches to Challenging Behaviors
 - Crisis Management
- › Module 5: Suicide Prevention

Mental Health Caregiver Level 2

Once you have completed your Level 1 training, complete an additional 12 hours of training for a total of 24 hours. Receive a certificate for Mental Health Caregiver Level 2.

Minimum requirements for certification: (i) Bachelor's degree with at least two years of full-time work experience in the applicable field; or (ii) High school diploma or equivalent, with four years full time work experience in the applicable field, including two years full time direct work experience with the applicable population of individuals

Choose a combination of modules to equal 12 hours of relevant training for your population/interest:

- › Anxiety Disorder
- › Autism
- › Bipolar
- › Depression
- › Personality Disorders
- › PTSD
- › Schizophrenia
- › Substance Abuse

Mental Health Caregiver Level 3

Once you have completed your Level 2 training, complete an additional 12 hours of training for a total of 36 hours. Receive a certificate for Mental Health Caregiver Level 3.

Minimum requirements for certification: (i) Bachelor's degree with at least three years of full-time work experience in the mental health field; or (ii) High school diploma or equivalent, with five years full time work experience in the applicable field, including three years full time direct work experience with the applicable population of individuals

Choose a combination of modules to equal 12 hours of relevant training for your population/interest:

- › Anxiety Disorder
- › Autism
- › Bipolar
- › Depression
- › Personality Disorders
- › PTSD
- › Schizophrenia
- › Substance Abuse
- › Traumatic Brain Injury (TBI)

Care Manager Certification

Advance your professional development and get your Care Manager Certification. Complete an additional 2 hours of training specific to the manager's role to receive a Care Manager Certification:

- › Resident assessment, admission, retention
- › Laws and regulations
- › Use and misuse of medication
- › Employee engagement (general)
- › Washington state requirements

Specialty Trainer Certification

Complete two hours of adult education training and document all trainer requirements as described in WAC 388-112-0385 to earn designation as a Specialty Trainer. Learning objectives for the adult education training include:

- › Actively involving learners in the learning process
- › Drawing out learners' experience and knowledge relevant to the topic
- › Providing clear course goals and objectives
- › Describing explicitly how and when the learners will be able to use/apply what they are learning
- › Using tones, gestures, eye contact and language to communicate respect for the learner.
- › Addressing VARK preferences in each class: visual, auditory, read/write and kinesthetic

Open online and/or in-person training to families and others

We heard from many stakeholders that these trainings would be valuable to a broader community than caregivers who are employed by Adult Family Homes or Assisted Living Facilities. Families who care for loved ones directly, families who want to understand the care provided for their loved ones, DSHS employees who oversee care programs, and Ombuds volunteers were all cited as possible audiences for these trainings. DSHS should consider charging a modest fee for the provision of this training outside the caregiver community, as an offset to other system expenses, particularly those related to the development of caregiver curriculum.

7 | Recommendations: Washington Administrative Code

The recommendations in this report, if adopted by DSHS, will also require changes to related passages in the Washington Administrative Code. Because of this likelihood, the outreach part of this process also served the purpose of allowing public input around potential WAC updates.

It is our belief that the changes recommended in this report can be undertaken without changes to the Revised Code of Washington, and that any changes would apply solely to passages of the Washington Administrative Code. In other words, these changes can be made by rule, and will not require a change in statute.

We have listed below the WAC sections that we believe are affected by each of our recommendations, though a thorough review of potential WAC changes and potential RCW intersections by DSHS staff and/or legal counsel is recommended.

Expand the basic mental health training to 12 hours – approximately half online, half in-person

The length of training is not specified in the WAC, and therefore this recommendation is not likely to require changes.



Create online learning modules that will total approximately 6.5 hours of instruction

WAC 388-112-0140 and 388-112-0142

Because the topics/modules are recommended to change, the learning objectives in this section of the WAC would need to be updated.

Redesign the instructor-led training materials to total approximately 5.5 hours of instruction

WAC 388-112-0140 and 388-112-0142

Because the topics/modules are recommended to change, the learning objectives in this section of the WAC would need to be updated.

Include Trauma-Informed Care (TIC) as a topic in the *Caregiving for Mental Health* module.

WAC 388-112-0142

The addition of TIC into the curriculum would require the addition of appropriate learning objectives in this portion of the WAC.

7 | Recommendations: Washington Administrative Code

Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of mental illness, other reference material, and contact information that becomes a tool for caregiver use.

WAC 388-112-0142

Because this may create a stand-alone module, which DSHS may want referenced in the WAC, attention should be paid to this section of the WAC if this recommendation is implemented.

Update the look and feel of the training materials to reflect the importance of the topics.

This recommendation does not appear to require a change to the WAC.

Enforce validation of subject matter expert (SME) qualifications for instructors

WAC 388-112-0385

This recommendation may require revision of this portion of the WAC, because we are recommending that assisted living facility administrators, adult family home providers, and their designees be required to demonstrate and document the same level of qualification as community trainers.

Verify and enforce adult education qualifications for instructors

WAC 388-112-0385

This recommendation may require revision of this portion of the WAC, because we are recommending that assisted living facility administrators, adult family home providers, and their designees be required to demonstrate and document the same level of qualification as community trainers.

Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.

WAC 388-112-0365

This portion of the WAC describes the rights of DSHS to terminate the approval of specialty training entities. Should this recommendation be carried forward, it may not require edits to the WAC, *oper se*, but DSHS may want to consider adding poor evaluations as cause for termination under this portion of the WAC.

Expand training to 12 hours, and split it into 2 parts:

- 6.5-hour competency-based online training
- 5.5-hour in-person skills training

This recommendation, in and of itself, does not appear to require a change in the WAC.

Update language options for trainings:

- Online training available in English, plus the five most commonly-spoken languages in care settings
- In-person training in English only

Training delivery language does not appear to be specified in the WAC. There is a requirement in WAC 388-76-10135 that the caregiver be able to speak and understand English, which we would not recommend changing—while caregivers need to be able to speak and understand basic English for their roles, we believe the complex information in the curriculum will be better communicated in native language(s). WAC 388-112-0305 states that DSHS must provide accessibility guidelines for students with limited English proficiency. While

7 | Recommendations: Washington Administrative Code

our recommendations would not require a change to this portion of the WAC, it may necessitate a change to DSHS's guidelines.

Bear the cost of basic mental health caregiver training directly through AL TSA, rather than indirectly through the daily rate.

This recommendation does not appear to require a change to the WAC.

Training validation: online training validated automatically by the training system; in-person training validated by the trainer

WAC 388-112-0155

Because online portions of the training will be auto-validated by the system, which was not foreseen by this portion of the WAC, an update is likely to be necessary if this recommendation is adopted.

Develop a two-hour online manager training for managers and supervisors in care settings where residents have mental illness, and require both online and in-person assessment of managers.

WAC 388-112-0160

Because this recommendation adds a general manager training for all specialties, changes are likely necessary for this portion of the WAC.

Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in any of the three caregiver specialties.

WAC 388-112-0400

Because we are recommending the development of a new adult education online curriculum, the details of this section of the WAC are likely to require updates.

Require active demonstration of training competency for managers or supervisors who wish to train their employees.

WAC 388-112-0385

Because this would add an additional qualification for trainers, this portion of the WAC would require updates.

Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.

WAC 388-112-0115

This recommendation is likely to require a change to this portion of the WAC because it will require more training than is currently required.

Rename the training, and develop additional levels of training in order to achieve "specialty" designation

WAC 388-112-0110

Because this recommendation will likely change the very definition of "specialty" training, this portion of the WAC will likely require updates.

Open online and/or in-person training to families and others

It does not appear that opening the training to others will require changes to the WAC.

8 | Resources & Bibliography

Works Cited:

- › Halperin, Diane F., Hakel, Milton D. (2003). *Applying the Science of Learning to the University and Beyond*. Change, July/August 2003.
- › Jennings, A. (2007b). *Criteria for building a trauma-informed mental health service system*.
- › Keesler J. *A Call for the Integration of Trauma-Informed Care Among Intellectual and Developmental Disability Organizations*. Journal Of Policy & Practice In Intellectual Disabilities [serial online]. March 2014;11(1):34-42.
- › Larson, S.A., Lakin, K.C., & Bruininks, R.H. (1998). *Staff recruitment and retention: Study results and intervention strategies*. Washington, DC: American Association on Mental Retardation.
- › Means, B., Toyama, Y., Murphy, R., Bakia, M. and Jones, K. (2010) *Evaluation of Evidence-Based Practices in Online Learning: A Meta-Analysis and Review of Online Learning Studies*. U.S. Department of Education Office of Planning, Evaluation, and Policy Development Policy and Program Studies Service. September, 2010.
- › Paraprofessional Healthcare Institute. (2008). *Adult Learner-Centered Training: An Introduction for Educators in Home and Residential Care*.
- › Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson (2014) *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. www.longtermsscorecard.org

Additional Sources of Information:

- › 18 V.S.A. § 8731. (n.d.).
- › ACAT Council. (2012). *Instructor Qualifications Best Practices*.
- › ACT on Alzheimer's MN. (2014). *Alzheimer's Disease Curriculum*.
- › Alaska Mental Health Trust Authority. (2014). *Alaska's Roadmap to Address Alzheimer's Disease and Related Dementias*.
- › Alberta Health and Wellness. (2001). *Health Care Aides Competency Profile*.
- › Alliance for Direct Support Professionals. (1997). *Educating Today's DSPs*. Frontline Initiative .
- › Alzheimers Association. (2005). *About Dementia: Improving Communication*. Alzheimers Association.
- › Alzheimers Association. (2005). *About Dementia: Understanding Behavior*. Alzheimers Association.
- › Alzheimers Association. (2009). *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes*. Alzheimers Association.
- › Alzheimers Association. (2009). *Dementia Care Practice Recommendations for Professionals Working in a Home Setting*. Alzheimers Association.
- › Alzheimers Association. *Foundations of Dementia Care*. Alzheimers Association.
- › Alzheimers Association Minnesota-North Dakota. (2009). *Understanding Memory Loss*. Alzheimers Association Minnesota-North Dakota.
- › Alzheimers Association New York City Chapter. (2014). *Palliative Care for Advanced Dementia: Training and Implementation*. LeadingAge, Annual Meeting. Nashville, Tennessee.
- › Alzheimers Association. *State Alzheimer's Disease Plans*. Alzheimers Association.
- › Alzheimer's Association, Greater Indiana Chapter. (2004). *Directing an Alzheimer's/Dementia Care Unit*.

8 | Resources & Bibliography

- › Alzheimer's Disease and Related Disorders Commission. *Dementia State Plan: Virginia's Response to the Needs of Individuals with Dementia and their Caregivers*.
- › Amado, A. N. (2010). *Agency Factors and Structures Which Increase Successful Outcomes in Community Participation and Socially Valued Roles*. Lutheran Social Services.
- › Arizona Direct Care Initiative. (2011). *Principles of Caregiving Developmental Disabilities Module*.
- › Arkansas Department of Health and Human Services Office of Long Term Care. (2006). *Barbara Broyles Alzheimer and Dementia Training Program for Nursing Assistants*.
- › Arkansas Department of Health. (2010). *Rules and Regulations for Private Care Agencies in Arkansas*.
- › Australian Government: Department of Social Services. (2014). *Home Care Packages Programme Guidelines*.
- › Australian Government: Department of Social Services. (2014). *Quality of Care Principles 2014*.
- › Bedard, M., Koivuranta, A., & Stuckey, A. (2004). *Health impact on caregivers of providing informal care to a cognitively impaired older adult: rural versus urban settings*. *Canadian Journal of Rural Medicine* , 15-23.
- › Bernardo, A. B., & Gaerlan, M. J. (2012). *Non-Native English Students Learning in English: Reviewing and Reflecting on Research*. *Global Perspectives, Local Initiatives* .
- › Bonner, A. (2013). *Improving Dementia Care and Reducing Unnecessary Use of Antipsychotic Medications in Nursing Homes*.
- › Brunye, T. T., Taylor, H. A., & Rapp, D. N. (2008). *Repetition and Dual Coding in Procedural Multimedia Presentations*. *Applied Cognitive Psychology* , 877-895.
- › Bustle, L. S. (2004). *The role of visual representation in the assesment of learning*. *Journal of Adolescent & Adult Literacy* , 416-423.
- › Cahill, S., O'Shea, E., & Pierce, M. (2012). *Creating Excellence in Dementia Care: A Research Review for Ireland's National Dementia Strategy*.
- › CareerForce. (2014). *Natonal Certificate in Health, Disability, and Aged Support*.
- › CareQuality Commission. (2010). *Essential Standards of Quality and Safety*.
- › Chappell, N. L., & Dujela, C. (2008). *Caregiving: Predicting At-Risk Status*. *Canadian Journal on Aging* , 169-179.
- › Cohen, S. (1988). *Psychosocial Models of the Role of Social Support in the Etiology of Physical Disease*. *Health Psychology* , 269-297.
- › Cohen, S. (2004). *Social Relationships and Health*. *American Psychologist* , 676-684.
- › Committee on Workforce Competency, Alaska Mental Health Trust Authority, Workforce Development Focus Area. (2010). *Alaskan Core Competencies for Direct Care Workers in Health and Human Services*.
- › Committee on Workforce Competency, Alaska Mental Health Trust Authority, Workforce Development Focus Area. (2011). *Assessment Tools for the Alaskan Core Competencies*.
- › Committee on Workforce Competency, Alaska Mental Health Trust Authority, Workforce Development Focus Area. (2009). *The Alaskan Core Competencies: Phase II Report on Development Process*.
- › Committee on Workforce Competency, Alaska Mental Health Trust Authority, Workforce Development Focus Area. (2008). *The Alaskan Crosswalk: Exploring Competencies and Credentialing for the State's Direct Care Workforce*.

8 | Resources & Bibliography

- › Department of Health and Human Services, Office of the Inspector General. (2006). *States' Requirements for Medicaid-Funded Personal Care Service Attendants*.
- › Department of Health, Social Services and Public Safety. (2011). *Improving Dementia Services in Northern Ireland: A Regional Strategy*.
- › Division of Health Facilities Evaluation and Licensing. (2005). *Training Curriculum for Certified Nurse Aides Licensed Practical Nurses Registered Professional Nurses & Other Health Care Professionals in Long-Term Care Facilities for Residents with Alzheimer's Disease and Other Dementia-Related Disorders*.
- › Doll, G. M. (2013). *Sexuality in Nursing Homes: Practice and Policy*. *Journal of Gerontological Nursing* , 30-37.
- › Dunn, R. (1984). *Learning Style: State of Science*. *Theory into Practice* , 10-19.
- › Epower & Associates. (2011). *TReSIA: Section 2 Trauma-Responsive Systems Implementation Advisor*.
- › Family Caregiver Alliance. (2013). *Fact Sheet: Taking Care of YOU: Self-Care for Family Caregivers*.
- › Galea, J., Butler, J., & Iacono, T. (2004). *The assessment of sexual knowledge in people with intellectual disability*. *Journal of Intellectual & Developmental Disability*, 350-365.
- › Gaugler, J. E. (2005). *Family Involvement in Residential Long-Term Care: A Synthesis and Critical Review*. *Aging Ment Health* , 105-118.
- › Glzman, J. M. (2004). *Quality of Life of Caregivers*. *Neuropsychology Review* , 183-196.
- › Government of the District of Columbia Office on Aging. (2013). *The District of Columbia State Plan on Alzheimer's Disease*.
- › Government of the District of Columbia, Department on Disability Services. (2013). *Direct Support Professional Training Procedures*.
- › Greenwood, N. W., & Joanne, W. (2013). *Sexual and Reproductive Health Care for Women with Intellectual Disabilities: A Primary Care Perspective*. *International Journal of Family Medicine* .
- › Halpen, D. F., & Hakel, M. D. (2003, July/August). *Applying the Science of Learning*. *Change* , pp. 36-41.
- › Health Canada. (2012). *Canadian Educational Standards for Personal Care Providers: Environmental Scan*.
- › Health Information and Quality Authority. (2008). *National Quality Standards for Residential Care Settings for Older People in Ireland*.
- › Health Information and Quality Authority. (2013). *Guidance for Designated Centres: Intimate Care*.
- › Hibbing, A. N., & Rankin-Erickson, J. L. (2003). *A picture is worth a thousand words: Using visual images to improve comprehension for middle school struggling readers*. *The Reading Teacher* , 758.
- › Hodas, G. R. (2006). *Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care*.
- › IAC 441-81.
- › Idaho Bureau of Facility Standards. (2013). *Staff Development: A Guide*.
- › Idaho Department of Health & Welfare. (2010). *Residential Care/Assisted Living Checklist - Staff Training*. Idaho Department of Health & Welfare.
- › Idaho Department of Health & Welfare. (n.d.). *Skills Training Matrix*. Retrieved from http://healthandwelfare.idaho.gov/portals/_rainbow/TrngModules/bltc_SkillsMtrx/index.html

8 | Resources & Bibliography

- › Idaho Division of Professional-Technical Education. (2010). *Idaho Nursing Assistant Curriculum*. Idaho Division of Professional-Technical Education.
- › IDAPA 16.03.22. (n.d.).
- › Illinois Department of Human Services. (2013). *Direct Support Person Training Program: Approved On-the-Job Activities and Competency-Based Training Assessments*.
- › Illinois Department of Human Services. (2012). *Division of Developmental Disabilities DSP Curriculum Presenter's Introductory Modules Guide*.
- › Illinois Department of Human Services. (2012). *DSP Notebook*.
- › Inclusion Ireland. (2007). *Making Inclusion a Reality: Inclusion Ireland Strategic Plan 2007-2012*.
- › Instructional Assessment Resources. *Instructional Best Practices*.
- › James, G. *Advantages and Disadvantages of Online Learning*.
- › Kessler, J. M. (2014). *A Call for the Integration of Trauma-Informed Care Among Intellectual and Developmental Disability Organizations*. *Journal of Policy and Practice in Intellectual Disabilities* , 34-42.
- › Larson, S. A., & Hewitt, A. S. (2012). *Staff Recruitment, Retention & Training Strategies for Community Human Services Organizations*. Minneapolis: Research and Training Center on Community Living.
- › Learning Disabilities Observatory. (2012). *Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs)*.
- › Lu, Y.-F. Y., & Wykle, M. (2007). *Relationships Between Caregiver Stress and Self-Care Behaviors in Response to Symptoms*. *Clinical Nursing Research* , 29-43.
- › Maine Aging and Disability Services. (2012). *State Plan for Alzheimer's Disease and Related Dementias in Maine*.
- › Maryland Department of Health and Mental Hygiene. (2012). *Trainer Qualifications for Staff Training & Certification*.
- › Massachusetts Department of Public Health. (2013). *Healthy Relationships, Sexuality, and Disability Resource Guide 2013*.
- › Mayer, R. E. *Cognitive Theory of Multimedia Learning*. In R. E. Mayer, *Multimedia Learning* (pp. 31-48). Cambridge University Press.
- › McConaghy, R., & Caltabiano, M. L. (2005). *Caring for a person with dementia: Exploring relationships between perceived burden, depression, coping and well-being*. *Nursing and Health Sciences* , 81-91.
- › Md. Code, Dept. Health and Mental Hygiene, 10.07.14. (n.d.).
- › Michigan Department of Community Health. (2002). *Providing Residential Services in Community Settings: A Training Guide*. Michigan Department of Community Health.
- › Miller, P. C., & Endo, H. (2004). *Understanding and Meeting The Needs of ESL Students*. *Phi Delta Kappan* , 786-792.
- › Ministry of Health. (2014). B.C. *Health Care Assistants Core Competency Profile*.
- › Missouri Department of Behavioral Health. (2013). *Community Support Training 101*. Missouri Department of Behavioral Health.
- › N.D.C.C. § 33-07-06.
- › National Alliance for Direct Support Professionals. (2011). *Building Successful Partnerships: A Family's Story of Working with DSP's*. Frontline Initiative .

8 | Resources & Bibliography

- › National Center for Assisted Living. (2013). *Assisted Living State Regulatory Review*.
- › National Center for Assisted Living. (2014). *Guiding Principles for Dementia Care*. National Center for Assisted Living.
- › National Dementia Education Project 2012. (2012). *A Guiding Framework for Education and Awareness in the Development of Person Centered Dementia Care*.
- › National Direct Service Workforce Resource Center. (2008). *A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health*.
- › National Institute on Aging. (2013). *Caring for a Person with Alzheimer's Disease Your Easy-to-Use Guide from the National Institute on Aging*. National Institute on Aging.
- › New York State Department of Health. (2007). *Home Care Curriculum*.
- › NH He-M 1201.06.
- › NH He-M 506.
- › NH He-P 600.
- › NH He-P 809.
- › NH He-P 820.
- › NH He-P 822.
- › O.C.G.A § 111-8-62. (n.d.).
- › OAR Chapter 411 Division 57. (n.d.).
- › OAR Chapter 411, D. 3.
- › OAR Chapter 411, D. 3.
- › OAR Chapter 411, D. 5.
- › Oregon Caregiver Training Workgroup. (2014). *Oregon Caregiver Training Work Group Report*.
- › Oregon Department of Human Services. *Developmental Disabilities Adult Foster Care Training Manual*.
- › Oregon State Board of Nursing. (2012). *Curriculum Content for Nursing Assistant Level One Training Programs*.
- › Paraprofessional Healthcare Institute. (2008). *Adult Learner-Centered Training: An Introduction for Educators in Home and Residential Care*.
- › Paraprofessional Healthcare Institute. (2013). *Personal Care Aide Training Requirements: Summary of State Findings*.
- › Pennsylvania Department of Human Services. (2015, April 30). *Direct Care Staff Training: Care of Residents with Dementia/Mental Illness/Mental Retardation*. Retrieved from Pennsylvania Department of Human Services: http://services.dpw.state.pa.us/pch_comptest/Modules/module5.html
- › Poe, L., & Edwards, G. (2002). *Mental Retardation Staff Orientation Workbook*. Office of Mental Retardation, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.
- › Quintero, M., & Flick, S. (2010, September/October). *Co-Occuring Mental Illness and Developmental Disabilities*. *Social Work Today* .

8 | Resources & Bibliography

- › Ray Marshall Center, The University of Texas at Austin. (2011). *Challenges, Promising Programs, and Effective Practices in Adult and Developmental Education*.
- › Reinhard, S. C., Kassner, E., Houser, A., Ujvari, K., Mollica, R., & Hendrickson, L. (2014). *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP.
- › Saginaw County Community Mental Health Authority. (n.d.). *A Guide to Evidence-Based Practices for Individuals with Developmental Disabilities v1.0*.
- › Scottish Social Services Council. (2012). *Dementia Skilled - Improving Practice Learning Resource*.
- › Scottish Social Services Council. (2012). *Guidance for assessors, educators, trainers and managers to accompany: Dementia Skilled - Improving Practice learning resource*.
- › Scottish Social Services Council. (2011). *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers*. The Scottish Government.
- › SDCL 34-12-13. (2012).
- › Servais, L. (2006). *Sexual Health Care in Persons with Intellectual Disabilities*. *Mental Retardation and Developmental Disabilities Research Reviews*, 48-56.
- › Service Alternatives, Inc Training Institute. (2014). *Becoming a Culturally Competent Presenter*.
- › Service Alternatives, Inc Training Institute. (2014). *Deeper Facilitation*.
- › Service Alternatives, Inc Training Institute. (2009). *Dynamic Presentations*.
- › Sexuality & Disability Consortium. *Myths and Misperceptions of Disability and Sexuality*.
- › Sexuality & Disability Consortium. *Privacy for adults with I/DD*.
- › Sierra Training Associates. (2007). *Adult Learning Theories & Practice*.
- › Skills for Care. (2010). *Common Induction Standards (2010 'refreshed' edition) Social Care (adults, England) with Glossary*.
- › Skills for Care. (2014). *Core Skills: A strategy to support functional and employable skills in the adult social workforce in England*.
- › Skills for Care. (2013). *Supporting Staff Working with People who Challenge Services: Guidance for Employers*.
- › SPADO Task Force. (2012). *State Plan for Alzheimer's Disease and Related Dementias in Oregon*.
- › State of Illinois Department of Public Health. (2014). *Alzheimer's Disease Illinois State Plan 2014-2017 Report and Recommendations*.
- › Tennessee Department of Mental Health and Substance Abuse Services. (2014). *Family Support Specialist Certification Program Guidelines, Standards, and Procedures*. Tennessee Department of Mental Health and Substance Abuse Services.
- › The Arizona Direct Care Curriculum Project. (2008). *Principles of Caregiving: Alzheimer's Disease and other Dementias Module*.
- › The Hospital & Health System Association of Pennsylvania. (2013). *Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes*.
- › The Idaho Alzheimer's Planning Group. (2013). *A State Plan for Alzheimer's Disease and Related Dementias: Addressing the needs of Idahoans with ADRD, their caregivers and family members*.

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- › The National Alliance on Mental Illness. (2014). *Public Policy Platform. The National Alliance on Mental Illness.*
- › The Northwest Institute for Community Health Educators. *Educator Trainer Assessment Tool.*
- › The Scottish Government. (2005). *National Care Standards: Care at Home.*
- › The Training Foundation. (2004). *Guide to the Trainer Assessment Programme.*
- › U.S. Department of Education. (2010). *Evaluation of Evidence-Based Practices in Online Learning: A Meta-Analysis and Review of Online Learning Studies.*
- › U.S. Department of Labor. (2011). *Best Practices in Instructional Design for Web-based Training.*
- › U.S. Department of Veterans Affairs. *National Caregiver Training Program Caregiver Workbook Module 1: Caregiver Self Care.*
- › Uchino, B. N. (2004). Theoretical Perspectives Linking Social Support to Health Outcomes. In B. N. Uchino, *Social Support and Physical Health: Understanding the Health Consequences of Relationships* (pp. 33-53). New Haven, CT: Yale University Press.
- › Vatland, C., Strickland-Cohen, K., Loman, S., Doren, B., Horner, R., & Walker, H. (2011). *Promoting Self-Determination for Adults: A Practice Guide.* U.S. Department of Health and Human Services.
- › Vermont Department of Aging and Disabilities. (2000). *Residential Care Home Licensing Regulations.*
- › Vermont Department of Disabilities, Aging, and Independent Living. (2003). *Assisted Living Residence Licensing Regulations.*
- › Vermont Department of Disabilities, Aging, and Independent Living. (2013). *Attendant Services Program Regulations.*
- › Vermont Department of Disabilities, Aging, and Independent Living. (2007). *Regulations for the Designation and Operation of Home Health Agencies.*
- › Vermont Department of Disabilities, Aging, and Independent Living. (2011). *Regulations Implementing: The Developmental Disabilities Act of 1996.*
- › Violence Against Women with Disabilities & Deaf Women Project of Wisconsin. (2011). *A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations.*
- › Virginia Department of Medical Assistance Services. (2003). *Personal Care Aide Training Curriculum.*
- › Vitaliano, P. P., Zhang, J., & Scanlan, J. M. (2003). *Is Caregiving Hazardous to One's Physical Health? A Meta-Analysis.* Psychological Bulletin, 946-972.
- › Washington State Department of Social & Health Services. (2011). *Trauma Informed Care.*
- › Washington State Department of Social and Health Services. (2006). *Developmental Disabilities Specialty Training.*
- › Washington State Department of Social and Health Services. (2006). *Developmental Disabilities Specialty Training Competency Test.*
- › Washington State DSHS. (2007). *Dementia Care Specialty Training.*
- › Welsh Assembly Government. (2004). *National Minimum Standards for Domiciliary Care Agencies in Wales.*
- › While, A. E., & Clark, L. L. (2014). *Development of a competency tool for adult trained nurses caring for people with intellectual disabilities.* Journal of Nursing Management, 803-810.
- › Wis Stat DHS 105.

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