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1.0 OVERVIEW

The majority of Job Corps students come from economically disadvantaged environments that offer limited opportunities for educational and social development. This can lead to social, educational, and employment adjustment issues. In addition, our population ranges between the ages of 16-24, which marks the transition from adolescence to adulthood. During this transition period, behavior can be inconsistent, inappropriate, and often constitutes testing one's own capacities and the governing rules and customs of society. It is a time (1) of experimentation with newly found sexual identities/gratifications and with alcohol and drugs, (2) when peer relationships are paramount, and (3) when society expects people to work to support themselves.

Mental health issues in our population can range from crisis behavior resulting from a relationship break-up to a major psychiatric illness. Because the Job Corps program is designed primarily to serve youth and young adults, it is important to note that:

- Some of our students experiencing mental health issues may not meet the DSM-IV criteria for a mental health diagnosis. These are students who have brief episodes of situational stress (e.g., family problems, relationship problems).

- Some of our younger students will encounter adolescent crises that may not meet the DSM-IV criteria for a mental health diagnosis, but require intervention.

- Some of our students will have significant mental health histories with documented DSM-IV diagnoses before arrival on center.

Mental health issues can affect vocational training and employment in a variety of ways. All students experience emotional reactions as they go through their training and some may need extra guidance. The irregular nature of mental illness can make it difficult for some students to maintain consistent training/work schedules, handle day-to-day stress, and appropriately navigate social interactions. The challenge facing the Job Corps mental health and wellness program is to help build a safe and constructive environment within Job Corps for these youth that supports psychological, intellectual, and social growth and ultimately prepares them for employment.

1.1 MENTAL HEALTH AND WELLNESS PROGRAM PHILOSOPHY

Job Corps operates within a framework entitled, Career Development Services System (CDSS). CDSS is a career-focused approach that provides individualized services to each student using activities and experiences as learning models. CDSS places a priority on collaborative career planning between Job Corps and the students. CDSS ensures that a career manager or career management team assesses the needs of the student and arranges, coordinates, monitors, evaluates, and advocates an array of services to meet the student’s needs.
This model compliments the structure of the mental health and wellness program’s emphasis on an employee assistance program (EAP) and case management model.

There are four CDSS periods within which health and wellness services and activities are conducted:

- Outreach and Admissions (OA) Period—During the OA period, applicants are introduced to the kinds of health and wellness services available at the center. Also, OA staff review requests for accommodation and secure partners in providing requested accommodations.

- Career Preparation Period (CPP)—Students are introduced to health and wellness services so that they understand and feel comfortable and supported by the health and wellness staff, including the center mental health consultant (CMHC); and staff serve as models for students who wish to job shadow for health-related training.

- Career Development Period (CDP)—Career management teams coordinate with the health and wellness center to provide appropriate interventions for students who need services. For example, CDP staff make sure students with disabilities receive necessary services/devices to participate, and assist students in perceiving good health as being critical to achieving career goals.

- Career Transition Period (CTP)—Students understand health-related aspects of independent living, students with special needs have support systems in place to support transition to and retention of employment, and post-center service providers know how to coordinate with Job Corps when needed to help graduates succeed.

The mental health and wellness program is integrated into each CDSS period throughout a student’s tenure at Job Corps. The mental health and wellness program is an essential part of the Job Corps program as required by the Policy and Requirements Handbook (PRH), Chapter 6: 6.10, R3. Although the center director is ultimately responsible for the provision of all aspects of the mental health and wellness program, the center staff implement the program with the support and technical assistance of the CMHC.

Acting in a consultant capacity, the CMHC should clearly define his/her role in the mental health and wellness program, provide program focus and material, and prepare the center staff to assume responsibility for various program components. The mental health and wellness program should reflect the CDSS model with a focus on employability, and the CMHC should view his/her role as the program’s administrator. Program effectiveness is directly related to the ability of the center director, key staff members, and the CMHC to (1) focus on the mental health aspects of the center program and (2) develop staff members’ capabilities for recognizing and addressing students’ mental health needs.
1.2 PROGRAM PURPOSE AND OBJECTIVES

The importance of mental wellness to the student’s ability to develop a positive self-image and to succeed in Job Corps and employment after graduation is recognized in the Code of Federal Regulations (20 CFR 638.510) and PRH-6: 6.10, R3. The PRH requires that each center director provide a mental health and wellness program that includes routine mental health services/intervention for all students, 24-hour emergency mental health care, qualified personnel to implement these services, and ongoing staff development. The center mental health and wellness program should:

- Provide environment that promotes the mental wellness of all students
- Support student mental health and wellness through the use of prevention-oriented principles and techniques that promote employability
- Provide an EAP model that includes the availability of professional evaluative and diagnostic services for students, brief intervention, group sessions, and a referral system that affords ready access to these services
- Promote a drug-free environment and workplace
- Provide mental health care to students through specific center programs as recommended by the Job Corps national office
- Provide staff development programs to enable staff to identify and appropriately respond to students undergoing periods of emotional stress

Each center’s mental health and wellness program must include the services of a CMHC, a trainee employee assistance program (TEAP) specialist, and a counseling component that focuses on students’ individual needs and progress in personal and social development, basic education, and vocational training. These counseling services are to be provided by career counselors, residential living staff, and other appropriate staff with the support and guidance of the CMHC.

In utilizing the center mental health and wellness program, students should learn:

- About the center’s health care delivery system and how to seek on-center health care
- How and when to access community health services
- About wellness concepts and the steps to take to maintain personal wellness
• About their individual mental health condition and prescribed treatment

• About appropriate lifestyle choices

• How to take personal responsibility for maintaining optimal health

• How employability skills can be enhanced in the course of obtaining mental health and wellness services

• That optimal mental health and wellness is a prerequisite to employment readiness

1.3. GENERAL PROGRAM COMPONENTS

The mental health and wellness program can be divided into two equally important functional areas: clinical services and staff development. Clinical services are the responsibility of center health professionals: CMHCs, TEAP specialists, physicians, and nurses. Folder reviews, disability accommodations, clinical assessments, brief problem-focused psychotherapy, case disposition recommendations, and crisis intervention are mainly reserved for these professionals. However, all personnel in contact with students, particularly career counselors, have roles to play in these and the other vital clinical functions (e.g., testing and evaluation, crisis prevention and intervention, and counseling). Some of these roles are described in Section 2.0 of this TAG.

Given the limitations of the CMHC’s time, the focus on employability, and the great needs of the students, it is best to conceptualize the clinical services of the mental health and wellness program as an EAP model with the following components:

• Initial evaluation and triage

• Specific problem-focused treatment plan that has a primary focus on employability and provides detailed follow-up requirements

• Referrals to groups, TEAP, community services

• Daily or regular check-ins with counselors or nurses that focus on coping skills to get through the program: “What are some ways to deal with your anger rather than punching a wall or cutting on yourself?”

The staff development component should focus on the center organization and the personal development of staff members’ skills. Organizational development is the responsibility of the center director who will call upon the CMHC for technical assistance. No less than 1 hour per 100 students per week of the CMHC’s time will be spent on ongoing staff consultation and training (PRH-6: Exhibit 6-5).
The general emphasis of both clinical services and staff development must be on prevention rather than treatment (PRH-6: 6.10, R3(a)). An integrated blend of preventive and treatment services, based on interaction among all center staff members, can best fulfill the variety of student needs.

1.4 INTEGRATION OF THE MENTAL HEALTH COMPONENT INTO OTHER CENTER PROGRAMS

Promotion and support of students' social and psychological growth and development require that the mental health and wellness program be integrated into overall center operations. Since program areas overlap, some topics may be covered in several programs and addressed from different perspectives by various staff members. Sexuality, for example, is discussed by center nurses, residential advisors, career counselors, and health education instructors.

While students should benefit from the perspectives and skills of different professionals, it is essential that:

- Center policy related to student behavior be clear, simple, and easily understood and followed
- Staff functions be clearly delineated
- Staff performance be guided by center policy rather than by individual values
- Continuity and consistency in services be fostered through staff coordination and communication

The following sections describe some of the more critical center programs into which mental health program services should be integrated.

1.4.1 Introduction to Center Life During the Career Preparation Period

Centers must plan and implement an Introduction to Center Life program that assists students in adapting to their new environment and familiarizing them with all aspects of the center. Students' arrival experiences are often critical in determining length of stay. Stresses of arrival may trigger transient emotional symptoms of anxiety, panic, anger, sadness, escape into alcohol or drug use, and/or physical complaints. To help students through this period and limit early resignations, center staff should recognize new students' heightened need for understanding and information. Staff should be alert to indications of insecurity and loneliness sometimes masked by appearances of confidence or bravado. The emphasis in meeting with new students should be on current, day-to-day issues and how to cope with homesickness and to adjust to the new setting. This is an excellent opportunity for the mental health and wellness program to present services and quickly identify students who may need assistance.
An important aspect during this period is the introduction of students to staff representing major components of the center. Guidance for new student orientation to health and wellness services is contained in PRH-6: 6.12, R10. In addition, every center must have its own student handbook (PRH-2: 2.2, R3). The student handbook presents simple descriptions of the incentive system, rules and sanctions, the center’s basic schedule and services, and other center-specific information important to day-to-day center life. A verbal orientation, supported by the material in the student handbook, and followed by small group or individual conferences, represents the foundation of support for new students.

1.4.2 Disability Accommodation Process During the Outreach and Admission and Career Preparation Periods

All applicants with disabilities are entitled to a reasonable accommodation process as provided under Section 504 of the Rehabilitation Act of 1973 (as amended). The term “disability” refers to a person who has a physical or mental impairment that substantially limits one or more major life activities. A mental disability would include mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. Persons diagnosed with a psychological disorder are protected if their condition substantially limits a major life activity such as learning, thinking, concentrating, interaction with others, speaking, or sleeping.

The CMHC may be asked by the center director’s designee (CDD)\(^1\) to participate on the interdisciplinary team to review students with disabilities. The CMHC may assist in gathering information to evaluate a reasonable accommodation and developing student accommodation plans. The CMHC may gather further information by asking the admissions counselor to obtain various records from schools, hospitals, physicians, and therapists in order to formulate an appropriate accommodation plan. The CMHC may even want to interview the applicant by phone or schedule a face-to-face interview. An interview is usually indicated when the CMHC has outdated information and needs to assess the applicant’s present status. Appendix A contains additional information on the accommodation process.

1.4.3 Health and Wellness Program During the Career Preparation and Career Development Periods

Routine as well as 24-hour emergency mental health services must be provided to all students (PRH-6: 6.10, R1(i) and R3). The first opportunities to identify students with possible mental health problems occur during either the cursory health evaluation conducted within 48 hours after arrival on center, or the entrance physical examination conducted within 48 hours after arrival on center, or the entrance physical examination.

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\(^1\) The CDD is the individual identified by the center director to coordinate services for students with disabilities requesting/requiring an accommodation.
conducted within 2 weeks of arrival. Later, health and wellness staff may identify students with emotional or behavioral disorders during a visit to the health and wellness center. It is the responsibility of the health and wellness staff to alert career counselors to students with mental health problems and to refer these students to the CMHC and/or TEAP specialist if indicated.

1.4.4 Trainee Employee Assistance Program (TEAP)

The center director will ensure that students with alcohol/drug-related problems receive counseling or therapeutic assistance and that all staff and students receive current and accurate information about the effects of alcohol and drug use. The center director must appoint qualified professionals to coordinate and implement a comprehensive TEAP (PRH-6: 6.11, R1). Program components must include assessment, intervention, counseling, relapse prevention, and prevention and education. TAG L: Trainee Employee Assistance Program discusses suggestions for TEAP-related policy implementation in detail.

1.4.5 Wellness Class During the Career Preparation, Development, and Transition Periods

The goal of the wellness class is to provide students with sufficient health information and decision making skills so that they can develop healthy habits and lifestyles that are conducive to long-term employment and physical and emotional well-being. Program requirements are stated in PRH-3: 3.19, R1. The CMHC can teach the mental health portion of the wellness class and specifically indicate how mental health issues affect student employability in the workforce (e.g., the relation of depression to job instability or how poor anger management can impair one’s employability).

The CMHC and/or career counselors may also be valuable resources in designing and/or conducting other wellness programs requiring behavior modification, such as weight improvement, hypertension, stress reduction, and diabetes.

1.4.6 Sexual Assault Prevention and Response

The PRH requires that each center director (1) establish a program for sexual assault prevention, intervention, treatment, and follow-up care, and (2) develop a team response to sexual assault that involves center staff and outside resources (PRH-6: 6.11, R6).

Education regarding rape and sexual assault prevention should be incorporated into Introduction to Center Life, the wellness class, and informal discussion groups.
Intervention for students who are sexually assaulted should include interviewing the victim and providing medical care, short-term mental health services, and legal assistance. Center career counselors, residential advisors, and/or other appropriate staff should provide support to help the victim cope with the trauma and readjust to center life. In cases where the student continues to show signs of withdrawal, hopelessness, depression, guilt, self-blame, and/or other symptoms, the center career counselor should refer the student to the CMHC for further consultation. If the student does not respond to mental health intervention, he/she may be medically separated and referred for care.

1.4.7 HIV Case Management

When a student tests positive for HIV, the CMHC should work with the physician and nursing staff to help communicate the results and provide short-term intervention and referral, as indicated. HIV-positive students who are medically and psychologically able to participate in Job Corps’ programs are case managed by a team that includes the center director, center physician, health and wellness manager, CMHC, and designated career counselor (PRH-6: 6.11, R5).

The CMHC provides the following clinical services to HIV-positive students:

- Performs post test informing and counseling
- Ensures that crisis intervention and treatment are provided as necessary
- Conducts complete psychosocial assessments in accordance with Job Corps protocols
- Makes psychosocial recommendations to retain or separate HIV-positive students
- Participates in case management team meetings
- Participates in the development and modification of case management plans
- Maintains contact with the case manager as needed
- Performs quarterly (or as needed) assessments

For further information and guidance on Job Corps HIV policy and procedures, refer to PRH-6: Appendix 6.3.
1.4.8 Standards of Conduct and Security

Job Corps policy regarding student standards of conduct is described in PRH-3: 3.4. The standards of conduct are designed to provide discipline adapted to individual circumstances, which is administered promptly, consistently, and fairly, and which is understood by the students. The standards of conduct should be corrective and educational rather than punitive. The CMHC should create links with the center standards officer (CSO) and assist in developing center operating procedures that address behaviors resulting from non-compliance with mental health recommendations.

Students with psychiatric disabilities should be disciplined in accordance with a center’s standards of conduct. It is important to address unacceptable behavior of students with psychiatric disability uniformly, using established guidelines and procedures. For instance, if a student with a psychiatric disability is found in possession of an illegal weapon on center, the student should be disciplined in accordance with the Job Corps zero tolerance policy.

The management of severely disturbed or destructive students is a security consideration. See Section 5.0 of this TAG for procedures regarding isolation, restraint, and emergency psychiatric services.

1.5 NATIONAL AND REGIONAL SUPPORT

1.5.1 Technical Assistance Scope and Process

The Job Corps national office is responsible for developing, implementing, and monitoring mental health and wellness program policies. Each Job Corps regional office has regional health consultants (RHCs) who assist in carrying out these responsibilities and provide technical assistance to Job Corps centers and the regional office. The RHCs assess center operations and provide assistance through on-site visits and by telephone.

RHCs may conduct on-center program assessments, provide technical assistance, or conduct monitoring visits at the request of the national or regional offices to ensure achievement of program goals and objectives and delivery of quality services. Centers can also request technical assistance from the regional mental health consultant (RMHC) by contacting their regional office project manager or the RMHC.
1.5.2 Regional Mental Health Consultant Support

The RMHC provides a wide range of supportive activities at the center, regional, and national levels. Areas in which assistance and advice are most frequently sought include:

- Review applications that have been recommended for denial by the center of assignment due to mental health reasons or alcohol or drug problems
- Provide technical assistance to center and regional office staff (the RMHC is available to assist center staff in developing procedures targeted to the center’s specific needs; the RMHC can share successful approaches used by other centers and advise centers on proposed corrective actions)
- Assist regional office and center staff in the recruitment of CMHCs and TEAP specialists (selection is made by the center operator; regional office concurrence is needed prior to the implementation of services)
- Assess the professional qualifications of CMHCs, TEAP specialists, and secondary subcontractors, and provide recommendations to center operator
- Consult with the regional office during the approval process of mental health or TEAP subcontracts
- Advise centers on matters such as cost containment, fees, and salaries for auxiliary staff, including the CMHC position
- Advise centers on staffing requirements for CMHCs and TEAP specialists
- Train CMHCs and TEAP specialists and assist national, regional, and center staff in providing training
- Review off-center mental health care and outside specialty referrals for their effect on the budget during the regional office center assessment process
- Investigate significant mental health-related incidents at the request of the national office

The RMHC frequently provides assistance by telephone and e-mail. The RMHC also provides assistance on-site during center assessments and technical assistance visits.
1.5.3 Regional Office Center Assessment Process

RHCs participate as team members when regional office staff conduct center assessments. The assessment serves to ensure that centers are providing services to students that meet the outcomes and quality standards prescribed by the PRH.

The center assessment process generally occurs as follows:

**Pre-site Analysis**—The regional office conducts a pre-site analysis to determine whether outcomes are being met. When outcomes are met, the assessment team focuses on selective requirements involving integrity issues (integrity issues relate to financial resources and data systems). The pre-site analysis determines the type of assessment that best serves the needs of the center. Center operators may be asked to conduct a self-assessment to prepare for the arrival of the regional office center assessment team.

**On-site Assessment**—When the team arrives on center, they will verify (1) issues identified during the pre-site analysis, and (2) targeted outcomes and quality indicators. The team will also review documents and interview staff, students, and community and business contacts.

**Brief-out Dialogue**—Before leaving the center, the team will share assessment results with the center operator and staff.

**Assessment Report**—After the assessment, the regional office issues a formal report detailing the assessment results, center ratings, and areas requiring improvement.

**Corrective Action Plan**—The center operator should submit a corrective action plan to respond to problems identified during the assessment and provide an action plan for improving identified weaknesses/problems.

**Follow-Up and Monitoring**—The center operator, the project manager, and the management team should provide regular follow-up and monitor corrective action plans.

1.5.4 Mental Health and Wellness Program Assessment

The mental health and wellness program is evaluated as part of the overall assessment of the center’s health and wellness program. The assessments will not only determine how well the CMHC is implementing and taking part in the entire wellness model of mental health consulting but also serve as a forum to provide some support on how to further develop the mental health and wellness program.
CMHCs should be prepared to describe to the assessment team the mental health and wellness program goals, performance expectations and standards, ways in which their individual performance contributes to the overall accomplishment of program and center goals, and their continuous quality improvement activities.

During a center assessment, the RHCs focus on the concerns identified during the pre-site analysis to customize the assessment process to resolve concerns and support continuous quality improvement. During the assessment, RHCs may:

- Examine quality indicators—the connection between program requirements and outcomes
- Evaluate the mental health and wellness program from the perspective of quantity and quality of services
- Investigate how the mental health and wellness program contributes to student outcomes, especially employability
- Examine the extent to which the mental health and wellness program is integrated with health and wellness center services and other Job Corps program components
- Determine the extent to which corrective actions taken for continuous quality improvement are producing the desired effect
- Determine the extent to which students are able to demonstrate the mental health and wellness skills they have mastered
- Organize and conduct student focus groups
- Provide mental health and wellness program assessment feedback to the assessment team

The RHC assesses the quality of mental health services provided by the center and the appropriateness of specified treatment plans through such activities as record reviews, staff interviews, student interviews, student focus groups, and observations.
2.0 RESPONSIBILITIES OF CENTER STAFF
IN THE MENTAL HEALTH AND WELLNESS PROGRAM

2.1 Center Director

The center director is ultimately responsible for all dimensions of the mental health and wellness program and should establish center policies that foster appropriate behavior and promote the psychological well-being of students and staff. Because the center director works with and through the staff to monitor and evaluate all aspects of the center program, he/she will wish to ensure that staff provide necessary student support. The center director should work with the CMHC to identify staff development needs, provide management consultation, and offer solutions to program deficiencies with the aim of preventing programmatic problems.

2.2 Health and Wellness Staff

Health and wellness staff may identify students with mental health needs and counsel and educate students about health-related issues such as alcohol and drug use, reproductive health, weight control, hypertension, etc. Since many students present physical health complaints of a psychosomatic nature, the center physician should refer to the CMHC so that appropriate psychological treatment is made available, as indicated.

Because of the interdependence of physical and emotional well-being, it is essential that an efficient system for student referrals and feedback exist among the health and wellness staff, the CMHC, career counseling staff, and other staff, as appropriate. Detailed information on mental health problem assessment together with the treatment plan must be filed in the student's health record.

To facilitate communication between the CMHC and health and wellness staff, the CMHC's office should be located in the health and wellness center. The health and wellness manager should ensure that logistical support (e.g., scheduling) is available to the CMHC.

2.3 Career Counseling Staff

Career counselors help students maintain contact with family and others in the home community. They assist students with suggestions and advice on how to negotiate the Job Corps system and attain their educational and vocational goals. Through regular individual and group counseling sessions, career counselors help students review their reasons for coming to Job Corps and their progress toward long-term employment goals.
Counseling interviews should focus on students' concerns, accomplishments, and goal setting, monitoring, adjustment, and achievement. There are typically three periods during a student’s stay that may require more intensive counseling activities:

- Soon after arrival on center, some students may experience some anxiety and/or homesickness.

- Sixty to 90 days after enrollment, students may question what they are doing in Job Corps, whether it makes sense, whether they want to continue to learn and change, and whether they actually want to work when they finish. They may appear unhappy, apathetic, indecisive, and unsure. Many are testing the sincerity of staff concern for them. If the student can be assisted to overcome doubts, this period can become a turning point towards maturation and growth.

- Another crisis may arise when a student loses a friend (roommate, girlfriend/boyfriend, etc.) to completion/graduation, a job, separation, resignation, or AWOL. Without this special person to anchor the student's resolve to remain in Job Corps, he/she may decide to leave prematurely.

When these stress periods occur, it is vital that students be given individual attention by a responsive listener. Sometimes, contact with a parent or other significant adult (including staff members) will help.

When counselors identify students in need of more extensive mental health evaluation and therapy, they should refer these students to the CMHC for further evaluation.

The career counselors should work closely with the health and wellness staff, the CMHC, and TEAP specialist, as necessary, since physical and emotional well-being are so closely related in health and wellness, sexuality, family planning, pregnancy, and TEAP programs. The career counselors, with technical assistance from the CMHC, should also work closely with residential staff to address students' problems.

2.4 Residential Living Staff

The residential living staff, which typically includes recreation personnel, works with students during weekends, holidays, and other hours not occupied with academic or vocational training, assisting students to use leisure time pleasantly and productively. More than any other staff component, they set the tone for group morale and individual pride, provide a sense of order, and offer models for conflict resolution and fellowship building among the students in their care.

Residential staff promote patterns of group process that helps to build character and skills both for living on center and for later in adulthood. The residential living function is not merely a custodial chore; the task is one of socialization. Providing appropriate
developmental experience and opportunity for limit testing and creativity while maintaining a safe and orderly environment is a major challenge that requires sensitivity, flexibility, and understanding. Helping students handle social interactions without the need for alcohol or drug use is a particular challenge for these staff.

2.5 Academic and Vocational Instructors

The task of accepting students at a wide variety of academic skill levels, evaluating them, and then delivering necessary educational content in a motivating manner requires good teaching skills. The task may be complicated by students' prior experiences in schools and workplaces outside Job Corps. Students are not only in need of remediation to bring skills up to age/grade level, but also may need desensitization to earlier negative experiences associated with learning. Heavy emphasis should be placed on the individual student's status and goals.

Academic and vocational instructors work together, stressing equally the educational and vocational aspects of Job Corps. Individual students are likely to have more interest in either the academic or vocational work. Competence in both is the Job Corps goal. The educational and vocational staffs work with other program staff to support, encourage, and motivate students, and are in the opportune position to identify and refer for counseling those students with adjustment-related problems. Academic and vocational instructors also participate with career counselors and residential living staff in assessing student progress.

2.6 Other Staff

Other staff members on center should also be mindful of their role in maintaining a sound mental health environment. All staff members are important role models for students. Students can learn appropriate behavior by observing staff on center. For example, if staff work well with each other and resolve conflicts appropriately, it sends a message that teamwork and communication are important.

Not every staff member is a counselor, a teacher, or a nurse; however, every staff member should be sensitive to expressed needs and be prepared to do a little counseling, teaching, or nurturing. Staff should be trained to recognize and identify emotional difficulties or stress.

When a significant question arises about the mental health of any student, staff members should seek consultation through established center channels. Depending upon center policy, written referrals may be directed through the career counselor or the health and wellness staff to the CMHC or TEAP specialist, as appropriate.
3.0 RESPONSIBILITIES OF THE CENTER MENTAL HEALTH CONSULTANT IN THE MENTAL HEALTH AND WELLNESS PROGRAM

3.1 Professional Qualifications

The mental health and wellness program must include the services of a qualified mental health consultant, i.e., a fully certified or licensed mental health professional who may be a qualified psychiatrist, clinical psychologist, or psychiatric social worker. Applicants for the position of CMHC should be able to practice independently. Any CMHC providing clinical care that does not meet these requirements must have direct supervision by a fully qualified mental health professional.

In addition to these licensure/certification requirements, experience in the following applied areas is desirable:

- Previous experience in a residential school or treatment facility serving youth, such as a hospital, halfway house, or vocational school

- Demonstrated understanding of accommodating students with special needs

- Demonstrated knowledge of community resources as obtained by work in a vocational rehabilitation office or a community mental health center

- Demonstrated understanding of disadvantaged youth as obtained through prior employment or through personal experience

- Demonstrated ability to provide for staff development needs as obtained through previous organizational development consultations or the design and delivery of staff training

- As a private contractor, the CMHC is responsible for maintaining a current license and liability insurance (at least $1 million, $3 million), and provide proof of these documents to the health and wellness manager to keep on file for regional office center assessments

Contracting the services of a qualified CMHC is important from both a standard of care and a legal perspective. These professionals are licensed and/or certified by states and governed by professional associations. They have completed a curriculum, accomplished supervised training experiences, and passed an examination. In addition, they are subject to peer review and have to comply with continuing education requirements. By employing certified or licensed CMHCs, center operators and the Job Corps have the best statutory assurance that the professional is competent and will abide by an ethical code of performance.
In the rare event that a center operator is unable to contract the services of a qualified professional, a waiver from the regional office must be requested [PRH-6: 6.12, R1 (a,b)]. The waiver process has the following goals:

- To document the need for the waiver (i.e., outlining an account of efforts to hire a qualified professional)
- To document the proposed relationship among the candidate, a supervisor, the center operator, and the regional office

It is recommended that a waiver be reviewed annually for renewal by the regional director. This review/renewal process should document the center operator’s progress in seeking a qualified person and/or the contracted CMHC’s progress toward becoming qualified.

### 3.2 Recruitment

The RMHC should be involved in the recruitment and evaluation of candidates for the CMHC position. As soon as the need for a CMHC is apparent, the center director should request assistance from the RMHC through the regional director. Selection of the CMHC should have the concurrence of the regional director prior to the implementation of contractual arrangements (PRH-6: 6.12, R1(b)).

### 3.3 Terms of Employment

The center director, in consultation with the regional office, determines the number of required on-center hours for the CMHC (PRH-6: 6.12, R1(a)). Except for emergencies, CMHC services will be provided on-center. The subcontract should require a minimum of 3 hours per 100 students per week on average (PRH-6: Exhibit 6-5). Center directors can exceed the minimum hours depending upon the needs of the center. Appendix B contains a prototype subcontract for CMHC services.

It is preferred that a subcontract be executed with one person to provide all CMHC services. In some cases, this may not be possible and two (or more) subcontracts will be necessary—one for direct services to students and case consultations with staff, and a second for staff development and organizational consulting. When more than one subcontract is negotiated, the expectations for each CMHC must be clear and a provision for additional time must be made for CMHCs to consult together on a regular basis. Another arrangement is a subcontract with a mental health facility. In this case, a qualified designated professional must be identified as the primary or lead CMHC. All the consultants assigned to the center must be identified and approved by the center with review by the regional office, if indicated.
3.4 Definition of Roles and Functions

The format in which the CMHC provides required mental health services varies among centers and depends upon how the scope of work recommended by the national office is perceived and defined by the center director with the CMHC. Therefore, it is essential that a new CMHC arrange to meet with the center director to define clearly the nature of his/her role.

Some center directors may have little experience in integrating a mental health professional into the center program and may not have a clear vision of what the consultant can offer the center. Therefore, it is important for the CMHC to clarify and set priorities with the center director regarding the services to be provided, based upon the center’s needs and the CMHC’s availability. It is also important to identify, at the outset, the specific mechanisms for monitoring the quantity, quality, and impact of these services. The original plan can be modified, if necessary, at subsequent periodic meetings. The EAP model should be the model of choice.

The center director and CMHC should:

- Determine the consultant's specific hours on center. As mentioned in the previous section, the number of acceptable CMHC hours per week is 3 hours per 100 students per week. Of the minimum required coverage, one hour must be used for staff training, development, and consultation; one hour must be used to provide clinical services to students; and one hour must be used to support the center’s TEAP. If a center contracts for more than the minimum hours, the number of clinical hours can be increased, but not at the expense of the required staff and organizational development time.

- Determine the CMHC's sources of support required for the provision of these services. The CMHC is ultimately responsible to the center director. This relationship helps the center director oversee the mental health and wellness program while enabling the consultant to deal directly with all program components.

- Work together to support communication between the CMHC and all center staff. As part of his/her orientation to the center, the CMHC should meet key staff members, as a group and individually, to promote a mutual understanding of roles and functions.

The PRH states that mental health consultants provide “prevention, early detection, identification of mental health problems, short-term counseling for manageable conditions, and crisis intervention.” However, the CMHC is also expected to provide treatment as part of an overall wellness care approach. Wellness focuses on helping students live a healthy lifestyle emotionally, physically and mentally.
3.4.1 Clinical Services

The CMHC clinical responsibilities should include:

- Evaluation of applicant folders and disability accommodations
- Advising the center director and staff on preventive mental health measures
- Providing early recognition of behaviors requiring clinical advice or referral
- Consulting on and monitoring the mental health referral and feedback system
- Conducting clinical interviews for purposes of evaluation, diagnosis, and disposition
- Performing or arranging psychological testing services as needed and authorized
- Preparing case management plans that identify specific expectations of staff and the student whose adjustment is at issue
- Maintaining clinical case histories and required communications, records, and forms, including provisions for confidentiality
- Providing clinical support to the TEAP specialist, as needed

3.4.1.1 Evaluation of Applicant Folders and Disability Accommodations

Although the activities described in this section are clearly a clinical service, the time devoted to folder reviews and accommodations should not be considered part of the 3-hours/100-students/week formula. The center director should contract separately with the CMHC to provide this service. The CMHC is a critical part of the applicant review process, specifically, those applications that note any mental health problems, special education requirements, and/or contact with the judicial system.

Requests for accommodation from students with psychiatric disabilities must be evaluated on a case-by-case basis. All requests for reasonable accommodation must be reviewed at the center level, unless the request is for accommodation for the admissions process. If the request for reasonable accommodation is determined to be complex, the CDD is required to convene an interdisciplinary team (IDT) to review the request.

The CDD is the chairperson of the IDT and should identify the most appropriate team members based on the accommodation requested and the needs of the student requesting the accommodation. IDT members will vary depending on the nature of the
request. It *must* include the student, and *may* include the center director; representatives of center departments that will be impacted by the accommodation; center health and wellness staff; school-to-work coordinator; counselor; representatives of referral agencies; vocational rehabilitation; social service providers; and the student’s parents.

If there is a reasonable belief, based on recent hospitalization, mental health treatment, or medication history, that the participant’s ability to perform in Job Corps will be impaired by the psychiatric condition, the CMHC may require that the student be evaluated. The CMHC may also require an evaluation if there is reasonable belief that the participant will pose a direct threat to self or others due to the condition. The requirement that a participant undergo an evaluation should not pose an undue hardship regarding either time or cost. Centers should assist participants in accessing resources such as community health programs or the department of vocational rehabilitation for evaluation.

A reasonable accommodation for a known psychiatric limitation must be provided unless it can be shown that the accommodation would pose undue hardship. The kind of accommodation provided should be determined on a case-by-case basis because individual participants will have varying needs. CMHCs may be able to suggest effective accommodations. Some examples include providing leave for disability-related treatment, installing partitions or other soundproofing barriers in the classroom to accommodate limitations in concentration, and providing a temporary job coach. Medication monitoring by itself is not considered reasonable accommodation. However, a center may need to modify a participant’s training schedule to accommodate medication side effects that make morning class attendance difficult.

There may be times a CMHC believes a student poses a direct threat and should not be admitted. A “direct threat” is defined as a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation. The determination that an individual poses a direct threat must be based on an assessment of the participant’s current ability using recent medical knowledge and objective evidence. Centers must identify the specific behavior that would pose a direct threat. A student cannot be determined a direct threat just by virtue of having a history of psychiatric disability or mental health treatment.

To assist the CMHC in determining if a participant with a psychiatric history can be provided reasonable accommodation, the Job Accommodation Network (JAN) and/or the department of vocational rehabilitation should be contacted as part of the IDT review of an individual’s request for accommodation. This contact should be documented as well.

JAN Website
http://janweb.icdi.wvu.edu/
After all of these steps have been completed and the IDT recommends a denial, the folder is forwarded to the regional office for review. Only the regional office can make the final determination of a student’s denial.

3.4.1.2 Prevention

Many clinical direct services provided by the CMHC will be in response to problems perceived by staff members. However, there are methods by which the CMHC can facilitate students’ success in Job Corps and prevent mental health problems. Incoming students’ mental health problems may be identified by a review of the self-reported medical history that is completed during the cursory health evaluation. Possible or potential mental health problems may also be identified during the social intake performed by career counselors. In addition, as part of the EAP model, consider providing pamphlets and brochures to students about mental health and wellness. Develop groups with a focus on how to deal with stressors in the job setting.

One way to prevent a problem from escalating to a serious crisis is to plan for early intervention. Toward this end, the CMHC should review existing mental health standing orders and tailor them to center-specific needs. Each center has specific procedures for the operation of most aspects of the health and wellness center. The CMHC would be responsible for drafting the procedures for emergency psychiatric situations such as suicide attempts, psychotic episodes, urgent referrals, and danger to others. As part of these procedures, there should be a process for 24-hour on-call coverage. The CMHC should review these standing orders annually and provide training for center staff regarding their use.

3.4.1.3 Referral and Feedback

The PRH requires a written referral and feedback system for mental health treatment (PRH-6: 6.10, R3(b)). To ensure that this requirement is met, it is recommended that the CMHC develop a mental health referral form in two parts:

- Part 1 would allow the referrer (e.g., career counseling, residential living staff, academic/vocational staff) to describe the student’s behavior and the need for a referral.

- Part 2 would provide the referring staff with a status response from the CMHC. This response should be somewhat general to protect confidentiality but provide enough information so that referrer believes there is follow-up to referrals; otherwise, referrals may stop.

Appendix C contains a sample referral form.
Before the referral is forwarded to the CMHC, the career counselor will perform a functional evaluation. Information in the evaluation report should include:

- Identifying information (name, SSN, DOB, DOE)
- Home address
- Current Test of Adult Basic Education (TABE) scores
- A statement of social history (a copy of the social intake form is desirable)
- A statement of adjustment in residential, vocational, and academic programs
- A statement of counselor/student relationship and work accomplished
- Clarification of the referral problem

The referrer should forward the referral and functional evaluation to the CMHC. In addition to written feedback, verbal contact among all persons involved is desirable. This contact may be accomplished with phone calls and case conferences.

3.4.1.4 Interview, Evaluation, and Diagnosis

The CMHC should review the referral material and the health record prior to the evaluation interview. The background and interview provide the CMHC with information regarding the physical and emotional status of the student. Once the interview/evaluation is complete, the results are entered in the student’s health record along with a working diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) for diagnostic categories (use of Axis I and Axis II is sufficient.

If the CMHC determines that the student requires care beyond those services available in Job Corps, he/she should provide a documented recommendation for separation with/without reinstatement to the center director through the health services manager. The decision to retain or separate the student rests with the center director. Note that most mental health referrals do not result in medical separations.

If the student is to be retained, the CMHC develops a written management plan (see Section 3.4.1.6 below) and discuss elements of the plan with appropriate staff. If the recommendation is to separate, then prepare a medical separation with reinstatement (MSWR) or a medical separation for mental health reasons; discuss with center director and HWM all medical separations.
3.4.1.5 Psychological Testing

Most students referred to a CMHC are suffering temporary situational or developmental problems that interfere with their social or educational adjustment. Psychological testing is costly and time consuming, but it may be necessary in very selected cases to complete an evaluation or to determine the disposition. Use of psychological test batteries to establish a diagnosis and clinical treatment plan is discouraged.

3.4.1.6 Management Plans

After evaluation of the student's mental health problems, the CMHC should make a confidential entry in the health record and prepare a management plan. The management plan should be tied to Job Corps program elements and specific staff members. A career counselor is the ideal case manager for an individual with academic or social problems. The case manager is responsible for following up on the management plan designed by the CMHC. The CMHC and case manager work together to provide a bridge between the student's needs and staff skills. For example, if the plan calls for group recreational activities, the career counselor and CMHC discuss this aspect of the management plan with the recreation staff. Out of the discussion, the recreation staff gains understanding of what the student needs and the CMHC gains awareness of what is available. Sometimes, only one intervention by the CMHC will be necessary and the counselor/case manager continues the follow through. In other cases, visits to the CMHC by the student may be an actual part of the management plan (e.g., brief therapy).

The management plan should be designed to improve the student's mental health and to strengthen his/her performance in the vocational and educational programs; it should be very specific and realistically tied to the center program. The CMHC should document the clinical impression and the management plan, including specific staff involvement in the student's health record. (In general, a management plan should be concise, no longer than one page.)

Counseling staff, and in some cases, selected health and/or academic/vocational instructors, are usually responsible for some aspects of the management plan. The case manager monitors nonhealth staff involvement in the plan and may work with a teacher to monitor the student on performance goals. The CMHC may also request that the case manager involve the student's parents/guardian in some aspect of the plan. The student should also be involved in a conversation about his/her management plan; expectations for behavior should be clearly outlined in writing.

Delegating management plan components does not relieve the CMHC of the responsibility for the clinical outcome. The case manager should keep in contact with the CMHC regarding the student's progress, and the CMHC should assess the effects
of the care provided by the health and wellness staff. The plan may need adjustment and revision as the student's needs and prognosis change.

3.4.1.7 Brief Intervention

Some students may benefit from brief therapy. The CMHC should consider two major options in this event: (1) on-center sessions (approximately five) conducted by the CMHC; or (2) off-center sessions conducted by a mental health professional.

The CMHC may not provide long-term psychiatric treatment to a student when this treatment would require significant expenditure of program funds or staff time. The CMHC may make a referral to an off-center provider if plausible. The CMHC should maintain contact with the off-center mental health provider to monitor the student's compliance and progress and to ensure that a copy of the provider's notes are entered in the student's health record. One exception to providing long-term treatment might involve monthly supportive psychotherapy treatment of individuals requiring long-term medication management.

Job Corps does not have the staff to provide extensive treatment for students with serious psychological and/or emotional problems. Clinical services are limited to those who are physically and emotionally able to participate in normal Job Corps duties without extensive medical and mental health treatment. While successive or intermittent interviews between a student and the CMHC may be scheduled, students whose treatment plans require extensive psychotherapy should be referred to a local provider in the community near the Job Corps Center. This would allow the student to continue Job Corps and receive the necessary services beyond the scope of the CMHC. Students requiring periodic (e.g., monthly brief visits) for medication management may be exceptions, if otherwise progressing in the program.

3.4.1.8 Documentation, Confidentiality, Informed Consent, Release Forms, Child Abuse Reporting Procedures, and Significant Incident Reports

Documentation

The wellness model is a multidisciplinary treatment team approach. It is important that the CMHC’s assessment, treatment, and case management notes are legible and part of the student’s health record. When writing notes consider, “If it isn’t charted, it didn’t happen.”

Intake notes should indicate, at the minimal level, reason for referral, presenting problem, history of presenting problem, mental status exam, diagnostic impression, and a clear management plan. The management plan will be multidisciplinary and describe various modes of treatment, including groups, TEAP counseling, medication evaluation, as well as off-center referrals.
Progress notes should indicate, at the minimal level, assessment, progress, and management plan. The notes should be written in the chronological portion of the health record so staff can track referrals and providers, treatment, and progress over time. One system used by many center health staff is the SOAP format, standing for Subjective (reported by the student), Objective (consultant observations, including mental status), Assessment (what is result or findings, including diagnostic impression, if any), and Plan (specific suggestions).

If the student’s health record is subpoenaed from the center or if a CMHC receives a subpoena to appear in court for a Job Corps-related issue, the center director and the regional office solicitor should be notified at once.

Confidentiality

When staff members work together to follow a management plan, the need to share information versus the requirement for ethical confidentiality often becomes an issue. Confidentiality is a sensitive subject in any health care setting and especially in one that serves youth. As a part of their development, students are extremely concerned with maintaining personal privacy, not being viewed as different, and being accepted by their peers.

Staff must use student information responsibly in order to establish trust and communication. The staff’s "need to know" versus the student's "right to privacy" can seldom be perfectly balanced. This balance can be effectively maintained by communicating only information that relevant staff needs to know to carry out their responsibilities. Students must be informed when and why specific information will be shared with other staff.

Three situations in Job Corps which warrant breaching confidentiality are: (1) a student's threat to harm self, (2) a student's threat to harm others, and (3) suspicion of child abuse. In these cases, the CMHC should inform the center director and health and wellness manager in writing immediately and provide recommendations as to a course of action. Unless specifically contradicted by State law, this reporting to center management fulfills the CMHC's legal responsibility to protect, inform, warn, and/or report.

Release Forms

The CMHC should provide functional statements and treatment summaries to off-center mental health providers. Prior to the release of this information, a release form should be signed by the adult or emancipated student or by the parent/guardian for the minor. If the latter is not available, the center director may authorize the release.
Informed Consent

CMHCs should be aware of the ethical and legal guidelines regarding informed consent and implement them on center. CMHCs should review the Ethical Guidelines for Psychologists, developed by the American Psychological Association in 1992, or similar guidelines for their profession (for non-psychologists). There are also State laws that govern appropriate informed consent for treatment.

Child Abuse Reporting Procedures

With society's increased awareness of the abuse of children, CMHCs will now be more likely than ever to hear reports of abuse from students (including physical or sexual abuse, and neglect). Every state government has established a department to handle these complaints, and state laws pertaining to reporting requirements and procedures vary. CMHCs should be familiar with their state laws and each individual center should comply with state regulations. All cases of suspected child abuse should be reported directly to the center director. The CMHC and/or the center physician may also be called upon to assist the center director when a report is made to another staff member.

Significant Incident Reports (SIRs)

When a mental health significant incident occurs, such as a suicide attempt, the CMHC is to draft a significant incident report (SIR) that includes the details of what occurred, interventions, and present status including follow-up with hospitals or referrals. This report must be written and e-mailed to the national office within 24 hours of the incident (PRH-5: 5.5, R2). CMHCs will submit the report to the health and wellness manager. There will be a follow-up SIR within a few days.

3.4.1.9 Support to the TEAP Specialist

The services of a TEAP specialist are provided on center to address the problem of alcohol and drug use among students. The CMHC should provide the TEAP specialist with clinical support by:

- Participating in the intervention and management planning process
- Providing direct support for difficult cases
- Authorizing medical separations with/without reinstatement for alcohol and drug related diagnoses
The TEAP specialist is not expected to be able to function independently. Time should be allowed each week for the CMHC and TEAP specialist to discuss cases. These meetings should be documented in the health record and initialed by both professionals.

3.4.2 Staff Development

Staff development activities are essential to establishing an effective mental health and wellness program. Planning for the provision of these services should be based on student and staff needs. The center director should meet regularly with the CMHC to discuss the status of the program, the staff contribution, and current student problems.

3.4.2.1 Organizational Development

The CMHC may serve as principal technical advisor to the center director and senior staff on managing organizational development. Organizational analyses may be conducted by examining patterns for delegation of authority and responsibility, observing the planning cycle and implementation of operational plans, analyzing interacting management styles, and assisting in developing needs assessments. These observations, their possible meanings, and various alternative models can be shared with the center management team with a view toward improving organizational effectiveness.

3.4.2.2 Technical Assistance

Staff development is enhanced when the CMHC works with staff members individually or in groups on "applied" topics. For example, through case conferences, the CMHC and a teacher may work on how to motivate beginning reading students; or the CMHC and residential living staff may discuss potential mental health problems encountered in the dorms. These technical assistance sessions can count toward fulfilling the requirement for general skills training; they provide on-the-job staff development using real cases as vehicles.
3.4.2.3 Skills Development

The CMHC contributes to staff training requirements through the staff development modules. These modules, contained in Appendix D, are a basic set of sessions. The basic presentation outline, overhead text, and handouts are provided for each module. Other modules can be added according to need. Delivery of these modules can be performed by the CMHC, but staff training experiences should not be limited to the CMHC's presentations.

Skills Development Modules

- Adolescent Development and Communication
- Alcohol and Other Drugs of Abuse
- Standards of Conduct
- Conflict Management
- Crisis Intervention
- Group Process and Leadership
- Intergroup Relations
- Life Trauma
- Mental Health Standing Orders
- Orientation
- Sexuality and Safer Sex Practices
- Student Motivation
- Supervision

3.4.2.4 Presentations to Admissions Counselors

The CMHC may be asked to participate in orientation sessions for admission counselors by making presentations on the center mental health and wellness program, the role of the CMHC in Job Corps, and mental health-related review concerns. These presentations should be aimed toward helping admission counselors understand their role and the importance of getting complete information.

3.4.3 Case Management

Considering the at-risk population and limited time on center, the CMHC will need an integrated case management approach. This will involve interaction with the TEAP specialist, counseling, residential life, and physician regarding student behavior, compliance, medication, side effects and treatment progress. Case management notes should appear in the health record, so there is documentation of follow-up care, even without face-to-face interaction with the student. If case management notes do not appear in the health record, it can only be concluded that follow-up care did not occur.

3.4.3.1 Psychotropic Medications

Some students will be on psychotropic medications. Since center staff is working as a treatment team, part of the CMHC’s responsibility is to help monitor how well the medications are working as well as noting side effects. The CMHC will need to be in contact with the health and wellness manager and the center physician to report side effects, medication effectiveness and compliance. On many centers, the CMHC will work with the physician to help choose an appropriate medication and treatment plan. It is important that the CMHC is up to date on most of the more commonly used psychotropic medications. Complicated psychotropic medication management may require the services of an off-center psychiatrist consultant.
3.4.3.2 Community Linkages and Resources

The CMHC’s clinical position is one of prevention, assessment, and triage. The practice of referring out to the community is a large part of this position, and therefore community linkages are key to implementing an effective mental health and wellness program. CMHC responsibilities would include some case management for those referred out, including documentation of treatment compliance and progress.

The following are a few examples of community resources that may be appropriate linkages and referral sources:

- Community educational groups for stress and depression management

- Emergency psychiatric facilities

- Planned Parenthood for students who are pregnant or dealing with issues of sexually transmitted diseases

- Graduate school programs that could provide student interns to provide entry-level mental health services on-center

- Specialized off-center referrals can provide treatment for people of different ethnicity or lifestyles (gay and lesbian) and at the same time support diversity

- Department of vocational rehabilitation can be a helpful referral for testing to assess present levels of ability and to help in planning an appropriate individual reasonable accommodation plan

- Psychiatry consults through a memorandum of understanding with a board-certified psychiatrist to have students evaluated and perhaps maintained on more complex psychotropic medications; the center physician is usually capable of prescribing the more common antidepressants and stimulant medications

Planned Parenthood Website
http://www.plannedparenthood.org/

The National Clearinghouse of Rehabilitation Training State VR Agencies Website
http://www.nchrtm.okstate.edu/resources.html
4.0 RESPONSIBILITIES OF THE TEAP SPECIALIST IN THE MENTAL HEALTH AND WELLNESS PROGRAM

The TEAP specialist plays a specialized and important role in the center mental health and wellness program. Working with the CMHC, center physician, health and wellness staff, career counselors, and other nonhealth staff, the TEAP specialist works to ensure the integration of alcohol and other drugs of abuse intervention services on center. He/she is specially trained in the areas of identification of abusive patterns of alcohol and drug use, alcohol and drug use intervention, relapse prevention, and codependency problems.

The TEAP specialist supports the health and wellness manager in implementing and monitoring the intervention component of the TEAP. TAG L describes the TEAP specialist’s full responsibilities in this role. The responsibilities that relate to the mental health and wellness program include:

- Developing and monitoring student intervention plans and documenting progress in the student’s health record
- Conducting ongoing counseling and support groups
- Soliciting staff input in developing and updating a student's intervention plan and behavioral contract
- Collaborating with the recreation department to assist in developing leisure-time activities and specific activities to reinforce an alcohol and drug free lifestyle
- Linking with community intervention resources

 Job Corps Health & Wellness Website/ TEAP TAG
http://www.jobcorpshealth.com/teap_tag/
5.0 EMERGENCY PSYCHIATRIC SERVICES

Centers must be prepared to provide emergency psychiatric services to ensure temporary isolation, proper care, and protection for students in crisis. In the event that the center physician or CMHC are unavailable when a mental health emergency occurs, center staff should follow center standing orders.

5.1 Temporary Isolation

Use of on-center isolation facilities may be needed for temporary segregation of students from their peers only when behavior constitutes an immediate threat to themselves, other person, or property (PRH-5: 5.4, R8(b)). If such isolation is used:

- Students who are a danger to self or others must be supervised continuously until the disposition of their cases is resolved
- Isolation may not be used as a punishment
- Health and wellness staff must be notified when a student is placed in isolation for any reason
- With suicidal or emotionally disturbed students, isolation should only be used for the shortest time necessary to arrange for a safer treatment option
- The student must be observed every 15 minutes and this observation must be documented on a signed log giving the exact time of observation and the signature of the staff member conducting the observation
- Isolation may not exceed 12 hours unless accompanied by a statement from the center physician that the isolation is not medically prohibited

When a physician or CMHC is unavailable, the student should be hospitalized. Delay in providing needed hospitalization can result in clinical, economic, and/or legal complications.

Tips for Action:

- Develop center operating procedure for psychiatric emergencies
- Define location and operation of temporary isolation facility for use in psychiatric emergencies
- Define use of physical restraint, if needed until further help arrives
- Train appropriate staff in isolation and restraint procedures, including regular updates of skills
- Establish necessary connections with psychiatric hospital facilities, including written agreements whenever possible
5.2  Physical Restraint

Physical restraint may be needed in situations where a student seriously threatens persons or property, including serious suicidal behavior. PRH-5: 5.4, R8(a) permits the limited use of restraint, although trained staff must be available to ensure that appropriate methods are used. The center director may also request the assistance of local medical and/or law enforcement personnel when a student’s behavior endangers the student or others. If physical restraint is used:

- The center director may permit only that amount of physical restraint required to prevent the student from self-injury, injuring others, or from damaging property
- No student shall be physically restrained for more than 1 hour without at least verbal consultation and approval of the center physician
- Staff may not use handcuffs, mace, pepper spray (or any derivatives) on students
- Restraint and isolation procedures and limitations should be established in writing at each center, including a process to keep a record of each restraint and the reason for use
- The CMHC or center physician should conduct a mental health evaluation as soon as possible and, if indicated, refer the student to emergency mental health services

A mentally disturbed student may be charged with a crime and taken into custody by the police. In such cases, the center director should make every effort to see that the student receives prompt psychiatric evaluation and treatment.

5.3  Hospitalization

Psychiatric hospitalization may be needed in serious situations of emotional disturbance. Even brief hospital stays can provide immediate safety for disturbed students as well as initial diagnosis and treatment.

- If emergency psychiatric evaluation is needed, the center should follow the procedures for reporting a significant incident, described in PRH-5: 5.5.
- If hospitalization occurs, procedures for medical separation with/without reinstatement are usually followed, as described in PRH-6: 6.4, R4 and TAG E: Medical Transfer, Separation, and Referral; Management of Student Injury and Death Under FECA/OWCP.
Hospitalizations may lead to different outcomes:

- Short-term hospitalization, defined as up to 2 weeks, may be indicated following emergency admission and evaluation. If this hospitalization is not unduly costly to the center and the prognosis indicates that the student will be able to resume a full training schedule, medical separation is not required.

- If the hospitalization after an emergency will exceed 2 weeks, the student should be medically separated as soon as possible.

Prior to medical separation, the CMHC with the assistance of the RMHC, if necessary, should attempt to arrange for transfer of the student to a facility in the student’s home community.

Brief involuntary hospitalization, even commitment, may be necessary if the student is suicidal, homicidal, or psychotic, but unwilling to enter a hospital voluntarily or is incompetent to make decisions. Laws and regulations regarding involuntary hospitalization and commitment vary from state to state. Information about commitment procedures may be obtained from the local mental health center, the State or local health or mental health department, or an attorney. Although involuntary commitment is seldom required, legal counsel should be obtained to protect the student’s rights at the commitment hearing. If necessary, legal fees will be assumed by Job Corps.

Parental or guardian consent for involuntary commitment is not required. Parents cannot provide the sole authorization for commitment. However, the center should inform parents and guardians of the circumstances and request that they send written or telegraphic acknowledgement. Unsuccessful attempts to reach parents or to obtain an acknowledgement should be documented in the student’s health record to ensure medico-legal protection.

Psychiatric hospitalization usually results in medical separation.

- At the time of medical separation, the center should indicate in writing that if the student desires to return to Job Corps in the future, written reports will be required from qualified mental health professionals that support the student’s application to return for training.

- Any student hospitalized for mental health reasons who subsequently wishes to reenter Job Corps should be evaluated by the CMHC, if at all possible.

The center director along with the CMHC, career counselors, and health and wellness staff need a clear understanding of the student’s needs when he/she returns to Job Corps.
Job Corps cannot provide long-term psychiatric or alcohol/drug use treatment. A student whose illness precludes continuing in the program will be referred to a mental health facility in his/her home community as part of the medical separation process. In the case of planned inpatient care for alcohol or drug use, the student should be medically separated soon after admission and considered for reinstatement.

To ensure appropriate emergency care and short-term services, each center should have a written agreement with a local health care facility, such as a hospital emergency department or a community mental health center, for 24-hour psychiatric emergency coverage and for short-term hospitalization. In making arrangements for emergency and short-term hospitalization, a meeting may be needed between the hospital administrator, medical director, and emergency department director to define the hospital's capabilities and limitations, the cost of such services, and emergency logistics. The hospital and the center should agree on communications procedures to be used during and following emergencies.

A subcontract for emergency inpatient psychiatric services typically ensures prompt admittance for periods of at least 3 days, during which longer-term disposition can be arranged. This subcontract guarantees prompt emergency evaluation and hospital services. Subcontracts for services should also include provision for short-term care. For centers with limited capabilities on center, the subcontract may also include services for diagnostic evaluation. Two prototype subcontracts for emergency inpatient psychiatric services appear in Appendix D.
6.0 TRANSFERS AND SEPARATIONS

6.1 Indications for Counseling

Leaving a Job Corps center can be a stressful experience for many students. Students who transfer to another center, resign, are discharged early, are absent without leave, or complete/graduate, may need assistance in easing the transition from center life to home and work environments.

6.1.1 Transfer

Student transfers to another Job Corps center are not common but do occur and involve certain stresses that should be recognized in order for the student to successfully meet them. Therefore, it is important to make constructive plans for assisting students during this period.

- A transfer should be discussed thoroughly prior to its initiation and the student should participate in the decision.

- The student can be helped to anticipate what transfer will be like. A complete and factual picture of the new center or program should be provided. The student's experiences during initial enrollment and arrival can often be used to explore concerns about transfers.

6.1.2 Early Separation

Students who leave Job Corps prematurely often face several different problems and have special need for the understanding and help of center staff. Some students may be considering resignation or leaving without authorization; others are being discharged for various reasons prior to completion. The following should be considered:

- It is essential that center staff maintain sufficient personal contact with students to predict most early separations. Residential life and counseling staff and other students are usually in the best position to learn of serious dissatisfaction or plans for leaving.

- When a student appears to be planning separation before completion, the career counselor and student should meet to discuss the student's intentions and concerns as well as the objective nature of the problem(s). Such problems may involve life on center or at home. For example, a student who is homesick may have difficulty adjusting to the new routine and may benefit from a discussion about overcoming the stresses of center life. If there is difficulty in the home situation, the precise concern should be clarified and some attempt made to alleviate the problem. The
admission counselors or agencies in the home community are often helpful in such cases.

- The center should devise plans for helping potential dropouts based on experience with various issues and needs. Many students will talk about leaving just to see if center staff care enough to encourage them to stay. Inquiry about a student's situation will often be enough to convey staff members' interest and concern. At other times, it will be necessary to explore the problem in detail.

- Potential dropouts may benefit from discussing their concerns with student leaders in peer support sessions.

- It is valuable for some prospective dropouts to go through a series of interviews before separation. These can be conducted with different people in the center (e.g., beginning with student leaders, going next to the residential advisor, then to the career counselor, then to the group living manager, and finally to the center director). This process will delay the actual departure, allow exposure to a number of people at the center, and convey the center staff's interest and concern. This sequence may provide a deterrent to separation if each person who interviews the student is able to convey a personal willingness to help.

- It may be helpful to use a buddy system through which experienced, sympathetic students who are friendly with the potential dropout meet as needed with him/her to discuss the situation. Buddies need supervision by a staff member.

- Whenever center staff is confronted with a potential dropout, the question that should be asked is, "Why now?" Frequently, an exploration of the stresses affecting the student will permit correction of inhibiting factors and prevent unnecessary dropouts.

- The CMHC can aid the staff in devising a preventive program designed to increase student retention by meeting their total needs. The professional will also be asked to meet with an individual student when appropriate.

When some students become upset and do not know what to do, they often leave the center for an indeterminate length of time. If they do not return immediately, they may be considered absent without leave (AWOL). For residential students, being AWOL is defined as unauthorized absence from center for two consecutive daily morning attendance checks. A nonresidential student is considered AWOL after unauthorized absence from one morning attendance check and failure to sign-in during that same training day.

Because of the multiple factors that influence a student's conscious or subconscious decision to become AWOL, the career counselor should make every effort to contact
the student to explore and clarify his/her reasons for leaving the program before initiating the separation process. Career counselors are encouraged to contact the student's parents or guardian. The parents or guardian may assist the career counselor in clarifying the student's reasoning and enhance student motivation to return to Job Corps.

In some cases, a student will become AWOL without realizing that he/she is no longer protected by active student status and may be subject to an administrative separation. The transition career counselor should work with the CMHC to ensure that a responsible individual (such as parent, guardian, or screener) is aware of the student's mental health needs. Referral for care should be available upon request even if the student resigns or is administratively separated.

### 6.1.3 Completion/Graduation

The center director should provide counseling for students to ease their transition back to the community and assist in job placement, college entrance, or military service.

At the time of impending separation, some students appear to cling to the center and return to old negative behavior patterns. Impending separation may lead to depression, fatigue, poor concentration, inability to complete tasks, trouble with potential employers, or loss of acquired skills. A plan for helping at this time should focus on the following:

- The decision to leave the center is one that should be made by the student in consultation with staff. It should be based upon their mutual perception of what the student has accomplished educationally, vocationally, socially, and personally.

- In individual counseling sessions, students should be given the opportunity to express their feelings about returning home and planning for the future. The career counselor should be prepared to discuss all issues related to leaving and should assist the student in anticipating what the period after graduation will be like. It may also be helpful at this time to emphasize the student's progress and accomplishments on center.

- It may be valuable for separating students to meet in small discussion groups for a month or so prior to separation. These groups might try to anticipate what it will be like to return to the home community. Discussion should focus on the everyday realities of working, planning, surviving, and deciding independently, without the structure, support, and direction of Job Corps.
6.2 Transfers and Separation for Mental Health Reasons

6.2.1 Challenging Mental Health Problems

Most students arrive at Job Corps without any identifiable emotional difficulties. However, many serious emotional disorders appear for the first time during the late teens and early 20s. Some students also arrive with a history of developmental difficulties, including learning disabilities (LD), attention deficit/hyperactivity disorders (ADHD), or with emotional problems which have been treated. However, some students develop disorders that may limit the student’s successful participation in Job Corps. Some of the more serious ones include:

- **Psychotic disorders**—Bizarre thinking, often involving auditory or visual hallucinations or paranoid delusions, and withdrawal from activities due to preoccupation with inner problems usually requires separation from Job Corps when it first occurs. Once stabilized on medications for a few months, some students will be able to return to the center and resume training, as long as they remain in treatment.

- **Bipolar disorders**—Extreme mood states, sometimes involving alternations between extreme high energy, elation, manic states, versus extremely depressed, sad, low energy states, may require separation for treatment. Even with successful treatment, moods may suddenly change so that medication and therapy treatments need to be adjusted. Such students can succeed in Job Corps with ongoing monitoring.

- **Suicidal and self-abusive behaviors**—Some students develop repeated impulsive behaviors, usually with suicidal ideas, that require ongoing treatment. Even with successful treatment, sudden stress can precipitate new episodes of self-abuse. With ongoing treatment, many students will be able to succeed in Job Corps.

- **Impulsive behaviors**—Some students have impulsive disorders that constantly get them into trouble, without any known connection with treatable psychiatric disorders. Some of these students will develop more severe psychiatric disorders, so that treatment of the disorder (e.g. bipolar mania) will help control impulsive tendencies. Other students can use counseling to help educate them in ways to control their impulses.

- **Attention deficit/hyperactivity disorder**—Adult attention deficit/hyperactivity disorder often follows students from adolescent days and usually requires some combination of structured educational techniques and medication. Because many of these students require stimulant medications (e.g. Ritalin, Adderall), which can be abused, centers must help students obtain their medication in a manner that does not lead to abuse by other students.
When a student develops a psychiatric disorder that clearly impairs his/her ability to complete or take part in the training program, the CMHC will need to do an assessment and possibly write a recommendation for a medical separation. It is important that the CMHC describe specific behaviors and symptoms that can be clearly related to the student’s inability to effectively take part in the Job Corps training program and not base the criteria of separation solely on a “borderline personality” disorder, for example. Medical separations are necessary so that a student can receive a higher level of care that goes beyond what Job Corps has to offer. Medical separations are also ethically appropriate since Job Corps is not a treatment facility or hospital; Job Corps would do the student a disservice by keeping him/her on center when it does not have the resources to maintain the student appropriately. It is important that the CMHC has demonstrated, in the health record, an interactive process of reasonable accommodation before concluding that the student cannot be accommodated and should be medically separated.

There are two types of medical separations. A medical separation with reinstatement (MSWR) is used when a student has a problem that can be resolved in less than 6 months, with appropriate treatment. At any time before 6 months, the center can re-evaluate the student’s progress and make a decision to reinstate the student. Medical separation, sometimes called a straight separation, requires the student to remain out of Job Corps for at least one year before the student can re-apply, and the application must go through the regional office for evaluation. A student who is initially placed on an MSWR and the problem does not resolve within 6 months automatically becomes a straight separation and must wait at least one year to re-apply.

6.2.2 TEAP Referral

Students who are identified as having a drug problem by a positive drug test at entry must provide a negative urine drug test before the end of the 45-day probationary period. Those students are informed, assessed for level of use, and counseled by the TEAP specialist. A student may be referred to the CMHC for evaluation or discussed in consultation with the CMHC if the initial assessment indicates that treatment beyond the scope of Job Corps is needed. A student who is assessed to need treatment beyond the scope of Job Corps, with a recommendation from the TEAP specialist and CMHC and the approval of the center director, may be granted an MSWR for further treatment. Students who test positive for drugs on suspicion who initially tested negative at entry, or request treatment for a drug problem, at any time during their enrollment at Job Corps, may be granted a MSWR, and a return to center after successful treatment has been documented.

Students with alcohol abuse problems, especially dependence issues, may request treatment at any time during Job Corps training. Students may not be automatically separated for alcohol issues unless a pattern of unacceptable, alcohol-related behavior
persists. Center operating procedures should define the process for TEAP referrals for drug and alcohol abuse and how they are to be handled.

6.2.3 Disciplinary Referral

A student may be referred to the CMHC because of a discipline problem. If the consultant identifies a mental health problem as the causative factor for the discipline problem, the consultant should recommend a medical rather than a disciplinary separation and make a mental health referral for continued care. If the CMHC determines that a disciplinary separation is appropriate, the student should be referred back to the CSO. Suggestions to modify the student’s behavior can be offered by the CMHC as well as a recommendation for mental health care if the student is separated after appearing before the center review board. One common situation involves students who receive a disciplinary separation because of serious behavioral infractions involving alcohol.

6.2.4 Resignation Referral

Students may voluntarily resign for a variety of reasons, such as family problems, relationship issues, or uncertainty about vocational choice. Many of these students receive counseling support prior to resignation.

In the event that a student with an identified mental health problem insists on resigning even after counseling, he/she should be allowed to leave as a resignation with a mental health referral. The student should be encouraged to receive follow-up at an appropriate mental health facility in the student’s home community.

6.2.5 Completions after Mental Health Care

A student who has received mental health care and is completing the program does not have to be medically separated. However, the CMHC might counsel this student about seeking continued care and/or offer a referral source, as part of their transitional needs assessment. Staff should try to help the student actually make an appointment before leaving the center, if possible, and make sure the student has health coverage to pay for the services. Whenever possible, the student who relied on regular mental health care may find it helpful to see the new therapist at least once before graduating, to help with the transition.

6.2.6 Transfer Procedures

Transfers may be recommended if a functional evaluation indicates that a student can gain a specific benefit from the Job Corps program at another center. Before the transfer of a student is approved, the student’s health status must be evaluated and recorded in the health record. This evaluation should include an examination for
evidence of emotional illness or instability. Final transfer approval is based on the receiving center’s acceptance and regional office concurrence. (See TAG E for transfer policies and procedures.)

6.2.7 Administrative Leave

The center director, with the CMHC’s or center physician’s recommendation, may grant administrative leave with allowances and transportation for a period of up to 10 days (up to 30 days without pay). Those students needing mental health treatment away from the center (except for the case of alcohol and drug treatment) may use this type of leave. Administrative leave may not be used to delay medical separation processing without the prior approval of the regional office.

6.2.8 Separation Procedures

Medical separation with/without reinstatement should be recommended if a functional evaluation identifies the student's mental health problem as the primary cause of failure in the program and/or indicates the need for long-term and/or costly therapy. Examples of mental/emotional problems that may result in medical separation include:

- Unremitting severe emotional difficulties or severe learning disabilities that interfere with the student’s ability to function in Job Corps and require long-term therapy or vocational rehabilitation
- Professional documentation of the potential for severe difficulties in the near future unless the individual receives intensive treatment
- A condition that precludes continued enrollment at the present time but does not preclude reentry into Job Corps after the condition has been resolved
- A student’s refusal to comply with a prescribed treatment plan

If there is a possibility that a student’s illness is caused by or aggravated by participation in the Job Corps program, the center should file a CA-1 or CA-2 claim with OWCP (see TAG E).

Once the CMHC makes the decision that medical separation is indicated, a confidential report should be prepared for the student’s health record that includes a functional statement, the student’s management plan while on center, and reasons for the separation recommendation.
No student may be medically separated for mental health reasons without an appropriate referral. The national and regional offices must be notified if a serious incident, including sexual assault, other assault, serious medical incident, attempted suicide, or serious drug related incident, has resulted in the medical separation. The following information should be included in the center director’s formal medical separation notification:

- **Diagnosis**—A numerical and narrative statement provided by the CMHC of the student’s condition according to DSM IV diagnostic categories, Axes I and II. If the diagnosis is drug-related, name all drugs involved. If there was a suicide attempt/plan/ideation, so state and outline the suicide plan.

- **Functional Statement**—A clinical statement written by the CMHC that includes a summary of clinical evidence and information gathered by a career counselor from the residential, vocational, academic, and health and wellness staff about the student's functional ability.

- **Escort**—The CMHC’s specific statement regarding the need for an escort to ensure that the student arrives safely at destination.

- **Referral**—The name of the mental health referral agency identified by the CMHC and the actual referral arrangements made by the center coordinator. Before leaving the center, the student should sign a release of information form so that the CMHC can provide the agency accepting referral with a treatment summary. Compliance with the referral recommendation will improve if (1) there is an actual appointment made prior to the student’s return to the home community; (2) if a family member or admissions counselor is advised of the problem and the need for follow-up on the referral; and (3) the student understands the reasons for the referral.

The CMHC should also evaluate the applicability of a MSWR for the student. Students who are medically separated for inpatient care should be considered for this type of separation as well as students receiving inpatient care for alcohol/drug treatment.
7.0 STAFF COMMUNICATION FOR MENTAL HEALTH

The foundation of the center mental health and wellness program is teamwork. Every aspect of the mental health and wellness program requires information sharing, planning, and evaluation by the CMHC, TEAP specialist, other health professionals, other center staff, and students.

When the team approach is functioning well there are advantages to the center. Indications of positive mental health changes in the student population include increased retention, decreased use of local emergency services, decreased visits to the health and wellness center, a decrease in positive biochemical tests after entry, and less fighting and vandalism. A well-integrated team also benefits staff. Positive changes may include lower turnover, decreased absenteeism, and increased cooperation within and between departments.

The following case studies illustrate the team approach as it applies to mental health planning for troubled students. These case studies point out that mental health plans are frequently interdisciplinary and include contributions from many departments or programs on center. While the team focuses on a particular student, it also strengthens the communication and problem solving links between staff members.

7.1 Case Study: Classroom Adjustment

Referral Problem—An 18-year-old male student has been referred for evaluation by the vocational director. According to the auto mechanics instructor, the student is an above average mechanic but frequently "mouths off" at the instructor and sleeps during class reading assignments. The counselor noted in the functional evaluation attached to the referral that the student adjusted well to the residential program, was average in math, but below average in reading. The student is described as wanting to stay in Job Corps. During the CMHC's interview, the student reports that he thinks the instructor should be given more actual working experience.

Management Plan—After the CMHC evaluates the student, the counselor is called in to discuss and help develop the management plan. In this plan, the counselor will help coordinate the efforts of the reading teacher and the vocational instructor through a behavioral contract. In the contract, the reading instructor and the student mutually agree that the student achieve certain reading goals each week. The reading instructor agrees to spend an extra hour helping him understand his mechanics manual when these weekly goals are met.

In the second part of the contract, the mechanics instructor agrees to a standard of acceptable behavior during the reading portion of the class time. If the student maintains a standard of "no disruptions, no sleeping" the instructor will allow him to
have more "hands-on" time and permit him to assist by helping other students with their mechanical work.

**Evaluation**—The counselor/case manager is responsible for follow-up and agrees to review the student's progress at 2 and 4 weeks. The CMHC will be available for further consultation but does not plan further direct contact with the student.

7.2 **Case Study: Aggression**

**Referral Problem**—A 16-year-old female student who has been on center 6 weeks is referred to the CMHC by her career counselor. The student was referred to the career counselor by a teacher for being inattentive in class and by a residential advisor for trying to start fights in the dorm and not participating in dorm details. The counselor has seen the student twice but has been unable to "get through" to her.

The CMHC's assessment on the initial interview is that the student has no severe emotional or learning disabilities. However, she does appear to be suffering from an "adjustment reaction" to living on center. This reaction is typical when younger adolescents are placed in predominantly older age groups. According to the CMHC, this student believes that the way to be accepted by the older students is to "get noticed and get a reputation." The student is worried about the CMHC's evaluation because she is doing well in her vocational training and would like the chance to get through the Job Corps program. At this time, the CMHC develops a 30-day plan. The question of the student's suitability for the program will be reevaluated at the end of the 30 days.

**Management Plan**—The career counselor will meet with the student once a week to monitor her progress in the dorm and classroom; the master instructor and residential advisor should be included on alternating weeks. The career counselor will also help the student to understand how her behavior may be decreasing her chances for acceptance by other students. She will explore nonaggressive alternatives for gaining recognition and support the student's struggle to develop a positive self-image.

The master teacher will monitor the student's classroom behavior using an activity schedule that will be submitted to the career counselor each week. The reading teacher will work with the student individually for 15 minutes twice a week to upgrade her reading ability and support her achievements.

The residential advisor will meet with the student to develop a behavioral contract for dorm detail and will assign a student leader to make individual contact with the student and provide acceptable models for peer group recognition and Job Corps success.

**Evaluation**—The career counselor will monitor the student's progress for the 30-day period. Final evaluation will take place at the regularly scheduled performance review.
8.0 STAFF DEVELOPMENT RESPONSIBILITIES

8.1 Overview

Job Corps centers are complex organizations to operate. Center directors and their senior managers are charged with overseeing and managing a number of different staffs (residential, academic/vocational, career counseling, health and wellness, security, food service, recreational, maintenance, etc.). Since most of the responsibility for day-to-day activities is delegated to senior staff, employee coordination requires teamwork and communication both within a particular department and across management lines.

The CMHC may serve as a valuable resource for suggestions, encouragement, support, and constructive comments to assist the center director and senior staff in managing the center. The focus is on fostering and developing organizational communication and cooperation skills necessary for smooth center operations. Working with the center director and senior staff members both individually and as a group, the CMHC can help them interpret both inter- and intra-departmental tensions and clarify communication channels.

The CMHC has a major responsibility for staff development as well as for providing clinical services to students and support to the TEAP. On average, the CMHC should spend about one-third of the time in each of the three segments (clinical, staff development, and TEAP). In the staff development capacity, the CMHC provides technical assistance and skills training in mental health topics for center staff with the aim of improving the overall quality and delivery of mental health services to students.

The CMHC’s staff development responsibilities should include:

- Advising the center director and staff on matters of organizational development
- Providing technical assistance to center staff in evaluating eligible students with disabilities and in providing necessary accommodations for such students
- Providing technical assistance in the development and implementation of student and staff orientation to include designing activities that decrease transitional stress, facilitating center acculturation, and helping to develop positive peer relationships and group cohesion
- Recruiting and ensuring integration of community-based (non-Job Corps) staff development resources in the center mental health and wellness program
• Providing skill development and consultation regarding staff/staff, staff/student, and student/peer living-learning relationships; emphasis should be on group resolution of problems with a focus on training staff to effectively promote positive mental health

• Offering consultation and technical assistance as a follow-up to all mental health staff development programs

• Conducting case conferences using the management plans of individual students for development of interdepartmental understanding and sensitivity to mental health issues

• Providing staff and student developmental training activities on some or all of the following topics:
  - Leadership skills
  - Supervision styles
  - Communications, feedback, and listening skills
  - Positive behavior management techniques
  - Behavioral contracts
  - Motivational techniques
  - Self-concept development
  - Staff team building
  - Conflict resolution strategies and crisis intervention

The CMHC may also conduct trainings with special mental health implications such as: life trauma, sexuality, and intergroup relations.

8.2 Policy

Each staff member must receive 5 hours of training in mental health topics annually (PRH-5: 5.3, R2). The CMHC will contribute to this training effort at least 1 hour per 100 students per week. For example, the acceptable CMHC time per week for centers with a capacity of 300-399 students is 9 to 12 hours; therefore at centers of this size the CMHC should spend at least 3 to 4 hours per week in staff development. Outside mental health agencies may also be contracted to provide training on specific topics of interest to the staff.

8.3 Staff Development Forums

There are several locations for the various staff development events: the CMHC’s office for individual sessions, the center director’s office for update sessions with senior managers, the conference room for small groups/case conferences, and the auditorium for training seminars. When a group of CMHCs were asked for the types of forums they used for staff development, the list included:
• Attending departmental meetings in the staff lounges

• Working with new staff on an individual basis in their work areas

• Having "working lunches"—either the culinary arts students can prepare the meal or staff can bring their lunch

• Bringing a staff member in to a session with a student in the CMHC’s office

• Going to a classroom or a shop to observe a student

• Co-leading a dormitory meeting

• Sponsoring off-center time for various groups of staff to convene without interruption or for individuals to attend conferences on topics related to their job

• Attending special center events—even weekend events

The emphasis of the suggestions from CMHCs was to move away from routine locations for staff development and have flexible schedules so that all staff can benefit. For example:

• Training on student travel days, especially after a holiday or on weeks students are on vacation

• Adjusting schedules in order to meet every shift of staff, e.g., at end of one shift and beginning of next

8.4 Facilitating Staff Development

The center director is the key to an active, productive staff development role for the CMHC and should meet regularly with the CMHC. The CMHC must work hard to schedule meetings/training sessions at convenient times, engaging the staff in the sessions, and making the material relevant and applicable. These sessions should be mandatory.

There will be initial preparation time the CMHC must devote to a first-time session. However, sessions can be repeated as needed (e.g., staff turnover creating the potential for a new audience) so that preparation time is minimized.

CMHCs should be informed about the job requirements of the different departments. The best source for this information is the PRH. The following table contains the chapters and sections that should be read in the PRH:

Job Corps Community Website
http://jcweb.jobcorps.org:7108/
Some CMHCs may experience a high demand for clinical appointments that exceeds the time they have available on center. However, if there is a good staff development program in place, reliance on the CMHC to intervene in interpersonal problems will be reduced. The role of the CMHC was never intended to be one of a super-counselor who sees students hour after hour. The health and wellness manager, working with the senior career counselor, should prioritize the appointments for the CMHC to protect the staff development schedule.

### 8.5 Meeting Organizational Challenges

Organizational analyses may be conducted by a CMHC to assist the center. Such analyses can include examining patterns for delegation of authority and responsibility, observing the planning cycle and implementation of operational plans, analyzing interacting management styles, and assisting in developing needs assessments to avert crises. These observations, their possible meanings, and various alternative models can then be shared with the center management team with a view toward meeting organizational challenges. Several applied examples follow.

#### 8.5.1 Communicating as a Team

One organizational challenge on a Job Corps center is developing a communication system. The center director works through the managers and supervisors to execute policy and programs. This teamwork is based on frequent, clear communications among managers and supervisors; yet, this open communication can be difficult.
The CMHC will often recognize when departments are not communicating or are unaware of how their actions affect other departmental operations. Subsequent stress on students is inevitable. Indications that the departments may need better communications include:

- The incentive system does not operate as intended
- Formal evaluations of students are not held in a timely manner
- Student accountability is poor (e.g., the pass system is not working, there is a high rate of broken appointments, follow-up on class cuts is minimal, etc.)
- Morale is low and attendance at center functions is minimal

Some examples of common situations follow:

(1) One reason communication can be difficult is the students. Some young adults have found that "divide and conquer" is the best way to get what they want. Therefore, if they can divide the staff, they will both get their way and not get caught in their manipulation. The CMHC is often in the best position to recognize when inter- or intra-departmental conflict is a result of student efforts to divide.

(2) Clear managerial communications may be difficult because of limited job experiences of some Job Corps employees. For example, an inexperienced manager (e.g., a recreation supervisor promoted to manager of residential living) with good technical skills must learn to manage as part of an on-the-job process. Another example is a young, inexperienced line staff member who may identify with students more than other staff members.

(3) During a staff development session, or while dealing with a student problem, the CMHC may notice a situation where staff maturity or limited experience is hindering communication among team members. The CMHC is encouraged to work individually with the staff member and his/her supervisor to facilitate better communication.

(4) Nothing happens in isolation on a center. For example, if the CSO restricts an entire dorm for a weekend, there will be added strain on the residential living department, the food services staff, and the safety officers. Of course, it is acceptable for the CSO to restrict students to center—even an entire dorm—but the CSO should communicate the plan, in advance, to at least the manager of residential living and the food services supervisor so that residential advisor coverage, on-center recreational activities, and meals can be planned. Otherwise, the CSO may arrive Monday and confront the consequences of poor communication, finding that many of the students were allowed to go home because there wasn't sufficient staff coverage.
or food for a weekend surge of students. The CMHC may become aware of this series of events through the "grapevine" complaints of staff or comments by students.

The lack of coordination described above will have various results. The CSO may feel unsupported by colleagues. The managers of the other departments may be unhappy about being put on the spot. The center director may be angry that the management team seems to require constant supervision rather than the ability to keep the day-to-day activities of the center under control. Finally, the students may believe the discipline system is an empty shell and sanctions are often meaningless. This is the most serious outcome, since lessons of discipline are possibly the most important mental health factor Job Corps provides. The CMHC can use this example of communication breakdown as part of team building sessions to prevent similar events or as part of hindsight review.

8.5.2 Defining a Team Purpose

An organization is several groups working together to achieve a common purpose. The organization's attitude is a direct reflection of the center director. The center director will set the tone and communicate the purpose of the center in simple terms. The CMHC may be able to help the center director state the purpose of his/her center.

The overall goal of Job Corps is to assist economically challenged young adults in attaining employment and contributing to society. However, each center director will have his/her own way of stating a center's purpose. This statement will help the CMHC and center staff focuses their efforts and activities. For example, a center director in the Southwest stated his center's purpose in terms of Job Corps being a family. Other center directors have emphasized the vocational aspects of Job Corps or the student's vocation as the primary focus.

CMHCs should be aware that the purpose may appear to vary over time. This is because a Job Corps center's performance is not always measured by how well the center performed as a "family" or how well students did in their vocation. Centers are run for profit, usually by major corporations, and retaining contracts is based on performance. Job Corps benefits greatly from the infusion of good business practices and the measurement of performance. Unfortunately, good business practices sometimes conflict with students' mental health needs. The CMHC and center director should acknowledge this dilemma and work toward a compromise. This collegial approach to such a fundamental problem is a good team-building topic.

8.5.3 Maintaining a Team

Maintaining a team in Job Corps is an organizational challenge due to constant change—new staff, new programs, and new students—on a weekly basis. Starting at
the top, a change in center director is a major transitional and organizational challenge. Center directors differ in their psychological, organizational, and leadership skills and a change at the top may bring a period of tension for both the staff and the CMHC. The CMHC should be an encouraging resource to help build working relationships.

New managers pose another organizational challenge. Some center directors are good coaches and can bring a new manager's skills along quickly. In other cases, the center director may call on the CMHC for consultation when the new team member appears out of step. For example, a change in center operators may occur. A new manager may be on a team of all new managers; or seasoned managers may find themselves on a team with new corporate policies, procedures, and titles. Not only will the managers be under stress, but also the rest of the staff may perform poorly while the senior staff attempts to form themselves into a management team. Providing team-building sessions for the management team is a valuable CMHC contribution to staff development.

At Job Corps, most program materials are written in the PRH, TAGs, and center operating procedures that help maintain continuity over time. However, Job Corps is a dynamic program that is often undergoing change based on national office priorities and directions, on regional office preferences, or on contractor desires or practices. The CMHC should keep up with these changes and help implement them when possible.

As a part of his/her organizational development responsibilities, the CMHC may be called upon to provide technical assistance to the center director (or senior managers) on successful management techniques. Center directors should be sensitive to chain-of-command issues in order to support their managers and supervisors. However, staff that feels that they have access to the center director will do less complaining to each other. CMHCs can help by encouraging an "open door" policy. In addition, a center director's visibility in the cafeteria, shops, classrooms, and recreation areas helps staff feel supported, encourages students to behave better, and gives both a sense of pride in their activities.

8.5.4 Working with Gangs, Alcohol and Drug Distributors/Loan Brokers, and Students who Profess a Belief in Satanism

A serious organizational challenge is the formation or revitalization of gangs, alcohol and drug distributors/loan brokers, and students who profess a belief in satanism.

- **Gangs**—Gangs often have city or neighborhood specific identities. The center director, with the technical assistance from the CMHC, can reduce gang identity by substituting identification with Job Corps.

  Special clothes, gestures, phrases, etc., associated with gang membership should be prohibited. Splitting up living arrangements/dorm assignments, and immediately
redirecting members' interests to their shop, current dorm assignment, and relationships with staff and other students, is a necessity. Focus on inter-shop and inter-dorm competitions may prove successful.

If there continues to be gang activity, and the CMHC’s evaluation indicates that efforts to redirect identification have failed, the center director should identify the member(s) and consider either separation or transfer after consultation with the regional office. Of course, any violent activities must be dealt with directly, consistent with zero tolerance mandates.

- **Alcohol**—The alcohol/drug distributors usually are picking up pocket change for their activities. Sometimes they are also the local source for loans (e.g., to buy a bus ticket home). Because money is involved, there is always a chance for a fight. If the CMHC/TEAP specialist becomes aware of such activity, inform the managers of security, residential living, and the CSO. They should work together to cut off the supply of alcohol and drugs and make legitimate loans available (usually through the student government association). Of course, distributors are usually dealt with through disciplinary separation from Job Corps as well as possible criminal prosecution.

- **Satanism**—The student who has satanic beliefs or evangelical religious beliefs should understand that they do not have to give up their belief to be in Job Corps, but they must adjust their behavior—that is, no rituals allowed or no proselytizing behaviors. The goal is to give them a sense of appropriate mastery and control over their social situation in order to bolster their self-image and self-esteem and possibly let the satanic or strict religious ideas drop away. Unless they can be convinced that Job Corps is a workplace and there are certain acceptable behaviors, a medical separation may be necessary.

As members of these groups, students find an identity and source of security. However, they also need to begin practicing appropriate workplace behaviors. The CMHC can help staff recognize and deal with offensive and inappropriate behaviors before they become out of control.

### 8.5.5 Working with Gay and Lesbian Students

The issue of sexual orientation is one of personal importance and can cause much anxiety to all youth. At Job Corps, we have an obligation to support and enhance the self-esteem of all students regardless of their sexual orientation—gay, lesbian, bisexual, and/or transgender. Gay and lesbian students may often feel invisible in their environments. Their invisibility is typically reinforced by heterosexism in their environment, which causes gay and lesbian young people to feel invisible, unsupported and isolated. This also may be an outgrowth of harassment, name calling, and homophobia by others.
As a role model for students, respond to homophobia immediately and sincerely. Encourage in-service trainings for staff and students on homophobia and its impact on gay and lesbian youth.

Additionally, gay and lesbian students should also understand that their behavior might make other students uncomfortable. All Job Corps students have a right to be accepted, but they must possess appropriate workplace behavior. In this sense, Job Corps is not a home away from home or a place where any type of social discourse is allowed. If appropriate, the CMHC may be asked to speak to students about specific behavior others find offensive. The student will usually have a positive response to such direct feedback.

Finally, encourage staff to create a cooperative learning environment where all students are safe to express themselves. Teach students that diversity is something to be celebrated rather than ridiculed.

8.5.6 Preventing Violence

Another organizational challenge is the management of violence among students. The best predictor of violent behavior is history. When performing the social intake of an applicant, counselors should be aware of school suspension patterns for fights, assault arrests, and self-reports of family violence. The more recent the violence, the more likely the student may express violent behavior on center. It is often difficult for counselors to assess anti-social personality types or anticipate aggressive/unsocialized conduct disorders. The CMHC, counselors, and CSO should work together to prevent center violence.

Students may be so disruptive and intimidating that the staff becomes fearful of them. Staff should be realistic about confrontations with potentially violent students, especially new students who have not adapted to center life. The CMHC can use several of the staff development modules in Appendix E to help staff prepare to manage this sort of crisis.

The CMHC may recommend that a student with an anti-social or conduct disorder diagnosis be medically separated. There must be a clear code that violence will not be tolerated; problems are to be talked through. The CMHC may even need to alert the center director to the need for precautions off center, e.g., putting a staff member at the bus station, at the movie theater, or at a shopping area frequented by students, if the potential for violence in these places surfaces during an evaluation.

8.5.7 Risk Assessment and Planning

Every center is required to provide and update annually a safety and occupational health plan, which includes the development of plans for managing organizational
crises. This planning process should identify training needs. The CMHC should provide technical assistance in the review of the risk assessment plan and support for training needs.

### 8.6 Building and Maintaining Relationships with Center Staff

Although all staff members have a responsibility to contribute to the mental health program, the health and wellness staff, the counseling staff, and the center mental health professionals are the three primary sources on center for identifying and supporting students’ mental health needs. Only when these three sources work together does the student receive comprehensive support services. Thus, the CMHC should work to foster good working relationships with these staff members.

#### 8.6.1 Health and Wellness Staff

The CMHC should work closely with center health and wellness personnel (including the center physician, health and wellness managers/nurses, TEAP specialist, and center dentist). These working relationships should establish well-defined systems for identifying and referring students for mental health consultation, developing treatment plans, documenting mental health interviews and clinical contacts in the health record, handling mental health emergencies, and processing medical separations for students with mental health problems.

Specific health and wellness staff development to be provided by the CMHC might include:

- Training health and wellness staff who review folders of eligible students to develop reasonable accommodations for students with specific mental health/behavioral needs
- Training in the identification of signs and symptoms of emotional disorders, the treatment of psychosomatic illness, and the mental health aspects of illness
- Training in stimulating motivation to adopt healthy lifestyles
- Training in counseling and interviewing techniques

The health and wellness staff should alert the CMHC to potential student mental health problems. In particular, admissions staff should help by obtaining and forwarding to the CMHC previous health records of all new students with a history of psychiatric hospitalization, therapy, evaluation, and/or psychotropic medication usage; or of all new students with a history of institutionalization in a social care facility, correctional facility, or special school.
8.6.2 Career Counselors

Because of the CMHC's limited time and exposure to students and the center program, he/she must depend on the career counselors' ability to recognize and address students' mental health needs. To ensure that career counselors are equipped to assume this responsibility, the CMHC should orient and provide ongoing development for all career counselors on the clinical aspects of their role. This development process should include at least:

- A review and discussion of the mental health and wellness program
- Training in interviewing techniques and group counseling skills
- Training in documentation and maintenance of the student counseling records to include the social intake\(^2\), anecdotal notes, and functional evaluation
- Training in obtaining and using information about students' status and/or performance through sources such as:
  - Family history from parents or guardians
  - Mental health problems identified by health and wellness staff during the cursory health evaluation, entrance physical examination, or biochemical testing results
  - Personal career development plan (PCDP) and counseling referrals from teachers and instructors
  - Incident reports from the CSO and other behavior reports from probation officers, lawyers, former teachers, etc.
  - Information from student support services about leave or AWOL days, clothing allocations, class cuts, etc.
- Training in case referrals to the CMHC including identification of cases and clarification of the referral process

In addition, the CMHC should maintain ongoing clinical supervision through counseling record audits and case conferences. This review should be performed in conjunction with the senior career counselor or career counseling staff manager.

Other center programs also address the mental health needs of the total student population. Although these programs are the primary responsibility of health and wellness staff, a student's career counselor will have the greatest influence to change behavior and will call upon the health professionals (including the CMHC) to provide

\(^2\) The Social Intake Form (SIF) or similar social history format is recommended for use with all students.
insight into the technical and/or clinical aspects of the programs. These programs include reproductive health, weight improvement, hypertension, and TEAP intervention activities.

### 8.6.3 Nonhealth Staff

Because of the constant contact between center staff and students, the CMHC should train the orientation staff, academic and vocational instructors, residential advisors, recreational specialists, CSO, and security staff to identify students with possible mental health problems and to make appropriate referrals through the career counseling and/or health and wellness staff. Since members of these units are frequently involved in the student’s personal career development plan, they should (when appropriate) attend case conferences.

In addition, the CMHC should provide ongoing staff development sessions for staff (see Appendix E, Modules 1-13). The general focus of these training sessions should be on the application of mental health principles to center life. Simply stated, these principles include:

- Staff as positive role models
- Consistent, clear limits, and predictable discipline
- Incentives and celebrations for accomplishments
- The safety to be judged wrong but given the chance to correct the behavior
- Encouragement to be responsible, respectful, and respectable
- Direction to bridge between their families and their new adult life

All staff must clearly understand and conform to the center policy that no staff member may have a personal relationship with students outside of their guidance role in center activities. In the event that a staff member violates this policy, and it comes to the attention of the CMHC in the course of a student interview, the CMHC should inform the health and wellness manager and the center director. This information is not considered confidential because the student’s well-being is at risk.

### 8.6.4 TEAP Specialists

The CMHC should build a relationship with the TEAP specialist and the TEAP (see PRH-6: 6.11, R11). In fact, the CMHC contract includes an average of 1 hour per 100 students per week for TEAP-related activities (PRH-6: Exhibit 6.5), usually split evenly between clinical and staff development objectives. The CMHC may provide some
technical assistance in the form of team building or consultation for the intervention and management of alcohol and drug using students. The CMHC may also include aspects of the TEAP in staff training conducted with all center staff.
9.0 STAFF DEVELOPMENT TRAINING MODULES

9.1 Staff Development Modules

The training modules in Appendix E provide the CMHC with the basic framework for staff development on center. This appendix contains 13 modules, approximately 22 training hours. To facilitate delivery, each module is divided into segments lasting no more than 45 minutes. Each module contains an overview, copy for overheads, and handouts.

The CMHC should expand and/or modify the modules according to an individual center's needs. Additional modules should be developed as new topics are identified or requested.

With the exception of first module (Orientation), there is no particular order for module delivery. The orientation module should be offered to all new staff members approximately 3 months after they begin working on center.

Staff development should be ongoing. Some module topics are for interdepartmental groups, while others are designed for intradepartmental staff only. For example, the sexuality and mental health standing orders modules are designed for cross sections of departments. The conflict management module would be more effectively presented to specific departments. It is recommended that the program staff attend all training modules; other staff should select those modules that are specific to their training needs.

The CMHC may also make use of a co-facilitator for these presentations (e.g., a career counselor or manager). The CMHC may also ask for help from participants to record comments and answers during the training sessions.

The center director should designate a staff member, other than the CMHC, to be responsible for training logistics, such as meeting space, preparation of training materials (e.g., overheads, pens) course announcements, and training records.

9.2 Presentation to Admissions Counselors

Admissions counselors are often invited to Job Corps centers so that they may familiarize themselves with the facilities and curriculum offerings of a specific center and accurately describe these to potential students. The CMHC may participate in these orientation sessions by making presentations on the center mental health and wellness program, the role of the CMHC in Job Corps, and mental health-related concerns. The Job Corps website on
accommodating students with disabilities contains sample presentations on a variety of topics relevant to the admissions process and the role of admissions counselors.
Appendix A: The Accommodation Process
What is a Disability?

Under Section 504 of the Rehabilitation Act of 1973 (as amended), disability refers to a person who has a physical or mental impairment that substantially limits one or more major life activities. A mental disability would include mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. Persons diagnosed with a psychological disorder are protected if their condition substantially limits a major life activity such as learning, thinking, concentrating, interaction with others, speaking, or sleeping.

**Physical impairment includes but is not limited to:**

Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, including but not limited to neurological, speech, respiratory, digestive, blood and lymphatic, skin, or other.

**Mental impairment includes but is not limited to:**

Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

**Physical and mental impairments include diseases and conditions such as:**

Orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV disease and tuberculosis, drug addiction and alcoholism.

**What is not included in the definition of physical and mental impairments?**

- Pregnancy
- Homosexuality or bisexuality
- Transvestitism, transexualism, pedophilia, exhibitionism, voyeurism
- Gender identity disorders not resulting from physical impairments
- Compulsive gambling
- Kleptomania or pyromania

However, persons with these characteristics may also have other conditions that meet the criteria for a recognized disability and may have related behavioral issues in some cases.

**How does Section 504 of the Rehabilitation Act of 1973 categorize drug addiction?**

Section 504 of the Rehabilitation Act of 1973 recognizes drug addiction as a disability if an individual has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use. Casual drug use is not a covered
Individuals currently engaging in illegal use of drugs are not recognized as having a disability by Section 504 of the Rehabilitation Act of 1973.

**How does Section 504 of the Rehabilitation Act of 1973 apply to people with psychiatric disabilities?**

Persons diagnosed with a psychological disorder are protected if their condition substantially limits a major life activity, including learning, thinking, concentrating, interacting with others, speaking, sleeping, and others. Chronic, episodic conditions may be included if they are substantially limiting when active and have a high likelihood of recurrence.
Reasonable Accommodation of Psychiatric Disabilities

Requests for accommodation from students with psychiatric disabilities should be evaluated on a case-by-case basis. The Interdisciplinary Team should use an interactive process that involves the student, parent (if appropriate) and a mental health professional. It is important to evaluate each case individually, and to avoid using broad generalization about the specific disability as a basis for determining the reasonableness of the request.

*Can we require that a participant with a psychiatric disability have a mental health evaluation?*

If there is a reasonable belief, based on recent hospitalization, mental health treatment or medication history, that the participant’s ability to perform in Job Corps will be impaired by the psychiatric condition, you may require an evaluation. You may also require a mental health evaluation if there is reasonable belief that the participant will pose a direct threat to self or others due to the condition. The requirement that a participant undergo an evaluation should not pose an undue hardship regarding either time or cost. Centers should assist participants in accessing resources such as community health programs or the Department of Vocational Resources for evaluation.

*What kinds of reasonable accommodation are we required to provide?*

You must provide a reasonable accommodation to a known psychiatric limitation unless you can show that the accommodation would pose undue hardship. The kind of accommodation you provide should be determined on a case-by-case basis because individual participants will have varying needs. Mental Health professionals may be able to suggest effective accommodations. Some examples include providing leave for treatment related to the disability, installing partitions or other soundproofing barriers in the classroom to accommodate disability-related limitations in concentration, providing a temporary job coach. Medication monitoring by itself is not considered reasonable accommodation. For instance, a center may need to modify a participant’s training schedule to accommodate medication side effects that make morning class attendance difficult.

*Can a Job Corps Center discipline a participant with a psychiatric disability?*

Participants with psychiatric disabilities should be disciplined in accordance with the behavior management system in place at each Job Corps center. It is important to address unacceptable behavior of participants with psychiatric disability uniformly, using the established center guidelines and procedures. For instance, if a participant with a psychiatric disability is found in possession of an illegal weapon on center, the participant should be disciplined in accordance with the Job Corps zero tolerance policy.
**What if the participant is determined to be a direct threat to other students or to self as a result of a psychiatric disability?**

Section 504 of the Rehabilitation Act of 1973 defines “direct threat” as a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation. The determination that an individual poses a direct threat must be based on an individualized assessment of the participant’s current ability using recent medical knowledge and objective evidence. Centers must identify the specific behavior that would pose a direct threat. A participant cannot be determined a direct threat just by virtue of having a history of psychiatric disability or a history of mental health treatment.

**How can we determine if a participant with a psychiatric disability can be provided reasonable accommodation without undue hardship to the center?**

The Job Accommodation Network (JAN) and/or the Department of Vocational Rehabilitation should be contacted as part of review of requests for accommodation for participants with psychiatric disabilities.
The Interdisciplinary Team

All requests for reasonable accommodation must be reviewed at the center level, unless the request is for accommodation for the admissions process. If the request for reasonable accommodation is determined to be complex, the CDD is required to convene an interdisciplinary team (IDT) to review it.

Who should be on the interdisciplinary team?

The CDD is the chairperson of the IDT and should identify the most appropriate team members based on the reasonable accommodation requested and the needs of the individual student who is requesting accommodation. The members of the IDT will vary depending on the nature of the request. It must include the participant, and may include:

1. Center Director;
2. Representatives of center departments that will be impacted by the accommodation;
3. Health and wellness staff, school-to-work coordinator, counselor;
4. Representatives of referral agencies, Vocational Rehabilitation, social service providers;
5. Student’s parents/guardians

What are the responsibilities of the interdisciplinary team?

The composition of the IDT is determined by the CDD; the CDD serves as chairperson of the IDT; the IDT should include a designated recorder in order to document the process of decision-making. The IDT:

- Reviews the request for accommodation;
- Recommends approval or denial of the request for accommodation;

What about confidentiality?

Information regarding a participant’s disability and any prior accommodation is confidential. Information and documentation regarding a request for accommodation is only available on a need-to-know basis to those involved in determining the reasonableness of the request and to those involved in implementing the accommodation. Information should be provided only to the extent necessary to ensure the accommodation is implemented effectively.
Appendix B: Prototype Center Subcontract for the Mental Health Consultant
PROTOTYPE SUBCONTRACT FOR CENTER MENTAL HEALTH CONSULTANT

The undersigned center mental health professional, referred to henceforth as the professional, agrees to provide students of the ___________________ Job Corps Center, referred to henceforth as the center, with the services stated herein. Such services will be provided as authorized by the center director or his/her representative. Remuneration for services rendered will be at the rate of $________dollars per hour for _________ total hours or _________ hours per week on average. The period of performance for this subcontract is from _______________ through ____________________.

(Date)         (Date)

The center and the professional hereby agree that the services to be provided will include, but will not be limited to those mental health services specified in the Job Corps Federal Regulations (Title 20, Code of Federal Regulations 638.510; the Job Corps Policy and Requirements Handbook, Chapter 6, Section 6.10, R3; and Technical Assistance Guide D: Center Mental Health and Wellness Program). The services to be provided include:

1. Staff Development (minimum 1 hour per 100 students per week):

⇒ Advice to the center director and health and wellness staff on all mental health matters and overall center program and organizational consultation to the center director and administrative staff on a regular basis. This will include staffing requirements.

⇒ Consultation on the development of a system to promote the coordination and integration of the mental health and wellness program with other center programs and activities such as counseling, residential life, and recreation. This will be done in cooperation with the health and wellness manager, center physician, center dentist, other health professionals, as well as any staff member involved with students.

⇒ Advice and assistance to wellness course instructors regarding mental health and wellness services during student introduction to center life.

⇒ Consultation with center health and wellness staff, counselors, residential advisors, instructors and other appropriate staff concerning the ongoing mental health problems of students.

⇒ Assistance with program development for the purpose of meeting the life crises of students in constructive ways. For example, involvement with the career preparation, development, and transition periods, the disciplinary program, the maximum benefits program, the intergroup relations program, and the trainee employee assistance program (TEAP).

⇒ Staff development on using mental health principles and techniques. This will include coping with problems of alcohol and drug use, sexuality, aggressive behavior, and poor communications.
2. Clinical Services (minimum 1 hour per 100 students per week):

⇒ Advice to the center director on the advisability of students' separations for mental health reasons, and the cost of mental health services, including inpatient facility use.

⇒ Ensure the maintenance, confidentiality, and safeguarding of all necessary mental health records.

⇒ Issuance and maintenance of signed and dated standing orders regarding mental health matters.

⇒ Diagnostic and evaluative services to students who are inpatients or outpatients.

⇒ Limited forms of psychiatric treatment including crisis intervention, brief psychotherapy, intermittent supportive psychotherapy, psychotropic drug management and group psychotherapy, as permitted by licensure or accreditation.

⇒ Assisting with appropriate referral for students who must be separated for mental health reasons.

3. TEAP Consultation Services (minimum 1 hour per 100 students per week):

⇒ Consultation on the development of a system to promote the coordination and integration of the mental health and wellness program with the TEAP and related centerwide programs.

⇒ Staff development on using mental health principles and techniques, including coping with problems of alcohol and drug use.

⇒ Providing clinical assistance to students and the TEAP specialist, especially with students who may have co-morbid psychiatric and substance abuse disorders.

4. Review folders and assist with the reasonable accommodation process. (This service should be contracted at additional hours as deemed appropriate by the center.)

The professional agrees to adhere to the policies, procedures, program instructions, and guidelines established by Job Corps. The professional and the center further agree that the professional will have primary responsibility under the center director's guidance to implement the program outlined above. The professional, with the concurrence of the center director, may delegate by written and dated standing orders any of his/her responsibilities set forth in this subcontract to appropriate qualified center staff.

The professional will be assisted by the Job Corps National Office, principal mental health consultant, and regional health consultants. The latter will act under guidance and direction from the National Office. Under this agreement, the professional is an independent contractor and not an employee or agent of the center contractor or the Department of Labor, Job Corps. The professional agrees to indemnify and save the center operator harmless from any expenses including attorney's fees and also claims on account of damage to property or bodily injury.
(including death) which may be sustained by himself/herself or his/her employees in connection with work performed.

This agreement may be terminated, with respect to the remaining term of the agreement, at any given time by either party upon a written notice thereof to the other, effective 30 days after acknowledged receipt of said notice.

The professional agrees to make no public statements concerning Job Corps students or Job Corps activities without prior written approval of the center director or his designated representative.

All research projects and/or publications relating to Job Corps mental health activities will be approved through the Job Corps National Office, Washington, DC.

This agreement contains the entire agreement between the parties. It may not be modified or added to except by a written instrument signed by both parties. It may be extended by mutual agreement of both parties. The maximum amount allocated to this subcontract is $____________ which amount shall not be exceeded without review of the work performed and a mutually agreed to modification to the subcontract.

APPROVED: *

__________________________________   ________________________________
AUTHORIZED OFFICIAL (SIGNATURE)   MENTAL HEALTH PROFESSIONAL

__________________________________   ________________________________
(NAME PRINTED)         (NAME PRINTED)

__________________________________   ________________________________
TITLE            DATE

__________________________________
DATE

*This subcontract should be signed by the appropriate authorized official of the center operator in accordance with the terms of the basic center contract or interagency agreement.

The concurrence of the Job Corps Regional Office must be obtained prior to the employment of full or part time center physicians, dentists, and mental health professionals [PRH-6: 6.12, R1(b)]. A copy of the professional's current license or accreditation (and malpractice insurance binder, if available) and backup documentation to show: 1) Regional Office concurrence and 2) review of the subcontract by the appropriate regional health consultant should be attached to the subcontract and kept on file.
Appendix C: Referral Sample
MENTAL HEALTH CONSULTANT REFERRAL

Student Name: ___________________________  SSN: ______________

Referred by: ___________________________  Date ______________

REASON FOR REFERRAL

__ Self-referral  __ Substance Abuse
__ Depression  __ Physical Abuse
__ Anxiety  __ Frequent absenteeism/AWOL
__ Mood changes/swings  __ Impulse control/aggression
__ Limited attention span  __ Frequent medical complaints
__ Obsessive/compulsive behavior  __ Adjustment problems
__ Other

Narrative:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

CMHC Recommendation:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Release of Information: I hereby give permission for the above information to be shared with: [e.g. Name of counselor, teacher]

____________________________________________________________________

Student Signature  Date

CMHC Signature  Date
Appendix D: Two Prototype Subcontracts for Inpatient Psychiatric Services
PROTOTYPE 1: THE SPECIFIC INCIDENT AGREEMENT

_______________________________ Job Corps Center, hereafter referred to as the center, and the _____________________ hospital, hereafter referred to as the hospital, of ___________________ hereby enter into a binding agreement for the provision by the hospital of emergency psychiatric evaluation and hospitalization services for students of the center.

Service provisions will include the immediate availability of emergency psychiatric evaluation services at the hospital, 24 hours per day, each day of the year, ________ through __________. In addition, in connection with such emergency evaluation, the hospital agrees to provide a psychiatric bed immediately at the hospital or, if a bed is temporarily unavailable at the hospital, at an affiliated hospital (_____________________ Hospital; ___________________ Hospital) if admission is needed in accordance with the condition of the student or the center's inability to care for the student on center regardless of the student's age. This judgment of admission need, together with the judgment of readiness for discharge, will be made jointly by the hospital and the center. In any case, the hospital guarantees to accept and keep a given student for at least 3 days and will apprise the center of the condition and progress of said student. The center meanwhile will make every reasonable attempt to make arrangements for the student to return to the center or to the student's home community, as it deems advisable, if the hospital does not wish to retain the student. Emergency transportation will be the responsibility of the center that has arranged with _________________ (ambulance service) to provide transportation to the hospital in cases where the center deems it appropriate.

Payment Provisions will be the responsibility of the center that agrees to guarantee, in full, payment for all necessary emergency psychiatric services for the period of evaluation, hospitalization, treatment, and disposition planning. It is understood that the hospital will be provided with the subscriber information for any student covered in part or whole by a health insurance policy. The center will pay, on receipt of a properly itemized bill, either any remaining amount or, where no collectible insurance exists, the entire amount. In any case, on demand from the hospital, full payment must be received within 60 days of the student's admission date. Centers are not responsible for payment beyond the date of a student's termination from Job Corps.
PROTOTYPE 2: THE RETAINER CONTRACT

__________________________  Job Corps Center, hereafter referred to as the center, and the ________________ Hospital, hereafter referred to as the hospital, of ________________ hereby enter into a binding agreement for the provision by the hospital of emergency psychiatric evaluation and hospitalization services for students of the center.

Service provisions will include the immediate availability of emergency psychiatric evaluation services at the hospital, 24 hours per day, each day of the year, ________ through ________. In addition, in connection with such emergency evaluation, the hospital agrees to provide a psychiatric bed immediately at the hospital or, if a bed is temporarily unavailable at the hospital, at an affiliated hospital (_____________________ Hospital; ________________ Hospital) if admission is needed in accordance with the condition of the student or the center's inability to care for the student on center regardless of the student's age. This judgment of admission need, together with the judgment of readiness for discharge, will be made jointly by the hospital and the center. In any case, the hospital guarantees to accept and keep a given student for at least 3 days and will apprise the center of the condition and progress of said student. The center, meanwhile, will make every reasonable attempt to arrange for the student to return to the center or to the student's home community, as it deems advisable, if the hospital does not wish to retain the student. Emergency transportation will be the responsibility of the center that has arranged with ________________ (ambulance service) to provide transportation to the hospital in cases where the center deems it appropriate.

Payment Provisions will be the ultimate responsibility of the center which agrees to provide a retainer to the hospital in the amount of ________ dollars in exchange for guarantee of the service provisions detailed in this agreement. In addition, the center will guarantee, in full, payment for all necessary emergency services for the period of evaluation, hospitalization, treatment, and disposition planning. It is understood that the hospital will be provided with the subscriber information for any student covered in part or in whole by a health insurance policy. The center will pay, on receipt of a properly itemized bill, either any remaining amount or, where collectible insurance exists, the entire amount. In any case, on demand from the hospital, full payment must be received within 60 days of the student's admission date. Centers are not responsible for payment beyond the date of a student's termination from Job Corps.
Appendix E: Staff Development Training Modules
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March 2003
MODULE 1: ORIENTATION
Module 1: Overview

Becoming a Job Corps staff member can be a bewildering experience for individuals who have not previously worked with a large adolescent and young adult population in a complex educational/employability program or residential setting. Orientation can help to offset this bewilderment. The mental health orientation is an adjunct to the general new staff orientations and should be presented at regular intervals (at least three times per year). The center’s personnel manager should ensure that all staff hired since the last presentation of this module are invited and attend.

This module identifies the major adolescent development issues that can affect student progress and create student distress. The presentation will familiarize new staff with the functions of the mental health and wellness program, the role of the CMHC, and the referral procedures for staff consultations, student appointments, and emergency situations.

The CMHC should know best how to accurately present the center’s mental health and wellness program as well as his/her own role and responsibilities. Therefore, this module presents only a brief overview as well as the general elements considered essential for an effective center mental health program. It is up to the CMHC, on an ongoing basis, to provide illustrations, discuss local variations in center procedures or emergency care, and elaborate on this format in order to reflect the reality of an individual center mental health and wellness program.

Module 1: Objectives

At the end of this training session, participants will be able to:

• Describe how the mental health and wellness program is a thread that runs through the fabric of the entire training program on center

• Describe the major aspects of the mental health and wellness program

• Explain when and how to refer students to mental health services

• Recognize the five periods of stress for students during their stay in Job Corps
Module 1: Lecture and Discussion

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1. Overview of Center Mental Health and Wellness Program (25 minutes). *This section is divided into three lecture segments: Overview, Need for the Program, and Program Policy.*

**Overview**

Many of you have been to a general orientation session that mentioned the center’s mental health and wellness program. At this early stage of your employment here, it is important to discuss the program more fully to:

- Familiarize you with some of the students’ personal and interpersonal issues that affect their success in Job Corps.
- Describe to you the CMHC’s clinical function and the mental health referral system.
- Make you aware of the organizational support and skill development programs that are available to you through the mental health program.

You arrived at this Job Corps center with varied work experience. Some of you may have worked in the human service field. Others may have worked with disadvantaged teenagers or had experience in the educational or vocational training areas. However, unless you have worked at another Job Corps center, it is difficult to imagine the professional challenges and rewards of working in this environment.

Job Corps is unique among federal, state, and private educational and vocational institutions. At a Job Corps center, disadvantaged adolescents from depressed economic and educational backgrounds are placed in a “total community” that provides a program of basic education, vocational skills training leading to employability; health education and care; and residential living. Through the coordinated efforts of all of these center programs, students may graduate with improved mental and physical health, better communication skills, a basic education, basic knowledge of a trade, and employability skills.
Since you have recently arrived at this center and have a different perspective from those of us who have worked here a while, let’s talk about any thoughts, concerns, or questions that you have about the role of the mental health program on center, such as:

- What are the most stressful features of living on a Job Corps center?
- What are the objectives of the mental health and wellness program?
- What role will you play in the mental health and wellness program?

**Exercise: Questions and Concerns**

Ask participants to share one question or concern they may have about working on a Job Corps center. Address these questions or concerns during the session or on an individual basis after the session. Allow 5 to 10 minutes for this exercise. Write each question on an easel pad. Look for themes, similar issues.

**Exercise: Self Assessment**

Ask participants to take 5 minutes to complete the *Handout 1.1, Self Assessment*. Review and discuss answers at the close of the session.

**Need for the Program**

The teenage years are full of sexual, physiological, and cognitive (perception, memory, judgment) changes. Students are faced with such issues as forming romantic and friendship relationships, group relations, incorporating adult values toward work, learning financial responsibility, and being exposed to and experimenting with alcohol and drug use. Naturally, this period of development entails a significant degree of anxiety, confusion, limit testing, and reliance on previous childhood behavior.

Most Job Corps students come from economically disadvantaged backgrounds, often with limited opportunities for educational and social development. A history of poverty appears to limit social, educational, and employment adjustment. Students, who can benefit from the program and have a history of emotional disorders and learning disabilities, are reasonably accommodated. The challenge to the Job Corps mental health and wellness program is to help build a safe and constructive environment that permits emotional, intellectual, and social growth in addition to helping students develop adaptive coping skills. The goal is to help students complete the training program successfully and develop a way of interacting with others that promotes and maintains employability.

Regardless of the student’s background, leaving familiar surroundings to train in a residential setting like Job Corps can be stressful. Students must quickly adjust to a
new geographical setting, conform to institutional rules and regulations, and come in
daily contact with a number of individuals from different social and ethnic backgrounds.

Also, students’ ranges of experience may be limited and uneven. For example, a
student may have a sophisticated knowledge of street culture but be unable to cope
with the regulated and disciplined setting of a center.

**Program Policy**

A student’s emotional well being is very important to his/her ability to develop a positive
self image and to succeed in Job Corps as well as to obtain and maintain long-term
employment post Job Corps. The Job Corps Policy and Requirements Handbook
(PRH) requires that each center provide a mental health and wellness program. The
mental health and wellness program is a thread that runs through the fabric of the whole
Job Corps program. Mental health support services should be part of the center CDSS
program that includes Outreach and Admissions (OA), Career Preparation (CP), Career
Development (CD), and Career Transition (CT). Mental health, as with all other
disciplines on center, addresses student employability during all phases of CDSS.

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**Center Mental Health and Wellness Program Goals**

- Promote social and emotional growth
- Focus on prevention, wellness, and employability
- Provide evaluation, diagnosis, and referral to the community for specialized
care, and referrals internally for psychotropic medication evaluation
- Provide staff development and training activities
- Provide and monitor disability accommodation plans
- Provide short-term, problem-focused care and case management.
- Promote employability, wellness, and student retention as part of center
interdisciplinary meetings.
- Provide information on a need-to-know basis
- Provide support to the TEAP specialist

The mental health and wellness program is directed toward the following goals:

- Creation and maintenance of an environment that promotes the social and emotional
growth and development of all students
• Support of mental health and emotional well being through the use of preventive principles and techniques

• Availability of professional, evaluative, and diagnostic services for students and a referral and feedback system that offers ready access to these services

• Short-term, problem-focused mental health treatment with case management and referrals to the community

• Disability evaluation and implementation of reasonable accommodations to help maintain employability for those students with a disabling mental health condition

• The mental health program is well integrated into the center community, with representation at multidisciplinary meetings to promote a team approach to mental health well being

• Staff development and training that enable employees to identify and appropriately respond to students undergoing emotional stress

Promotion and support of students’ social and emotional development require that the mental health program be an integrated component of center operations. Staff teamwork is at the foundation of this preventive approach. While program functions range from direct student services to staff development, every aspect of the program requires information sharing, mutual planning, and evaluating among the CMHC, staff, and students. However, there should be appropriate confidentiality of student mental health information, with sharing to staff on a need to know basis only.

The Job Corps program must also have a counseling component that focuses on individual students’ personal needs and social development, basic education, and vocational training. Counseling services are provided by counselors, residential living staff, health staff, and other appropriate staff with the support and guidance of the CMHC.

The PRH specifically requires that the center mental health program provide:

• Routine mental health services for all students
• 24-hour emergency mental health care

1. **CMHC Role and Functions (20 minutes).** *This section is divided into two lecture segments: Clinical Services and Staff Development.*

The CMHC, who is ultimately responsible to the center director, provides clinical services to students and training to staff. Communication between the CMHC, center director, and staff helps the center director to read the center’s mental health situation,
and enables the CMHC to work directly with all center components to facilitate mental health treatment and training.

**Clinical Services**

The CMHC has the following clinical responsibilities:

- Consulting on and monitoring the center's mental health referral system
- Arranging for appropriate psychotropic medication evaluations
- Conducting clinical interviews for purposes of evaluation, diagnosis, and disposition
- Preparing reasonable accommodation case management plans to include identifying specific expectations of staff for students with poor adjustment to center life
- Providing appropriate case feedback to center staff on a need-to-know basis
- Contributing clinical case histories and required communications, records, and forms to the permanent health record
- Providing clinical support to the TEAP specialist and the TEAP intervention component
- Providing short-term, problem-focused treatment and making referrals to the community as indicated and available

**Discussion:**

Since this presentation is designed for new staff, the clinical discussion should focus on the mental health referral process from different departments, illustrations of the treatment plan and counselor's case management, and a description of the documentation procedures and confidentiality issues. Blank copies of referral forms can be made available as a handout. You may want to invite the health and wellness manager and/or the counseling supervisor to discuss the center referral system.
Staff Development

Role of CMHC: Staff Development

- Advise center director and staff
- Contribute to student and staff career preparation (introduction to center life)
- Suggest other staff development resources and provide training
- Provide individual skill development and consultation for staff
- Offer consultation and technical assistance to all staff disciplines on center

The following are CMHC staff development responsibilities:

- Advising the center director and staff on organizational development and team work issues

- Maintaining direct involvement in the development and implementation of student and staff orientation (includes designing activities that decrease transitional stress, facilitate center acculturation, and foster positive peer relationships and group cohesion)

- Suggesting other staff development resources in the mental health area

- Providing staff development and consultation regarding staff/staff, staff/student, and student/student living and learning relationships. (Emphasis should be on group resolution of interactional problems, with the focus on training staff to promote positive mental health)

- Offering consultation and technical assistance as a followup service to all mental health staff development programs

- Conducting interdisciplinary case management meetings to help maintain student retention and employability

- Engaging in staff and student developmental training activities, including some or all of the following curriculum areas:
  - Leadership skills
  - Conflict resolution strategies
  - Crisis intervention
  - Supervision styles
  - Communication, feedback, and listening skills
  - Positive behavior management techniques
- Behavioral contracts
- Motivational techniques
- Self-concept development
- Staff team building

The CMHC may also teach classes with special mental health implications, such as sexual orientation, diversity, sexuality, and HIV.

3. Student Stress and Preventive Techniques to Foster Mental Health *(45 minutes)*

Emotional problems, interpersonal conflicts, or learning difficulties may arise at any time during a student's stay on center. However, experience has pinpointed specific periods of high stress for students during their stay on center. We will now discuss what preventive actions staff members can take to decrease the negative effects of stressful periods on students.

### Periods of Student Stress

- Arrival
- Staying in the program
- Loss of a friend, family member or ending of a romantic relationship
- Administrative and medical separations
- Completion/graduation

**Arrival**

Students' early periods on center are critical in determining whether they will stay. Stresses of arrival may trigger transient emotional symptoms, such as anxiety, panic, anger, sadness, or physical complaints. To help students through this period and reduce the number of early resignations, center staff must recognize new students' heightened need for support and be alert for indications of insecurity and loneliness.

**Discussion:**

Ask participants to identify ways that staff can alleviate student's arrival stress. Capture participant suggestions on an easel pad.

If not mentioned during the discussion, highlight the following:

- The center director and other key staff should meet and welcome the new students on the day of arrival. *Note:* Many centers use a pre-arrival phone call and letter to
begin the orientation process as early as possible. A staff member who calls could tell the group how this process helps new students to adjust.

- Many centers use a big brother/big sister-type program, pairing new students with more experienced students during the orientation period.

- Staff should realize that symptoms of stress will vary greatly among students. Some may seek assistance and appear outwardly upset, while others with similar feelings and needs may present a facade of hardness or aloofness.

- Individual or group sessions with new students should emphasize current reality issues. In general, delving into past events and behavior is inappropriate except as it directly affects the student's entry into Job Corps. Specific areas that would be covered with each student include:

  - **Feelings on arrival**—How does the student feel about his/her new position? About the lack of familiar surroundings? About what is happening now inside his/her heart and head? Staff must realize that a student's homesickness involves both feelings of insecurity in the new environment and concerns for people at home.

  - **Questions about the future**—Discuss both good and bad aspects of Job Corps; include racial concerns, town reactions and reception, free time, or other concerns. This helps the student form a realistic picture of center life. Students may need help in recognizing what Job Corps can and cannot provide. Staff should be careful not to add to the student's possible disappointments and frustrations by trying to sell the center as utopia. Rather, try to ascertain what the student's perception is of Job Corps and correct any misconceptions as soon as possible.

- To foster early and complete involvement in Job Corps and to make the students feel at home, pay close attention to each student's reason for enrollment (e.g., job training or basic education). Explore the student's interests and aims and involve him/her in appropriate class and leisure activities.

- A successful Career Preparation program helps the new students adjust to a different environment and prepare for new responsibilities and decisions. Possible stresses should be anticipated during Introduction to Center Life and watched for continuously. Those in closest contact with a student, particularly counselors and residential advisors, are in the best position to help the student with periods of stress or with any immediate emotional difficulties. When staff need assistance in helping students, they should contact the center mental health consultant according to the center's referral process.
**Staying**

Many students experience a period of difficulty approximately 60 to 90 days after enrollment. During this time, they may question what they are doing in Job Corps, whether they want to continue to learn and change, and whether they actually want to work when they finish. They may appear unhappy, apathetic, indecisive, and unsure of themselves. Many will test the sincerity of staff concern for them. If the student can be assisted in overcoming various doubts, this stress period may become a turning point in the direction of maturation and growth.

In addition to maintaining sensitivity toward student problems, there are other means of handling this period:

- The student needs individual attention from a responsive listener. After the student has expressed everything fully, discuss the next best step. If remaining in Job Corps appears to be the best available alternative, then the student should be reminded of his/her accomplishments to date and original motivation for entering Job Corps.

- Small group discussions with a counselor, residential advisor, or other staff members may be helpful. Senior students should be encouraged to join the discussions and explain how they have dealt successfully with similar problems.

- A visit home may help during this adjustment period for students who live far from the center; a phone call home or a visit to a local friends' home may also help.

- The individualized personal career development plan (PCDP) may provide needed support to students during this period.

**Loss of a Friend**

Another crisis time may arise when a student loses a friend (roommate, girl/boyfriend, etc.) to completion/graduation, a job, termination, resigns, or AWOL. Without this special person to anchor the student’s resolve to remain in Job Corps, he/she may decide to leave prematurely.

During this time, staff should:

- Acknowledge and validate the student's feelings of loss.

- Help the student understand that reactions to loss often include angry feelings and a sense of "why me," and that, over time, a replacement/healing process will begin.
• Help support positive coping skills in dealing with a loss; develop a specific behavioral plan to help the student through this difficult time.

**Transferring/Administrative Leave of Absence/Medical Separation**

Make constructive plans for assisting students during this potentially stressful period. Such a plan might include:

• Discuss the change of status with the student and encourage expression of emotion and thoughts regarding the situation.

• Help the student understand the cause and terms of the leave or transfer.

• Help the student make plans for the immediate future; where will he or she live, when to return to center, what treatment or changes are necessary before returning to center.

**Completion/Graduation**

At this time, some students may seem to cling to the center and may return to patterns of behavior that center staff thought they had outgrown. Some find leaving very difficult, while others react by leaving prematurely, even near the end of courses. The stresses of leaving may lead to problems such as depression, fatigue, poor concentration, inability to hold a job, trouble with employers, or loss of newly acquired skills. Staff can help students prepare for such difficulties by focusing on the following:

• The decision to leave should be made by the student in consultation with staff and should be based on the student's educational, vocational, and personal accomplishments. Students and staff should jointly set a date for leaving.

• Give the student an opportunity to express his/her feelings about returning home and about planning for the future during individual counseling sessions. The counselor should be prepared to discuss all issues related to leaving and should assist the student in anticipating the graduation period. Emphasize the student's progress and accomplishments on center.

• Small discussion groups of completing students may meet periodically beginning a month prior to completion/graduation, during Career Transition. The group leader should highlight concerns about returning home. Have students anticipate what it will be like to return to their communities, family, and friends. Focus on their anticipated reactions to entering their old home environments with new skills and ideas. Discuss the everyday realities of working, planning, surviving, and deciding independently, without the structure, support, and direction provided by Job Corps.
Discussion and Wrap Up:

Close session with review of answers to the mental health program self assessment. (Distribute the answer key.) Address other concerns or questions.
Handout 1.1

Orientation Self-Assessment

Instructions: In response to each statement, circle True (T) or False (F).

1. The center mental health consultant interviews all new entries within 2 weeks of arrival. T F
2. Job Corps will provide mental health treatment to students over a long period of time. T F
3. Only the CMHC is involved the mental health program. T F
4. Anyone may refer a student to the CMHC, but it is best to do it through the counselors and in writing. T F
5. There are several different stress points that may occur in a student's tenure. T F
6. All staff should be able and willing to listen, encourage, teach, and comfort students. T F
7. The mental health program is a thread that runs through the fabric of the whole center program. T F
Handout 1.1 (Continued)

Orientation Self-Assessment Answer Key

1. **False.** Students are referred to the CMHC through counseling, health and wellness, academics, vocations, and residential life, as distress becomes apparent. The center physician does a complete physical on all students within the first 2 weeks and will assess the psychiatric problems that may be present. The health and counseling staff also evaluate the student for any problems needing the CMHC’s expertise during routine visits.

2. **False.** The emphasis of the Job Corps mental health program is on preventing emotional concerns from interfering with the student’s ability to complete the program. Any student in need of treatment beyond a few sessions of the services of the CMHC will be referred to the community for longer-term treatment. Students in need of treatment beyond what is available on center or in the community may be medically separated. The student may return once the problem is resolved or under control, as evaluated by health and wellness.

3. **False.** All staff who have contact with students are involved the mental health program.

4. **True.** Remind the participants of the availability of the appropriate form.

5. **True.** These stress periods may occur:

   - On arrival
   - 60 to 90 days into the program
   - At the loss of a friend
   - Upon transfer to another center/program
   - Upon completion/graduation

6. **True.** However, all staff must also recognize the importance of knowing when to call on the counselor, health staff, or CMHC (e.g., suicidal or homicidal thoughts, intense anxiety, depression, etc.). Staff must also be mindful that although they should be friendly to students, they should not try to act like their peers.

7. **True.** The mental health program is a thread that runs through the fabric of the whole Job Corps program. TAG 6-D: Mental Health and Wellness Program describes the range of center programs that address student mental health needs.
MODULE 2: ADOLESCENT DEVELOPMENT AND COMMUNICATION
Module 2: Overview

Good communication skills are requisite for a career in any human service organization. The ability to communicate clearly is especially important to achieving rapport with students to help them reach their educational and vocational goals, resolve interpersonal conflicts, and develop plans for the future.

This module presents adolescent development issues, such as ego identity and peer group formation, that influence staff/student communication. The module also examines the characteristics of effective and ineffective communication and explores each participant's communication strengths and weaknesses. Staff will practice positive verbal and nonverbal communication styles during role plays and feedback sessions.

This session examines basic communication skills. More advanced communication skills such as paraphrasing, self-disclosure, and feedback systems are presented in other skill modules and can be incorporated into this session (see Module 3: Group Process and Leadership, Module 4: Crisis Intervention, Module 5: Student Motivation, and Module 8: Supervision).

Module 2: Objectives

At the close of this training module, participants will be able to:

- Identify four adolescent developmental characteristics that influence staff-student relations
- Explain four conditions necessary for effective interpersonal communications
- Recognize three characteristics of effective and ineffective communications
- Determine personal strengths and weaknesses that influence individual staff members' ability to communicate with students
- Demonstrate communication skills

Module 2: Lecture and Discussion

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Each student's vocational achievement and personal growth depend heavily on the staff's ability to communicate effectively. Effective communication skills are the basis of
supervision, vocational counseling, discipline, crisis intervention, and dorm management. These skills are also used to develop staff/student relationships during dorm meetings, group sessions, and recreational activities.

Effective communication requires insight into the client population. Adolescents have unique developmental concerns that are not usually shared by children or adults. It is important to recognize these differences when developing your communications skills.

**Exercise: Adolescent Characteristics**

Write the following headings on two easel pad pages and record participant responses. When processing, identify common themes and variations in the answers.

- Adolescent Behavioral Characteristics: Appreciated Most
- Adolescent Behavioral Characteristics: Appreciated Least

1. **Adolescent Development Theory (45 minutes).** *This section is divided into five lecture segments: Ego Identity, Cognitive Development, Physical Maturation, Independence Development, and Peer Culture.*

As the exercise should reveal, students present a wide range of contradictory behaviors. Often, adolescence is marked by characteristics that would traditionally categorize the individual as emotionally disturbed. Students may seem disorganized, unfocused, and confused. They may act quarrelsome, uncommunicative, moody, or intolerant.

As adults, we have a convenient way of selectively forgetting or fogging over the difficult periods in our own adolescence. Many of us in middle adulthood already reminisce about those carefree adolescent years without parental obligations and mortgage payments.

However, adolescence is far from carefree. Teenagers are making lifelong decisions concerning vocations, sexual relationships, alcohol and drug use, etc. They are often making these decisions with little information or experience, with few appropriate adult role models, and in an environment of conflicting social values.

In addition, some middle adolescents (16- and 17-year-olds) may look older than they really are. As staff members, we must guard against having expectations of behavior for which the middle adolescent is not developmentally ready.

The following is a summary of adolescent development characteristics that are relevant to staff/student communication and relationship building.
Ego Identity: Who am I?

As adolescents, students face the significant task of carving out an integrated self-identity, an identity that will consist of personal motives, values, interests, and skills. The self-identity should be composed of both positive and negative aspects ordered so that the individual sees him/herself as both consistent and unique.

Ironically, to acquire this consistent self-identity, adolescents may try disparate behaviors modeled after admired peers and adults. These forms of imitation can often be observed in generations of adolescents (and some adults) who have tried to emulate movie, music, and television personalities. In general, these behavior shifts are skin-deep and are not harmful, although they may temporarily confuse adults. The typical adult response is, "How could she act like that?" or "It's so unlike him."

However, constant role switching and inconsistent behavior can indicate a more profound developmental problem. In a modern society filled with mass communications, conflicting values, and complex career choices, ego confusion is a developmental danger. For example, the results may appear as high-risk sexual behavior, drug and alcohol use, self-mutilation, suicide gestures and attempts, eating disorders, depression, anxiety, and antisocial behavior (that which violates the rights of others and in direct conflict with authority).

Discussion:

Ask participants to recall experiences with students who temporarily took on the speech patterns, mannerisms, or dress of other students whom they admired. Have participants recall more serious instances of students who appeared to completely lose their identity. Ask participants to identify how these students differed from their peers and what the participants did to effectively communicate with them.

Cognitive Development: Analytical and Critical Thinking

During adolescence, the individual reaches a new stage of cognitive development. This stage includes the ability to think abstractly and to analyze problems logically. Now,
adolescents have the opportunity to compare the actual with the ideal as they view society, their parents, and themselves. Unfortunately, the powerful media often portrays people and life in an idealized way, which most adolescents and adults have difficulty approaching. For example, ask any adolescent female if she feels overweight.

At the personal level, this analytical ability can influence ego identity since adolescents often feel self-conscious, self-critical, and depressed about the prospects of ever "getting it all together." This self-appraisal process is especially difficult for physically and/or and mentally/academically disabled adolescents who may believe that they can never reach their potential or be accepted by society. These hypercritical self-evaluations can also affect students' relationships with adults and peers.

**Discussion:**

Ask participants to describe communication techniques that they use with students who are temporarily down or withdrawn due to vocational setbacks, relationship problems, etc. Discourage the often-voiced notion staff have that "I got mine through hard work, now you get yours." Students in Job Corps need support to get to a point that they can work hard.

**Physical Maturation: Effects on Identity Formation**

Physical maturation presents a major obstacle to the adolescent who is trying to develop a consistent, positive identity. Body parts change in size and functions. Once nearly dormant, sex drives now appear in full force. Acne, awkwardness, and society's "beauty contest" values add to the difficulties. True human beauty may be more than skin deep, but for adolescents, physical appearance is an integral part of self-esteem. Too often adolescents interpret "You look awful" as meaning "You are awful." Adolescence is a very difficult period for late-maturing male youths whose physical stature, features, or coordination are below the group norm. Many early maturing female youths experience difficulty, as they might feel awkward or different from other females their own age. Many are not prepared to deal with the sudden male attention. Late maturing males and early maturing females may be extremely concerned about peer acceptance and often are tense, insecure, and depressed. At the same time, most adolescents are concerned about peer acceptance, regardless of physical maturation.
Discussion:

Ask participants to talk about styles of dress in relation to body shapes that they find: silly, ugly, vulgar, unacceptable or attractive. Discuss the styles from the students' point of view. Discuss the body types and styles portrayed in the media versus what teens experience on a daily basis.

Independence Development: Moving on or Holding Still

A critical element in adolescent identity formation is the individual's passage from dependence on authority figures to independent decisionmaking with input from others. Without this developmental shift, adolescents will find it difficult to adjust to new social responsibilities including positive love and peer relationships, job fulfillment, or positive child-rearing practices.

Unfortunately, our culture does not clearly mark this transition for adolescents. Significant adult age requirements for activities such as voting versus joining the military vary. To add to this confusion, the adolescent learns quickly that independent behavior depends on adults' expectations. Not only do these expectations vary among adults, but also individual adults may send a mixed message to the adolescent during a single conversation. For example the parent may say, "I can't tell you what to do. After all, you are an adult now and have to learn to make your own decisions." However, if that decision is not agreeable to the parent, the next statement might be, "I don't care what I said before, I simply will not have you hanging out with that bunch of bums."

To add to all this confusion, there are certain adult leadership styles that either inhibit or promote independence in others. This is especially relevant to counselor/client relationships as well as to other staff/student interactions. Autocratic and permissive adult caretakers promote dependence. On the other hand, it appears that democratic caretakers promote increased self-confidence, a sense of fairness, and increased decisionmaking skills among adolescents. (For indepth definitions of adult/leadership styles, consult Module 3: Group Process and Leadership.)

Discussion:

Ask participants to list what they believe are the key leadership elements for promoting increased student independence, self-confidence, and responsibility? In what ways do they convey these values through their communication styles as well as specific verbal and nonverbal cues?
**Peer Culture: Conformity or Independence**

Although peer group pressure and individual conformity are widely known developmental phenomena, they are usually perceived as negative components of adolescent growth. To many adults, even to counseling and mental health personnel, "the peer group" conjures up images of slave-like obedience and unthinking behavior. In fact, peer groups can have a number of natural and positive functions. The peer group is important because:

- It allows adolescents to test out adult behavior, practice new interpersonal skills, and discard inappropriate childhood behavior.
- It gives adolescents a sense of common ground with others who are involved in the same biological and social transition.
- It gives adolescents others to communicate with, since relations with adult caretakers are often strained during this period.
- It allows adolescents to be different in superficial ways such as dress, music, and fads, without necessarily rejecting deep social values.

Adolescents often spend a disproportionate amount of time with peers rather than adults. Even so, most adolescents do not differ greatly from their parents in terms of basic values and attitudes. Those adolescents who become extremely peer-oriented usually do so in response to parental disinterest or neglect.

Sometimes staff feels that trying to hold back the tide of peer group opinion is futile. However, in terms of major life questions, more adolescents are influenced by adults than by their peer groups. Since staff role modeling, emotional support, and help in problem solving are crucial for student growth, staff members should actively make themselves available to students.

**Discussion:**

Ask participants to identify the communication strategies they use to make their feelings and opinions known but that do not interfere with positive peer group processes.
2. Conditions for Positive Communication (*45 minutes*). This section is divided into four lecture segments: Genuineness, Positive Regard, Empathy, and Concreteness.

Your role is to provide the conditions that will enable students to release their natural capacity to overcome personal, social, and vocational problems. Research has indicated four primary conditions that facilitate accurate and effective interpersonal communications. These conditions are especially important when dealing with students who are in experimental, often confusing, and hypercritical stages of development. The four communication conditions are:

**Genuineness**

You should be aware of your feelings and be able to communicate them openly when necessary. Your statements should match your feelings and your verbal responses should match your nonverbal cues. Your level of authenticity is directly related to the student's ability to engage openly in discussion about his/her beliefs, values, and problems.

**Positive Regard (Respect)**

This is the ability to communicate a deep and genuine caring for the student as an individual. Positive regard is closely related to your ability to communicate commitment, your effort to understand, and your spontaneity.

**Empathy**

Empathy involves your ability to perceive the student's feelings and experience sensitively and accurately. It also includes your responsiveness to both the student's underlying and stated feelings. The success of this process hinges on your ability to suspend judgments temporarily, to understand the student's experience from his/her perspective, and to reflect this experience back to the student.
Concrete responses are specific, fluent, and direct expressions. Concreteness helps the student in at least three ways. First, the response is not too far removed from the student's feelings and experience. Second, it promotes communication accuracy. Finally, it helps the student focus on specific feelings and experiences rather than abstract behavior.

**Exercise: Positive Communication**

Divide participants into groups of four or five and ask them to appoint a recorder/spokesperson. Ask them to review Handout 2.1, *Conditions for Positive Communications*, list in order of priority those communication conditions most essential to effective student communication, state why they chose the priority, and cite specific examples for each condition. After 15 minutes, ask for a report from each group.

To communicate effectively, you must be aware of your verbal and nonverbal responses. *Handout 2.2, Effective Communication*, identifies emotional characteristics and verbal responses that can positively or negatively affect the communication process.

**Exercise: Effective Communication**

Distribute *Handout 2.2, Effective Communication*, allowing 5 minutes for review. Ask participants to circle their personal strength and two blocking responses they consider to be weaknesses. Allow 5 to 10 minutes for group discussion of communication strengths and weaknesses.

**Exercise: Role Play Scenarios and Wrap-Up**

Ask for four volunteers to act out the scenarios in *Handout 2.3, Role Play Scenarios*. Actors should demonstrate some examples of positive or negative responses during the role play. In discussing the role play, ask all participants to identify responses (verbal and nonverbal) that either encouraged or blocked effective communications. Close session with question and answer period.
Handout 2.1

Exercise: Conditions for Positive Communications

Instructions

Review the communication conditions below. List in order of priority those communication conditions most essential to effective student communications. Cite specific examples for each condition.

Your role is to provide the conditions that will enable students to release their natural capacity to overcome personal, social, and vocational problems. Four primary conditions facilitate accurate and effective interpersonal communication. These conditions are especially important when dealing with students who are in an experimental, often confusing, and hypercritical stage of development.

The four communication conditions are:

- **Genuineness**—You should be aware of your feelings and be able to communicate them openly when necessary. Your statements should match your feelings and your verbal responses should match your non-verbal cues. Your level of authenticity is directly related to the student's ability to engage openly in discussion about his/her beliefs, values, and problems.

- **Positive Regard (Respect)**—This is the ability to communicate a deep and genuine caring for the student as an individual. Positive regard is highly related to your ability to communicate commitment, your effort to understand, and your spontaneity.

- **Empathy**—Empathy involves your ability to perceive the student's feelings and experience sensitively and accurately and includes your responsiveness to the student's underlying as well as stated feelings. The success of this process hinges on your ability to suspend judgments temporarily, to understand the student's experience from his/her perspective, and to reflect this experience back to the student.

- **Concreteness**—Concreteness concerns responses that are specific, fluent, and direct expressions. Concreteness helps the student in at least three ways. First, the response is not too far removed from the student's feelings and experience. Second, it promotes communication accuracy. Finally, concrete responses help the student focus on specific feelings and experiences rather than abstract behavior.
Exercise: Effective Communication

Instructions

The following characteristics can enhance communication and responses that can block communication. Review these lists and indicate the characteristic that is your personal strength and two blocking responses that are personal weaknesses.

Characteristics that assist in the appropriate expression of emotions (anger, sadness, frustration, fear) in effective communication:

1. Be aware of your emotions.
2. Admit your emotions. Do not ignore or deny them.
3. Own your emotions. Accept responsibility for what you do.
4. Investigate your emotions. What caused this particular reaction? Has it happened under similar circumstances? Has this reaction occurred only with this person?
5. Report your emotions. Effective communication means an accurate match between what you are saying and what you are experiencing.

Responses that can block further effective communication:

1. Ordering, directing: "You have to..."
2. Warning, threatening: "You'd better not..."
3. Preaching, moralizing: "You ought to..."
4. Advising, giving solutions: "Why didn't you..."
5. Lecturing, informing: "Here are the facts..."
6. Evaluating, blaming: "You're wrong..."
7. Name calling, shaming: "You stupid..."
8. Interpreting, analyzing: "What you need..."
9. Sympathizing, supporting: "You'll be O.K...."
10. Questioning, probing: "Why did you..."
11. Withdrawing, avoiding: "Let's forget it..."
Exercise: Role Play Scenarios

Instructions

Demonstrate positive and negative responses during the role plays.

Scene I (Role for Student and RA)
You are a student who is trying to decide whether to leave or stay in the program. You have been at the center for 3 months and are doing satisfactory work in academics and vocational training. However, you are also receiving heavy pressure from relatives and friends to return to your home. You decide to discuss this situation with the RA.

Scene II (Role for Student and Nurse)
You are a student who is depressed. It is just before Christmas. Your work record is so-so and you have few friends. You tell the nurse that you are unhappy here.
MODULE 3: GROUP PROCESS AND LEADERSHIP
Module 3: Overview

A basic understanding of small group dynamics can greatly enhance communication and leadership skills. Knowledge of group development is important since center life is built around group activities such as departmental problem-solving sessions and residential meetings.

This module provides a staged theory of group development, identifies youth issues that affect inter-personal relations, examines leadership tasks and maintenance roles, and gives participants an opportunity to practice leadership skills by conducting small group meetings.

Module 3: Objectives

At the close of this training module, participants will be able to:

- Describe six phases of group development
- Recognize four characteristics of adolescent development that affect how a student functions in a group
- Demonstrate skills that promote healthy group development
- Describe five areas of small group processes that influence effective group development

Module 3: Lecture and Discussion

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1. Group Development Theory (20 minutes) This section is divided into two lecture segments: Phase I: Authority Issues, and Phase II: Membership Issues.

Group development skills are a natural outgrowth of effective leadership abilities. However, a special understanding of group processes is integral to your role in Job Corps since you are constantly involved in group activities, such as policy and planning sessions with other staff, weekly residential group meetings, and numerous informal meetings. These activities deal with residential conflicts, departmental concerns, and general student management issues.
Staff should realize that meetings with students can be exciting teaching moments that can challenge adolescents to develop interpersonal and leadership skills. An understanding of group development will help you make the most of all these group interactions.

Group development theory is based on the premise that, regardless of the "work group" nature of meetings, there is another level of unspoken interpersonal activity that can determine a meeting’s outcome. The group leader’s function is to help students understand the interpersonal nature of groups and how this may influence the group’s decisionmaking process.

Group development theorists state that group formation moves from confronting authority issues to dealing with personal relationships among members. During each phase, some individuals will be in conflict about being involved in the group. Individuals who are either highly dependent or counter-dependent on leadership will have difficulty confronting the early issues. Similarly, group members who are afraid of being rejected will become either over-personal or counter-personal and will be uncomfortable when the group focuses on interpersonal contact. Most groups are composed of individuals who are comfortable dealing with both the leadership and membership issues that are a natural part of group life.

**Phase I: Authority Issues**

**Subphase A:** During the initial stage of group formation, members often seek to ward off anxiety. Member behavior during these first meetings may include doodling, telling stories, and complaining about having to meet. Other members will make statements that they believe will gain the approval of the leader. Some may hope that the leader will give them complete instructions to follow, while others want the leader to give directions so that they may rebel.

**Subphase B:** If the leader attempts to share leadership responsibility with group members it may be interpreted as leaving a power vacuum in the group. One or more members may try to take over the leadership position, creating a very uncomfortable period in group life that is marked by hostile remarks toward the leader. Often the leader’s comments are ignored and no one is allowed to fill the vacuum. There may be open conflict concerning how much structure the group requires. The group may decide to vote, elect a chairperson, and promptly ignore the chair.

For those who are ambivalent about authority, the unspoken hope is that the leader will take full control once more so that the dependents can cooperate and the counter-dependents can rebel in the usual manner.

**Subphase C:** Two important factors happen during sub-phases A and B that affect the group’s development. First, as group members discuss and argue the question of
leadership, they also make friends and allies with other group members. They now feel less alone, less insecure, and less anxious. Second, members who have not invested in the leadership issue may be quietly listened to and accepted by others with the result that members who are in conflict with authority will look to these independent members for resolution.

By the end of this phase, the group has established a norm of shared responsibility. Within this norm, individual contributions are evaluated on the merits of what is said, not on any magical powers attributed to the leadership role.

**Phase II: Membership Issues**

**Subphase A:** Once the authority issue is settled, group attention shifts to personal relations, such as the levels of shared responsibility, intimacy, and friendship. During the first part of this phase, the group is enveloped in mutual acceptance. After all, they have just resolved the authority issue that was an uncomfortable process for many of them.

The unstated norm at this point is universal harmony at all costs. Unfortunately, maintaining that tranquil facade means that group members are not allowed to express even minor negative feelings about individuals or the group as a whole. The members must behave in ways that are alien to their feelings. Toward the close of this phase, there is the rising irritation that "we should be able to work with each other, but we can't" and that perhaps belonging to a group leads to entrapment.

**Subphase B:** At this time, the members who are in conflict with the process usually ally themselves with one of two groups. The overpersonals want unconditional love so that everyone is accepted; the counterpersonals resist further involvement. While the behavior of these two groups is quite different, the motivation is similar. Both groups feel that intimacy breeds contempt and that if others really knew them, they would be rejected by the group.

During this phase, some members make disparaging remarks about the group, compare it with other groups, act bored, or miss meetings. Other group members call for "brotherly love" and consideration of everyone. Much of this behavior is based on unrealistic expectations about the consequences of group involvement.

**Subphase C:** As in the previous resolution phase, the independent members who are not in conflict about their personal relations begin to act in ways that lower other member’s anxiety. They begin to make self-disclosing statements and request feedback about their behavior from group members. When that feedback proves to be constructive and noninjurious, the other members’ fear of rejection fades and they initiate self-disclosing behavior that leads to increased feedback, involvement, and group cohesion.
During all of these phases, the catalytic power of the leader lies mainly in his/her ability to be free from anxiety-based reactions to the problems of authority or intimacy. Thus, the leader has the extra freedom to be creative in searching for a way to reduce group tension.

2. Leadership Guidelines *(25 minutes)*

Center staff will have to be aware of other group development dynamics that may occur in an ongoing group composed of both male and female adolescents whose membership constantly changes because of enrollment and graduation. Group leadership in Job Corps calls for special insights, guidelines, and interventions.

**Discussion:**

To develop leadership guidelines, ask participants to identify approaches that they have found to be successful in conducting student groups. Record approaches on easel pad.

If not mentioned, include the following points in the discussion:

- **Set the basic ground rules**—The time, place, membership, attendance expectations, expectations of contributing to the group discussion, and the purpose/goal.

- **Share your feelings**—Argument and intellectualization are avoidance techniques that youth often use to avoid their feelings. Try not to out-talk or out-argue them. Your role is to allow students to recognize their avoidance without joining them in the process. Your ability to share your feelings openly with the group is important for breaking that cycle.

- **Don't push**—Although an adolescent's ability to share feelings in a group setting is an important step in development, you should not try to bring out feelings solely for developmental purposes.

- **Avoid making alliances**—Do not try to assume the role of the "good parent." This alliance happens most often when a staff member takes sides with a student concerning center rules and regulations. In the long run, this alliance is detrimental to all staff/student relationships since students are looking for an adult model who appears objective, self-controlled, and who deals with his/her value conflicts directly with other adults rather than indirectly through student.

- **Set limits**—Occasionally, you may have to be involved in limit setting during group meetings. Adolescents are more likely than adults to make aggressive, hostile, or reckless comments to each other. These verbal assaults may lead to hurt feelings
that are unspoken and can escalate conflict. If not confronted, these can lead to the
disintegration of the group. Your job is to help the group to set up norms that allow
anger to surface and be resolved honestly through dialogue. If staff members
demonstrate positive conflict resolution with individuals in the group, students may
change their behavior toward each other.

- **Regulate control**—As the group facilitator, you have the dilemma of how much
  control to exercise in the group. On the one hand, most adolescents need to know
  that there is a dependable external structure of behavior rules. At the same time,
  adolescents are striving for independence from authority figures and need to make
decisions interdependently within the group rather than following the wishes of the
leader. Your ability to give up control can be as important to students' growth as
knowing when to apply it.

3. **Group Leadership Roles and Observation Guidelines (45 minutes)**

There are several leadership functions in groups that should be recognized and
nurtured by the staff. They can be broken into two categories—task and maintenance
(see Handout 3.1).

**Exercise: Leadership Roles**

Taking one function at a time, ask the participants to identify those leadership roles
listed in *Handout 3.1* that they believe they consistently practice and to explain why.
Instruct other participants to give feedback on their perceptions and to discuss any
differences of observation/perception.

During group meetings, participants tend to focus their energies on the content, the
agenda, and the task at hand. Agenda completion and solving problems depend greatly
on the group's ability to recognize group process difficulties early and to deal with them
effectively. *Handout 3.2, "Observation Guidelines,"* can be used by group leaders to
identify group problems, plan appropriate interventions, and review the successful
elements of past meetings. It can also be used as a teaching aid to help students
understand their own roles and responsibilities in facilitating successful meetings.
**Exercise: Role Plays**

Divide participants into three groups of actors: 1) staff, 2) students, and 3) observers.

Ask participants in the staff group to plan a residential meeting (dorm, wing, or club meeting) with an agenda that includes the discussion of an interpersonal conflict and group problem solving on a selected issue. After developing the agenda, participants should pick one or two members to actually conduct the simulated meeting. (Other staff may act as consultants to the leaders if the latter requests advice during a particularly difficult meeting situation.)

Ask participants in the student group to take on various stereotypical roles that might be present at any student meeting. These roles might include student leaders, quiet students, the group "clown," serious students, and rebellious or hostile students. It is important that the group characters in the role play reflect the true composition of a typical student group. Once the role play begins, ask participants to maintain those roles throughout.

Ask participants in the observer group to sit on the outside of the group meeting and observe the group dynamics using the Observer guidelines. They may divide *Handout 3.2* into sections among themselves and each focus on specific group issues such as participation, influence, and decisionmaking functions. At the end of the role play, the observers will give feedback concerning the group processes and leadership effectiveness.

**Discussion and Wrap-Up:**

When processing the role plays, focus on the perceptual differences among staff, student, and observer groups, and on common themes which must be recognized and dealt with in staff/student groups. Summarize and clarify the major points in *Handout 3.2*. 
Handout 3.1

Exercise: Leadership Task And Maintenance Roles In Group Development

Instructions: Indicate which leadership roles you take in groups.

**TASK ROLES**

**Initiator:** Proposes tasks or goals, defines a group problem, and suggests procedures or ideas for solving a problem.

**Information Seeker:** Requests facts, seeks relevant information about group concerns, requests a statement or estimate, solicits expressions of value, and seeks suggestions and ideas.

**Information Giver:** Offers facts, provides relevant information about group concerns, states a belief about a matter before the group, and gives suggestions and ideas.

**Classifier:** Interprets ideas and suggestions, clears up confusions, defines terms, and indicates alternatives and issues before the group.

**Summarizer:** Pulls together related ideas, restates suggestions after the group has discussed them, and offers a decision or conclusion for the group to accept or reject.

**Consensus Tester:** Asks to see whether group is nearing a decision and sends up trial balloon to test a possible conclusion.

**MAINTENANCE ROLES**

**Encourager of Participants:** Warmly encourages everyone to participate, gives recognition for contributions, demonstrates acceptance and openness of others' ideas, and is friendly and responsive to group members.

**Gatekeeper:** Helps to keep communication channels open, facilitates the participation of others, and suggests procedures that permit sharing remarks.

**Harmonizer and Compromiser:** Persuades members to analyze their differences constructively in opinions, searches for common elements in conflicts, and tries to reconcile disagreements.
Tension Reliever: Eases tensions and increases the enjoyment of group members by joking, suggesting breaks, and proposing fun approaches to group work.

Process Observer: Watches the group process and uses the observations to help examine group effectiveness.

Standard Setter: Expresses group standards and goals to make members aware of the direction of the work and the progress being made toward the goal, and to get open acceptance of group norms and procedures.

Active Listener: Listens and serves as an interested audience for other members, is receptive to others' ideas, and goes along with the group when not in disagreement.

Interpersonal Problem Solver: Promotes open discussion of conflicts between group members to resolve conflicts and increase group cohesion.
Handout 3.2

Observation Guidelines

A. Participation

One indication of involvement in groups is verbal participation. Look for differences in the amount of participation among members.

- Who are the high participators?
- Who are the low participators?
- Do you see any shift in participation (e.g., highs become quiet, lows suddenly become talkative)? Do you see any possible reason for this shift in the group’s interaction?
- How are the silent people treated? How is their silence interpreted? As consent? Disagreement? Disinterest? Fear? etc.
- Who talks to whom? Do you see any reason for this in the group’s interactions?
- Who keeps the ball rolling? Why? Do you see any reason for this in the group’s interactions?

B. Influence

- Influence and participation are not the same. Some people may speak very little, yet they capture the attention of the whole group. Others may talk a lot but are generally not listened to by other members.
- Which members have great influence (i.e., when they talk others seem to listen)?
- Which members have little influence (i.e., others do not listen or follow them)? Is there any shift in influence? Who shifts?
- Do you see any rivalry in the group? Is there a struggle for leadership? What effect does it have on other group members?
Handout 3.2 (continued)

C. Decisionmaking Procedures

Many kinds of decisions are made in groups without considering the effects of these decisions on other members; some try to impose their own decisions on the group, while others want all members to participate or share in the decisions that are made.

- Does anyone make a decision and carry it out without checking with other group members (self-authorized)? For example, someone decides on the topic to be discussed and starts talking about it immediately. What effect does this have on other group members?

- Does the group drift from topic to topic? Whose topic jumps? Do you see any reason for this in group interactions?

- Who supports other members' suggestions or decisions? Does this support result in two members deciding the topic or activity for the group? How does this affect other group members?

- Is there any evidence of a majority pushing through a decision over other members' objections? Do members call for a vote (majority decision)?

- Is there any attempt to get all members to participate in a decision (consensus)? What effect does this seem to have on the group? Does anyone make any contributions that do not receive any kind of response or recognition? What effect does this have on the member?

D. Task Functions

These functions illustrate behaviors that are concerned with getting the job done or accomplishing the task that the group has before them.

- Does anyone ask for or make suggestions as to the best way to proceed or to battle a problem?

- Does anyone attempt to summarize what has been covered or what has been going on in the group?

- Is there any giving or asking for facts, ideas, opinions, feelings, feedback, or searching for alternatives?

- Who keeps the group on target? What prevents the group from jumping from topic to topic or from going off on tangents?
MODULE 4: CRISIS INTERVENTION
Module 4: Overview

On a Job Corps center, both individual and collective adolescent crises present the staff with a variety of difficult situations and challenges. Crisis intervention training provides participants with a theoretical foundation and practical guidelines for handling crises. This module explores the root causes and the signals of developmental stress. Through discussion and feedback, participants will examine how their own values and feelings influence their crisis intervention styles. Participants will practice front-line counseling and referral skills for assisting students in resolving crisis situations through conflict management, problem solving, and contracting techniques. Finally, participants will reassess their center’s procedures and resources for responding effectively to critical situations.

Module 4: Objectives

At the close of this training module, participants will be able to:

- Recognize the differences between stressors, stress, distress, and crisis
- Describe the psychological process that leads from stress to crisis
- List types of stressors that often affect students
- Recount strategies to manage an emergency or urgency

Module 4: Lecture and Discussion

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1. Stress and Crisis (15 minutes)

This session examines crisis intervention models and crisis prevention techniques. Before exploring these areas, we will discuss how a student can move from a healthy state of adaptation into a crisis situation.

In everyday conversation, the word stress generally connotes an unpleasant, negative occurrence. You have heard yourself or someone else say, "I'm under a lot of stress." The key words in this sentence are "a lot" rather than the word "stress." Everyone needs some stress; we all operate at a level of tolerable stress (equilibrium) that contributes to heightened functioning and performance. The cause of stress can be pleasant or unpleasant and the effects depend upon the intensity or number of
demands and the body's capacity to meet the demands (adapt). What we usually mean when we use the word "stress" is "distress."

Looking at stress in this manner when working with a student allows one to:

- Consider the total number of demands (pleasant and unpleasant) as well as the intensity of demands in the adjustment to center life
- Assess the student's internal and external resources to meet those demands
- Develop preventive measures to reduce the amount of stress and/or increase the student's resources for managing the stress
- Understand the various ways in which stress can lead to crisis

The model illustrated in *Handout 4.1, Stress Model*, illustrates the specific ways in which stress can lead either to the use and enhancement of coping skills (the more often we successfully master problems in our environment the better our coping skills become) or to a crisis state. The terms in the boxes are defined as follows:

- **Stressors**—Any demand on mind or body
- **Stress Filter**—Individual values, beliefs, feelings, thoughts, and attitudes that determine the meaning, intensity, and/or impact of the stressors
- **Stress**—Any demand placed upon the body causing the body to mobilize energy resources
- **Adequate Coping Response**—A realistic perception of the event, adequate situational supports, and utilization of coping mechanisms leading to resolution/mastery of the problem and meeting the demand
- **Inadequate Coping Response**—Lack of adequate coping mechanism and situational supports, and/or distorted perception of the stressors, resulting in an inability to master the situation or resolve the problem, leading to a rise in tension
- **Distress**—Intense stress, growing out of lack of success in dealing with the problem; tension increases and the person feels increasingly helpless; can lead to damaging wear and tear on body or mind and serious interference with daily life
- **Crisis**—A state in which usual coping patterns have failed in attempts to master a problem most often accompanied by feelings of anxiety, frustration, discomfort, and pain
The amount of stress experienced is determined in part by the number and intensity of the factors that cause stress. For example, a student who is adjusting well to center life and managing the stress of everyday demands may, over a short period of time, fall behind in class, have a falling out with a roommate, have a minor disagreement with the vocational instructor, and lose a favorite possession. This accumulation of minor problems may cause a stress overload.

Another determinant of the degree of stress experienced is the stress filter. You have probably noticed students who overreact to everything. In their view, they are not overreacting; their stress filter is signaling "threat" in many situations that are not threatening to other students. In the same way, a student whose stress filter contains a value that says fighting and yelling are dangerous and wrong will react more strongly to a fight in the dorm than other students whose stress filters say, "That is a perfectly normal way to act."

The adequate coping response leads to management of stress, and equilibrium is restored with no crisis occurring. For example, the student with the problems mentioned above may ask the instructor to explain the materials, work things out with the roommate, decide that the minor disagreement with the vocational instructor was "no big deal," and accept the loss of the possession. Inadequate coping responses lead to distress. Imagine the added problems if the same student starts to skip classes, stops speaking to the roommate, acts up in vocational class, and accuses another student of taking the lost possession. At this point, most people marshal all of their additional resources. If these additional resources lead to management of stress, a crisis is avoided. In many cases, additional resources cannot be found, or ineffective ones are chosen, such as alcohol/drug use or outbursts of anger. The failure to cope leads to a continuation and worsening of the problem, accompanied by intolerable feelings of anxiety, fear, frustration, and/or panic, and the crisis state is activated.

The important connection between crisis and crisis intervention is the realization that a student may experience an exhaustion crisis or a shock crisis.

- An *exhaustion* crisis can occur as the result of having to deal with too many stressors over a period of time.

- A *shock crisis* is induced by intense sudden stress such as the death of a loved one, a rape, or a violent attack.

As one staff member put it when speaking of a student who had terminated after 2 months on center, "I was on the lookout for something major or traumatic. It never occurred to me that all the little things she was dealing with could add up to the same thing when there was too much for her to cope with."
2. **Student Stresses and Crisis Prevention (30 minutes)**

**Student Stresses**

It was mentioned at the beginning of this session that everyone experiences some stress in his/her daily lives. To many of us, the parade of adult stresses appears endless—from financial burdens to parenting responsibilities. However, adolescents, in general, and students, in particular, have their share of normal and unexpected stress that can lead to either growth opportunities or crisis situations.

<table>
<thead>
<tr>
<th>Suggested Overhead 4.1</th>
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<tbody>
<tr>
<td><strong>Stressors in Job Corps Environment</strong></td>
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<tr>
<td>• Transitional Stress</td>
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<td>• Situational Stress</td>
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<td>• Peer Group Stress</td>
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<td>• Adolescent Motivation Stress</td>
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Let's consider some of the stresses in the Job Corps environment according to four primary categories:

- **Transitional stress**—Arrival on center, separation from friends and family, "culture shock," orientation, etc.

- **Situational stress**—Items related to adapting to the center environment, such as roommate conflicts, educational difficulties, loneliness, love relationship problems, transferring, graduation, etc.

- **Peer group stress**—Subgroup competition, cliques, inclusion/exclusion issues, racial tension, etc.

- **Adolescent motivational stress**—Normal development concerns over physical appearance, sexuality, hygiene, self-esteem, etc.

**Exercise: Student Stress**

Divide participants into small groups, and instruct each group to appoint a recorder and spokesperson. Ask them to identify and list specific student stresses from one or more of the four categories and recommend a way(s) to reduce the stress or each example. Allow fifteen minutes for this exercise. Instruct group recorders to list specific examples and recommendations on butcher’s block paper. Allow 10 minutes for report out.
**Crisis Prevention**

*Note:* Refer to *Handout 4.1, Stress Model*, during the discussion of crisis prevention. When possible, use examples of stress from the previous exercise.

Crisis prevention involves helping students manage their stress at a tolerable level. Preventive measures are useful at any step in the stress model prior to the actual crisis state. The measures include:

- Reducing the number of stressors (e.g., making certain a student is not placed in inappropriate vocational and academic classes)
- Adjusting the stress filter (e.g., working with a student to adjust his/her belief that "something must be wrong with me" because he/she is homesick)
- Developing adequate coping responses (e.g., assisting a student in resolving a minor disagreement with a roommate before it becomes a major conflict)

### 3. Emergencies, Urgencies, and Referrals (45 minutes)

To some extent, all crises are urgent in that the student's ability to cope with the distress he/she experiences is inadequate. The potential for the situation to get worse is inherent in the concept of crisis. Some situations, however, require a more rapid assessment and referral than others. This section will cover these emergency/urgency situations and situations requiring mental health support.

To respond to emergencies and/or make appropriate referrals, you must know:

- The center's policies and procedures for managing an emergency or urgency (including which staff member has authority to do what)
- The symptoms and characteristics of the student requiring emergency intervention or referral
- Techniques for handling the situation until other help arrives and/or techniques for gathering information to make referrals

*Note to CMHC:* Review the center's policies/procedures for handling emergencies or urgencies.

It is important to be able to recognize the symptoms of serious mental disturbances and to describe the specific behavior you have seen or heard.
If the student exhibits one or more of the following behaviors, he/she should have a mental health evaluation within 4 hours (urgent situation):

- Sudden radical change in general behavior patterns
- Loss of touch with reality (does not know date or time of day; is unresponsive)
- Memory loss
- Denial of own identity (thinks he/she is someone else—often someone famous)
- Holding one-sided conversations in public places
- Hallucinations (sees/hears things that are not there)
- Disorganized thinking and morbid interests
- Expressions of self-destructive or homicidal threats
- Fantastic ideas (bizarre fantasies, e.g., believes something is eating his/her brain)

In response to these behaviors, you should:

- Contact health staff
- Disperse any crowd
- Stay with the student
- Remain calm and reassuring
- Ignore verbal abuse—these people are often upset and frightened
- If the nurse, physician, and/or CMHC are not available within 4 hours, you should transport the student to the emergency facility according to center procedures

There are other less obvious behaviors that may also indicate the need for mental health support. The following may be symptoms of a crisis state or, if continued, could precipitate a crisis state:

- Disruptive behavior—student is constantly disruptive in group situations
- Self-preoccupation—student is preoccupied with personal problems or withdrawn and unable to participate in group life
- Excess activity—student is restless, overactive, or unable to relax
- Excessive demand for attention—student solicits or requires constant staff attention and supervision
- Persistent absenteeism—student frequently misses class for no apparent reason
• Impulsive behavior—compared to others, student acts without thinking and shows extremely poor judgment

• Excessive aggressiveness—student exhibits repeated or prolonged outbursts of rage with little or no provocation

• Extreme negativism—student shows opposition and resistance to whatever is suggested, refuses to talk, or fails repeatedly to comply with requests

• Disruptive sexual behavior—student engages in exhibitionism or aggressive sexuality

• Persistent antisocial behavior—student engages in acts of stealing, vandalism, arson, etc.

• Depression—student is always sad

• These behavior patterns often indicate a need for a more detailed evaluation by the center mental health consultant or the health staff.

4. Major Crises: Suicide and Drug and Alcohol Use (45 minutes)  This section is divided into two lecture segments: Suicide and Drug and Alcohol Use.

**Suicide**

When a student threatens suicide, staff reactions often range from fear and anger to denial and dismissal of the threat. A suicide threat should always be taken seriously and the student should be referred for a mental health evaluation immediately. Some of the indicators are:

• Giving away prized possessions
• Asking how large a dose of something (e.g., gas, medicine, drugs) would be fatal
• A preoccupation with death and dying with no apparent reason
• Depression

When these indicators (or others) are present, staff should not hesitate to ask a student if he/she is considering suicide. An attempted suicide is considered a psychiatric and medical emergency and center procedures should be followed immediately.
Discussion:

As a basis for discussion, distribute *Handout 4.2, Facts About Suicide*, and ask participants to complete the true/false quiz in 5 minutes. Discuss the correct answers to the quiz based on information in the answer key. Allow 10 minutes for discussion.

**Suggested Overhead 4.2**

**Suicidal Risk Characteristics**
- Specific Plan
- Overwhelmed/Hopeless
- Previous Attempts or Threats
- Relationship Break-Ups
- Medical Illness
- Bereavement
- Talk of Death, Suicide Threats
- Mental Disorders/Alcohol or Drug Abuse

The following characteristics are an indication of high suicidal risk:

- **Specific Plan**—If a person has a detailed suicide method and the means to carry it out, he/she should be considered high risk.

- **Overwhelmed/Hopeless**—Giving up hope of ever resolving a situation that seems overwhelming is a frequent characteristic of suicide victims.

- **Previous Attempts or Threats**—A past history of suicide attempts or threats increases the likelihood of suicide.

- **Medical Illness**—Illness (especially chronic) increases the risk.

- **Bereavement**—An actual or pending loss of a loved one may trigger suicidal ideation.

- **Talk of Death, Suicide Threats**—Most suicide victims give a warning before committing the act.

- **Mental Disorders/Alcohol or Drug Abuse**—The presence of either of these states increases the risk factor.
**Major Crisis: Alcohol or Drug Use**

The center director has overall responsibility for prevention and control of alcohol and drug use on center. He/she must provide counseling or other therapeutic assistance for students with alcohol and drug-related problems and must provide students and staff with current and accurate information on the effects of alcohol and drug use (PRH-6: 2.8). Instruction for staff should include information on how to handle alcohol and drug use incidents and emergencies.

**Note to CMHC:** Tell participants that additional information about alcohol and other drugs of abuse will be addressed in the *Module 7: Alcohol and Other Drugs of Abuse.* Determine if there are any questions about center policy or procedures in any emergency situations. Remind participants that in many of these situations, they will not have the luxury of time to figure out what to do.

**Discussion and Wrap-Up:**

Allow 10 minutes to discuss other potential student crisis situations and procedures that should be effected to ensure rapid response.
Handout 4.1

**STRESS MODEL**

- **Stressors**
  - **Stress Filter**
    - **Stress**
      - **Adequate Coping Response**
        - **Management of Stress**
          - **Equilibrium**
            - **NO CRISIS**
      - **Increases Coping Resources**
        - **Distress**
          - **Failure to Cope**
            - **CRISIS**
      - **Inadequate Coping Response**
Handout 4.2

Facts About Suicide

Instructions: Circle True (T) or False (F) in response to each statement.

1. People who talk about suicide usually do it. T F
2. Suicide happens without warning. T F
3. Suicidal persons are fully intent on dying. T F
4. All suicidal persons are insane. T F
5. Suicide risk is not over after improvement of the crisis state. T F
6. The rate of suicide attempts is the same for males and females. T F
7. Males commit suicide more frequently than females. T F
8. Alcohol and other drug abuse increase the risk for suicide. T F
Handout 4.2 (continued)

Facts About Suicide: Answer Key

1. **True.** Eighty percent of all suicidal persons give warning of their intentions.

2. **False.** Studies show that people give clues and warnings as to their suicidal intentions.

3. **False.** Most are undecided--almost no one commits suicide without letting others know how they feel.

4. **False.** Studies of hundreds of suicide notes indicate that while the suicidal person is extremely upset, he/she is not insane.

5. **True.** Fifty percent of all people in suicidal crises who later committed suicide did so 3 months following "improvement."

6. **False.** Females make three times as many suicide attempts as males.

7. **True.** Males do commit suicide more frequently than females.

8. **True.** Alcohol and other drug abuse does increase the risk of suicide.
MODULE 5: STUDENT MOTIVATION
Module 5: Overview

Many center staff have experienced the satisfaction of helping a student to turn around from self-defeat to self-development. This module presents a systematic and practical approach for changing students' negative behavior, attitudes, and habits. The training reviews the basic social development needs that motivate students' behavior and explores intrinsic and extrinsic rewards that fulfill those needs. Participants will identify staff communication and leadership styles that promote or inhibit change in students’ attitudes toward study habits, interpersonal cooperation, and constructive participation in center life. Participants will also examine the center organizational structures that provide incentives for peer support, individual recognition, and student influence.

Module 5: Objectives

At the close of this training session, participants will be able to:

- List three factors influencing motivation and achievement
- Describe three types of rewards for promoting student achievement
- Describe encouragement as a positive reinforcer for student achievement

Module 5: Lecture and Discussion

<table>
<thead>
<tr>
<th>Content</th>
<th>Process</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Theory</td>
<td>Lecture/Small Group Exercise</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Unmet Needs and Educational Achievement</td>
<td>Lecture/Small Group Exercise</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Leadership and Adolescent Motivation</td>
<td>Lecture/Discussion</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Incentives and Student Motivation</td>
<td>Lecture/Small Group Exercise/Discussion</td>
<td>40 minutes</td>
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1. Needs (15 minutes)

There are many different motivational theories in social and political science literature. This session will concentrate on the needs, goals, and environmental conditions that promote students' social, educational, and vocational achievement.

Each of us has internalized a complex set of learned needs that directly influence our social, vocational, and spiritual lives. These needs, which direct our behavior, include security, stimulation, intimacy, and recognition.
Exercise: Needs

Divide the participants into two groups. Each group will address one of the following topics:

(1) Discuss and list the needs that are important in the Job Corps work setting.
(2) Discuss and list the needs that you think affect student behavior.

Process the entire group for both staff-focused and student-focused motivations. Note and expand upon the need constructs common to both groups.

2. Unmet Needs and Educational Achievement (30 minutes)

The cliché often heard about today's youth is that they just aren't as motivated as teenagers used to be. This statement, made by every successive generation of adults about teenagers, may reflect our modern society's inability to meet even the basic needs of a large number of our citizens and our anxiety that young people may reject certain key social values.

Factors Influencing Motivation and Achievement

- Health and Education
- Socioeconomic Background
- Family History

Medical and educational research has identified many factors that affect motivation and achievement levels of disadvantaged youth, to include:

- Significant numbers of disadvantaged children are developmentally impaired at birth because of inadequate maternal diets and lack of pre- and post-natal care.

- During preschool and elementary school, children of lower socioeconomic populations often have chronically poor diets and inadequate medical care that affects cognitive as well as physical development.

- Educational preparation is further hampered by physically inferior, poorly equipped, and understaffed schools in disadvantaged and minority neighborhoods.

- Racial and class prejudice within the educational system often discourages minority and low-income children's progress. Schools in poor and working class neighborhoods are often staffed by administrators and teachers who have middle
class values. Schoolbooks and curriculum are designed to accommodate middle class language patterns, interests, and activities. Since most minority and lower socioeconomic students do not fit this mold, they enter the educational system less prepared and become quickly discouraged about their academic futures.

Although a large percentage of minority and disadvantaged adolescents complete high school, most Job Corps students are dropouts. This section will explore the social, familial, and personality factors that influence youths’ decisions to drop out and those factors that motivate them to return.

The social and economic factors include:

- Most dropouts are found in ethnically segregated groups in both rural and urban areas.
- Many adolescents who leave school are poor.
- Most dropouts are 2 years behind in reading and math skills by the seventh grade.

Family history factors include:

- Overall communication between adolescent dropouts and their parents is significantly worse than that of those who remain in school.
- Parents of dropouts are less accepting of their children.
- Families of adolescents who leave school are often socially isolated from their neighbors and their community; when friendships do exist, they are more superficial.
- Historically, families of dropouts have shown little interest in their children’s academic achievements.

<table>
<thead>
<tr>
<th>Psychological Characteristics Of Adolescent Dropouts</th>
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<tbody>
<tr>
<td>• Less confident</td>
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<tr>
<td>• Less clearly defined values</td>
</tr>
<tr>
<td>• Display anger toward authority</td>
</tr>
<tr>
<td>• Exhibit behavior influenced by frustration</td>
</tr>
<tr>
<td>• More impulsive</td>
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<tr>
<td>• View world as unpredictable</td>
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Certain psychological characteristics are common among adolescents who leave school:
They are less confident and often lack a clearly defined self-image or sense of purpose.

They have less clearly defined values.

They often display a great deal of anger and hostility toward authority figures.

They exhibit behavior that is influenced by frustration rather than positive goal seeking.

They are more impulsive.

They view the world as unpredictable and characterized by exploitation of others. Long-term planning is often seen as meaningless and futile.

The Job Corps Program must address students' needs for them to achieve their full vocational and social growth.

**Exercise: Student Needs**

Divide participants into small groups and have groups appoint a recorder and spokesperson. Distribute Handout 5.1, Needs Worksheet. Ask the groups to list student needs, identify how the center program addresses these needs, and, in the event that these needs are not addressed, make recommendations for center program expansion or modification.

When participants have completed the exercise, ask each group to report their findings. The needs list should include:

- The need for basic health care and nutritional education
- The need for educational and social experiences that relate to students' backgrounds
- The need for acceptance and recognition from staff
- The need for social skills and peer support groups
- The need for a positive self-image and sense of purpose
- The need for nonviolent conflict resolution skills
- The need for trusting relationships and open communication with staff

**3. Leadership and Adolescent Motivation (5 minutes)**

The relationship between a staff member and student can often have an important impact on the student's motivation and achievement. This is not surprising, since the adult leadership qualities that promote adolescent progress are quite similar to effective
parenting, supervising, and management characteristics. In general, adolescents respond most favorably to adult leaders and teachers who are warm, enthusiastic, and open to suggestions; who recognize individual differences; and who treat discipline issues in a fair and impartial manner. Adolescents are least motivated by adults whom they view as hostile, authoritarian, sarcastic, rigid, and aloof.

**Discussion:**

Ask participants if, based on their Job Corps experiences, there are any other staff leadership attributes that positively influence student achievement. Emphasize the concept of role modeling.

4. **Incentives and Student Motivation (40 minutes).** *This section includes three lecture segments: The Use of Rewards, Types of Rewards, and The Use of Encouragement.*

Reinforcement methods are a primary feature of all human motivation theories. Rewards and encouragement are significant, especially for students whose positive vocational and interpersonal achievements have been historically unnoticed and unsupported. The following section explores the role of rewards and encouragement as positive motivational factors.

**Suggested Overhead 5.3**

**The Use Of Rewards**

- Difference between reward and bribe
- Reward must be earned
- Reward to one may not be reward to another
- Attaining tangible rewards should not be goal of behavior
- Consider frequency when giving rewards
- Timing is important
- Choice of reward is important

**The Use of Rewards**

Rewards can help students internalize the benefits of appropriate behavior and achievement. Points to consider when using rewards for accomplishing this goal are:

- **There is a difference between a reward and a bribe.** A bribe is something that is promised to an individual to induce him/her to do something. It is often offered as a frantic reaction to disobedience. Using bribery is risky because it may invite manipulation.
• **A reward must be earned to be effective.** If a reward is automatically given, it loses its effectiveness. There needs to be a clear relationship between effort and achievement.

• **What is rewarding to one individual may not be rewarding to another.** Rewards need to be meaningful to recipients to be effective. They should be individualized to recognize individual efforts. A useful technique in a large group system like Job Corps may be to combine a standard reward with individual words of recognition, praise, and encouragement.

• **Attaining tangible rewards should not be the goal of students’ behavior.** Their greatest reward should be an internal feeling of accomplishment. Tangible rewards represent external reinforcement and recognition of success. Staff may need to encourage students to feel proud of themselves and to teach them how to graciously accept a reward.

• **It is important to consider frequency when giving rewards.** It may be necessary to reward a behavior each time it occurs to reinforce that behavior. It may even be necessary to break behaviors down into smaller steps that are recognized and rewarded. Once a behavior is learned, it must be maintained. Continued appropriate behavior may need to be recognized and rewarded from time to time. Encouragement is a useful tool in this process.

• **The timing of rewards is often an important element.** Depending on the individual and/or the situation, some behaviors must be rewarded immediately to be meaningful. This is particularly important when an individual is struggling to learn a new or difficult behavior or task. If rewards are delayed too long, they often lose their impact as positive reinforcers.

• **It is important to choose the appropriate type of reward.** There are three basic types of rewards that can be used individually or in combination—tangible, activity, and social.

**Types of Rewards**

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<th>Types Of Rewards</th>
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<tbody>
<tr>
<td>Tangible</td>
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<td>Activity</td>
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<td>Social</td>
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The following types of rewards can be used individually or in tandem. The selection depends on the individual, the situation, the particular behavior and its importance and/or difficulty, and on the length of time the behavior has been sustained. Some
rewards can be given informally; others are awarded more systematically and/or publicly.

- **Tangible Rewards**—This category includes tangible items that provide pleasure to the recipient. They can be either consumable awards such as food, or permanent awards such as T-shirts, mugs, or trophies. Tangible rewards are particularly effective when the recipient plays an active role in selecting or designing them.

- **Activity Rewards**—An activity reward allows the recipient to engage in pleasurable activity. It can be a special privilege for a period of time or an excuse from a particular task. However, this type of reward must be used with caution. For example, relief from chores might imply that chores are negative to begin with.

- **Social Rewards**—Social reinforcers include recognition, praise, attention, smiling, and appreciation. These rewards are part of a supportive, positive atmosphere that should permeate a center. Social rewards can come from peers, such as election to an office or nomination for a particular formal award.

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**Exercise: Student Reward System**

Divide participants into groups of four. Ask each group to list current center rewards in each of the three categories (tangible, activity, social) and to add other incentives that might be instituted. Compile a final list on an easel pad. Examples of rewards by category can be included as a handout (see **Handout 5.2, Student Reward System**).

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**The Use of Encouragement**

Encouragement is a powerful tool that should accompany the use of rewards. It can be dangerous to use rewards alone because an individual may begin to equate his/her value solely with success at specific tasks. In so doing, the fear of failure at these tasks may seriously affect behavior and confidence.

Encouragement is the verbal acknowledgment of an individual's efforts toward success. It is a supportive process that facilitates growth, as opposed to merely rewarding it.

The following additional points concern the use of encouragement to facilitate growth and self-discipline:
Elements Of Successful Encouragement

- Place intrinsic value on individual
- Show faith in ability to succeed
- Recognize individual's effort to succeed
- Encourage individual to take risks
- Support development of success skills
- Recognize and focus on individual's strengths

- **If the encouragement process is to be successful, intrinsic value needs to be placed on the individual.** The individual needs to be viewed as being worthwhile in his/her own right despite whether or not he/she succeeds in certain tasks or behavior. An individual needs to feel that he/she is important and has a place in society in order to achieve.

- **To encourage an individual is to show faith in that individual's ability to succeed.** A person who encourages believes in the individual and his/her abilities to succeed and grow. This demonstration of faith helps the individual have faith in him/herself.

- **Encouragement recognizes an individual's efforts toward success.** This is one of the most important aspects of the encouragement process. Some would argue that recognition of effort is more crucial than recognition of success because the effort must always be there to bring about the success. An individual's effort can become easily thwarted if his/her attempts are recognized only if they result in success. Encouragement motivates people to continue trying.

- **Individuals need to be encouraged to take risks.** Taking risks is an essential part of growing up and learning. However, taking risks does not always mean that one will succeed in his/her efforts. Again, the efforts need to be recognized and encouraged, regardless of success. By allowing an individual to take risks, one is placing faith in that person and his/her abilities.

- **Encouragement supports the development of success skills.** By using positive descriptive feedback in the encouragement process, the skills that are important to achieving a task or to performing and maintaining a behavior are learned.

- **Encouragement recognizes and focuses upon an individual's strengths.** In the process of focusing on strengths, weaknesses should not be denied/ignored. Rather, in a quiet way, the individual is encouraged to strengthen all skills.

Encouragement is a process and an attitude that should accompany the use of rewards. It is a process that helps internalize the positive benefits of achievement and discipline.
Discussion and Wrap-Up:

Ask participants to identify ways in which students receive encouragement on center, both on an individual and a program basis. Ask for recommendations to integrate additional systems of encouragement into the program.
Handout 5.1

Needs Worksheet

<table>
<thead>
<tr>
<th>Student Needs</th>
<th>Center Program Components that Address Needs</th>
<th>Recommendations for Expansion or Modification of Program</th>
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### Handout 5.2

**Student Reward System**

<table>
<thead>
<tr>
<th><strong>Tangible Rewards</strong></th>
<th><strong>Activity Rewards</strong></th>
<th><strong>Social Rewards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>Special classes</td>
<td>Variety of passes</td>
</tr>
<tr>
<td>Jackets</td>
<td>Classroom aide</td>
<td>Honor dorms</td>
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<tr>
<td>Appliances for dorm</td>
<td>Advance notice of activities</td>
<td>Public recognition</td>
</tr>
<tr>
<td>Honor rooms/areas</td>
<td>Free tickets to events</td>
<td>Dorm offices</td>
</tr>
<tr>
<td>Bonds</td>
<td>Picnics</td>
<td>Cadets</td>
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<tr>
<td>Belt buckles</td>
<td>Dining hall privileges (special menu, location)</td>
<td>Commendation to parents, or in center newspapers</td>
</tr>
<tr>
<td>Blazers</td>
<td>Admission to clubs</td>
<td>Student of the month</td>
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<tr>
<td>Carrying cases</td>
<td>Pool hall privileges</td>
<td>Incentive system</td>
</tr>
<tr>
<td>Watches</td>
<td>Banquet</td>
<td>Teacher's aide of the month</td>
</tr>
<tr>
<td>Rings</td>
<td>Trips</td>
<td>Attendance certificates</td>
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<td>Trophies</td>
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<td>Pins</td>
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<tr>
<td>T-shirts</td>
<td>Student government</td>
<td></td>
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<tr>
<td>Merit increases</td>
<td>Excuse from activity</td>
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<tr>
<td>Suit bags</td>
<td>Drivers Education priority</td>
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<td>Buttons</td>
<td>Scholarships</td>
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<tr>
<td>Bumper stickers</td>
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MODULE 6: STANDARDS OF CONDUCT
Module 6: Overview

The Job Corps environment is designed to teach self-discipline. Staff members’ varied personal values about limit setting and behavior management often make consistency and enforcement difficult.

This module will help center staff understand, predict, and uniformly control student behavior. The presentation includes alternative models for understanding and controlling negative student behavior. Participants will identify developmental factors and personal values that influence their disciplinary role, practice positive communication strategies, and focus on a five-stage approach for writing fair and accurate behavior incident reports.

Module 6: Objectives

At the close of this training session, participants will be able to:

- Recognize five elements that create a positive environment on center
- Define a discipline problem
- Demonstrate an understanding of "I-message" communication
- Explain the steps of a disciplinary action plan
- Describe six elements that promote objective documentation of behavioral incidents

Module 6: Lecture and Discussion

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1. Introduction (10 minutes)

Center staff have a duty to teach students to take responsibility for their safety, their property, their issued tools, their actions toward others, and their performance—all the things that any person is responsible for during life.

Teaching self-discipline to students can be a difficult and complex task. As children, many of us learned only one discipline model from our parents. Many staff members may rely on a traditional disciplinary model of threat, rigidity, and strict enforcement.
because they perceive it as the fastest, most efficient method of student control. However, numerous adolescent research studies have indicated that these techniques often promote dependency, hostility, and dissatisfaction rather than self-discipline. Individuals living in these settings tend to have low morale, high turnover, and low achievement.

Students can also make the staff-teaching task more difficult. Depending on the situation, a student may want complete authority to handle a task or may want the staff member to tell him/her exactly what to do.

Many students are ambivalent about authority figures because of their previous negative experience with such people. Staff members are simultaneously role models that students admire and adults to be questioned and tested.

Teaching self-discipline is a challenge. It takes planning, energy, patience, and commitment. In spite of the difficulties, it is a teaching process that cannot be disregarded since self-responsibility underlies Job Corps vocational and citizenship goals. This module examines the multiple features involved in an effective center behavior management program. No single approach can accommodate all of the individual or collective behavior management issues on center. All elements of the center’s behavior management program must be coordinated to help students learn self-awareness and self-responsibility.

2. Developing a Positive Center Environment *(20 minutes)*

The first step in eliminating many behavior problems on center is to develop a positive environment. This involves:

- Developing positive two-way communications skills—Effective communication between staff members and students is an important topic that is discussed in almost all skill-building sessions. Although we will focus on communication strategies later in this session, staff members generally can defuse conflict and increase students’ self-discipline by:
- Not using provocative verbal or nonverbal responses when disciplining students
- Using objective data when evaluating student behavior
- Developing an action plan based on an individual's behavior and not on his/her history

• **Taking the time to show concern, respect, recognition, and encouragement for each student**—Unfortunately, many students receive attention only when they are the focus of disciplinary action. Negative attention is not the sort of attention that fosters self-respect or self-discipline.

• Adolescents need to try out behaviors, take risks, and learn their own limits and the limits of their environment. Thus, this period of growth is ripe for misunderstandings and disciplinary problems. Staff must be willing to listen and to be aware of the difficult changes adolescents must undertake to become responsible, rational adults.

• **Making sure students know the rules and limits of different settings**—Rules are reviewed during orientation, but they probably need to be discussed in the context of each particular setting. For example, the rules and limits of behavior in the recreation facility are different from those of the vocational classroom. Furthermore, each setting has some informal rules that may not be incorporated into the Student Handbook.

• **Maintaining a smooth and timely flow of activities**—Some Job Corps settings are more structured than others, and each has specific scheduled activities. For example, the classroom settings for academics and vocational training are more structured than the dorm setting. Some recreational events, such as intramural games, may be more structured than open hours in the recreation room or ball games on the field.

As students move from one setting to another, misunderstandings and potential disciplinary problems can be diminished by staff members who are aware of the differences in these environments. Students often need to "shift gears" because the situation requires a different set of behaviors. For example, appropriate behavior in the poolroom after lunch is different from appropriate behavior in math class after lunch.

In addition to providing cues to aid in the transition, staff members in charge may also need to allow a brief but reasonable period of time for the behavioral transition to take place. Working under the expectation that students will automatically and immediately shift gears may only cause problems.

When activities move along at an appropriate pace, there will be fewer discipline problems. The pace of activities should be neither too slow nor too hectic. With students, acute boredom can be the breeding ground for creating more interesting,
often disruptive, diversions. If the pace is too fast, they may become discouraged or frustrated and act out in disruptive and inappropriate ways.

- **Be aware of potential problems before they become serious**—If you can anticipate problems, you can help avoid them. Each of the four areas just discussed outline points to avoid or promote. Refer to these areas when planning an activity. Keep in mind the nature of the activity and the personalities of the students who will be involved.

- **Be consistent**—Students have a strong sense of fairness and notice differential treatment. The inconsistent application of punishment or rewards can be very disruptive. It is often difficult to remain flexible while at the same time being consistent. Make sure that there is justification for "bending a rule" or handing out a sanction. It is critical that all staff be aware of and consistently adhere to center rules.

- **Arrange the physical space so that it is comfortable and meets the needs of the situation**—If students' physical needs are not met, they can become agitated and create behavior problems. Some important points for you to consider in special arrangements are:
  - Is the space large enough for the activity? Is there "breathing" as well as working room for each student?
  - Is the space too large for the activity? Is there too much room between people who need to interact, or between the students and the supplies or equipment necessary for the activity?
  - Are the lighting, heating, and air conditioning adequate?
  - Are there adequate chairs, tables, and equipment for the activity? This may require that you reduce the size of your group, or have alternative tasks for some members.
  - Are known enemies separated from each other?
  - Are close friends subtly separated if "cliques" will be a problem for the activity?
  - Can the instructor encourage, support, and monitor the activities without disrupting the group?
Discussion:

Ask participants if they have comments on or suggestions for developing a positive center environment. Ask them to identify those categories that are especially important for decreasing student discipline problems on center.

3. Communication Techniques for Identifying and Evaluating Behavior (45 minutes)

Even in a well-structured, positive environment, student experimentation, mistakes, and limit testing are a natural part of the growth process. The process of identifying and evaluating disruptive behavior is one in which both students and staff take part.

Definition: Discipline Problem
- Behavior in violation of established rules.
- Consistently/excessively ignores or interferes with rights of others.
- Seriously interferes with functioning of the center and/or casts serious discredit on Job Corps.

A discipline problem ensues from behavior that violates established rules. A discipline problem also exists when a student consistently or excessively ignores or interferes with the rights of others or with the functioning of a center and casts serious discredit on the Job Corps.

When staff members become aware of students' unacceptable behavior they often mentally run through a series of questions to determine whether to take action and what action to take. These questions should be:

- What is the exact behavior causing the problem?
- Is the behavior violating a center rule? Is something/someone being adversely affected by the behavior?
- How often is the behavior a problem?

The answers to these questions offer a preliminary understanding of the situation.

Often, a student will talk about why his/her behavior is necessary. He/she will offer excuses and/or blame others rather than acknowledge the behavior as his/her own. In cases like this, it is often useful to ask the student another set of questions:

- What are you doing (not why)?
- Is it helping you or someone else?
• Is it hurting you or someone else?

Discuss your preliminary understanding with the student and listen to the student's side of the story. The student should understand the effect of his/her inappropriate behavior and why it should not continue.

Establish a problem behavior statement that pinpoints the behavior and its effect. Sample statements include:

- When you talk during study time, other people cannot concentrate.
- When you don't return the baseball equipment, other people cannot use it.

This acknowledgement of the behavior and its impact allows the student to initiate a change in behavior and assume responsibility for his/her actions.

This initial intervention is the most crucial step in the entire disciplinary, problem-solving cycle. Depending on the staff member's communication skills, confrontation can either become an opportunity for learning and growth, or escalate into a win-lose power struggle between a staff member and student. The difference in these two paths often hinges on the staff member's verbal and nonverbal messages during the first few moments of the interaction.

**Exercise: Key Communication Elements**

Using an easel pad, ask participants to identify the key communication elements in the following four staff/student interaction categories:

- Staff verbal cues that are likely to escalate a disciplinary situation
- Staff nonverbal cues which are likely to escalate disciplinary situations
- Staff verbal cues which calm a disciplinary situation
- Staff nonverbal cues which calm a disciplinary situation

During this discussion, the following types of cues should be identified:

- **Staff verbal cues that are likely to escalate a disciplinary situation**—cursing at a student, yelling, insulting a student's abilities in front of peers, using ethnic slurs.

- **Staff nonverbal cues which are likely to escalate disciplinary situations**—Sitting behind a barrier (desk), standing over students, avoiding eye contact, trying to stare down students, finger pointing, aggressively gesturing like hitting table, kicking trash can, opening and closing fists.
• **Staff verbal cues which calm a disciplinary situation**—Listening fully to students’ explanations, focusing on the present special situation rather than past history, showing concern for students, showing how behavior affects others.

• **Staff nonverbal cues which calm a disciplinary situation**—Meeting privately with students involved, appearing concerned rather than angry, making frequent eye contact, using calm voice.

When dealing with students in a disciplinary situation, you may have strong feelings about inappropriate behavior and how it affects you. These feelings can cause your disciplinary message to come across as a harsh accusation that condemns the student. The "I-message" technique is a useful mechanism for descriptive feedback that confronts behavior and also constructively acknowledges your feelings.

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<td><strong>Definition: I-Message</strong></td>
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<td>Concise one- to two-sentence statement that describes:</td>
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<tr>
<td>• Specific inappropriate behavior</td>
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<tr>
<td>• Your reaction to behavior</td>
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<td>• Why that behavior causes problems</td>
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An I-message is a concise, one- or two-sentence statement that describes the specific behavior that is inappropriate, your reaction to the behavior (the "I" part of the message), and why that behavior causes problems.
**Exercise: I-Messages**

Using one of the following examples, ask participants to demonstrate how an I-message can be used to identify appropriate behavior and acknowledge feelings without accusing or condemning the student. Elicit additional examples from participants.

1. Landscape Instructor to Gary—Gary has just walked over the barricade that protects the new grass.

   "I get frustrated when you cut through the lawn to get to the cafeteria because you kill the grass that I'm trying to grow there."

**Exercise: I-Messages (continued):**

2: The CSO to Freddie—Freddie just pushed into the cafeteria line.

   "I get angry when you cut in line because other kids have been waiting and deserve to be served first."

   Counselor to Jean—Jean just demanded her resignation papers because she's angry with her RA.

   "I feel insulted when you threaten to leave the Job Corps because I feel I may have wasted my time."

Each I-message expresses how you feel about an issue but still allows the student to take the responsibility for changing her/his behavior. The I-message does not evaluate the student; rather, it states specific inappropriate behavior. It places responsibility on the student to respond to your feelings and change the inappropriate behavior.

Telling how you feel in an I-message is constructive because:

- **It does not attack or criticize the student**—It encourages a positive self-concept and integrity, while it lets the student know that he/she needs to change some behavior.

- **It provides the student with the opportunity to take responsibility for his/her own behavior**—When staff members demand that students behave in certain ways, students are not allowed to set their own behavior in a responsible fashion. Taking charge of one's own behavior is one of the most important ingredients in learning to become a responsible adult.
• **It helps the student to respect and understand the feelings of others**—Being able to respond to someone else's problems is part of being sensitive to others.

**Exercise: I-Message Format**

Distribute *Handout 6.1, I-Message Format and Exercise*. Using the I-message format, ask the participants to transform five provocative disciplinary statements into more productive I-message statements. Process the entire group for I-message misinterpretations as well as variations.

4. **Disciplinary Plan (55 minutes)**

A successful disciplinary plan requires that the staff member and the student work together to develop a realistic plan to modify behavior in a reasonable length of time. Using this process, the student learns how to take responsibility for his/her behavior and learns problem-solving skills. Building a plan, however, is not easy, particularly the first few times a student tries. A staff member can facilitate this difficult process by helping the student to identify the goal(s) of the plan, the ways that goal(s) can be met, and the specific steps to be followed.

A variety of factors should be considered in this process:

- **A good plan should be simple and realistic**—If a plan is too difficult or too complicated the student may just give up on the process.

- **A plan should not be just an apology**—Although an apology may help the staff member feel better or more powerful, it does not change a behavior.

- **A plan should not be just a promise**—A promise, such as "I will not fight anymore," or "I will not be late to class," is not a plan. These are statements of ultimate goals. A plan focuses on specific steps to accomplish goals.

- **A plan should explore a number of options**—Identify the target behavior, develop a number of options for modifying it, and decide together which option or combination of options to use.
• A plan should be a short series of specific steps

**Exercise: Disciplinary Plan Case Study**

Distribute *Handout 6.2, Disciplinary Plan Case Study*, and ask participants to develop a disciplinary plan that identifies options and states a specific series of steps. Allow 15 minutes for this exercise. Ask several participants to discuss their plan. Review and distribute *Handout 6.3, Sample Plan*, which gives an example of a plan for discussion.

5. **Documenting Critical Incidents (5 minutes)**

Job Corps centers are very action-oriented environments. Clear and effective verbal communications among and between staff members and students are highly regarded. As a result, staff planning and writing skills may be de-emphasized. However, if the center is to have a consistent, accurate, and fair behavior management system, behavioral observation reports and written behavioral contracts are necessary.

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<td>• Document current incident only</td>
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<td>• Document pertinent environmental information</td>
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<td>• Describe:</td>
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<td>- Who was involved</td>
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<td>- What occurred</td>
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<td>- Where it occurred</td>
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<td>• Describe conversation with student</td>
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<tr>
<td>• Have student sign report</td>
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<tr>
<td>• Avoid center-specific acronyms</td>
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<td>• Avoid classifying transgression</td>
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<td>• Sign name and title</td>
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No matter which report form your center uses to document critical incidents, there are some key points you should follow to ensure fairness, accuracy, and efficiency:

• **Document what you see, not what you think**—Leave implications and value judgments out of your descriptions. Note actual behaviors and the various conclusions possible.

• **Document current incident only**—Your discussion should not refer to past incidents, which should already have been documented in previous reports.
- Document pertinent environmental information surrounding an incident—
  (e.g., empty beer bottles, roach clips, etc.).

- Make sure that the following questions are answered to the best of your
  ability:
  - Who was involved? Include names of witness.
  - What occurred? Describe the behavior observed.
  - When did it happen? List the date and time. Include duration, if known and
    applicable.
  - Where did it occur? Describe the area surrounding the situation. If it took place
    in more than one area, include that information as well (e.g., the incident started
    in the cafeteria and moved outside).

- If you talked to the student, include a brief description of your conversation.

- Have the student sign the report if possible—If it is not possible, indicate the
  reason on the form (e.g., "Student refused to sign, saying it didn't happen that way;"
  "Student left the scene immediately and was not available to sign;" etc).

- Avoid using center-specific acronyms or code numbers—Take the time to spell
  them out.

- Avoid classifying the transgression—Your report should be an accurate
  description of the event. The center standards officer can then classify it, based on
  the facts.

- Make sure your name and title are legible.

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Discussion and Wrap-Up:

Review the sessions’ objectives and ask participants if they have any questions or
comments.
Handout 6.1

I-Message Format and Exercise

A useful format to follow when giving both positive and negative I-messages is:

When You ___________________________,
(Describe specific behavior.)

I __________________________________________   __  _,
(State feeling or reaction.)

because _________________________________
(State problem or benefit that results from the behavior.)

Transform the following five statements into more productive I-message statements:

1. "The next time you show up late for curfew, you can just catch the 'A train' out of here."

2. "I want the bathroom cleaned now. I don't want excuses; I want results."

3. "You have got to get your act together in shop class. Time is running out."

4. "How could you do something stupid like this? Why do I waste my time with you?"

5. "If you ever bully somebody like that again, I'll make your life so miserable you'll wish you'd never heard of Job Corps."
Handout 6.2

Disciplinary Plan Case Study

Sharon is constantly late to class. The instructor identifies her persistent tardiness as an unacceptable behavior. The instructor has a problem because he has to stop everything when Sharon arrives, and repeat the information or instructions that she has missed. In addition, this demonstrates poor employability skills.

Through discussion, Sharon evaluates her behavior and decides that it is not helping anyone to be tardy. As a matter of fact, she is actually hurting herself because the instructor only has time to summarize the information she has missed. Since both the instructor and Sharon are having problems with this unacceptable behavior, a plan needs to be built to modify her behavior.
Handout 6.3

Sample Plan

"I'm sorry that I'm late" will not change Sharon's behavior. "I'll be on time starting tomorrow" does not outline any steps the student can make. If she is late every day, there must be a reason for her behavior. If she is late every day, saying she won't be late tomorrow does not help her know how she can keep her promise or prepare her for the "real world" of work.

By using positive communication techniques, a further discussion might reveal that Sharon is tardy because she finishes breakfast late. She finishes eating late because she arrives at breakfast late because she is always last in the bathroom. A reasonable plan may naturally develop from this cause-and-effect situation:

- **Step 1**—This afternoon, Sharon will ask for an alarm clock that she can use to wake up 15 minutes early. If she needs help arranging this, she can ask her career counselor to accompany her to the dorm.

- **Step 2**—Sharon will then use the bathroom before most of the other girls get up so she can start her morning chores early.

- **Step 3**—If she is still a little tardy, she will set her clock 20 minutes early.

This is a plan that outlines specific steps and builds employability. Step 3 builds into the plan an extra option in case the first is unsuccessful. Once the plan is developed, a commitment to follow it should be made.

In the example just described, Step 1 requires the student to take an immediate action. The first step should always be identified and spelled out in enough detail so that the student knows exactly what action he/she is to take and within what time frame.

In some situations, it may be helpful to write down the plan after it has been developed, or even to have the student write it and sign it. This contract sometimes helps a student realize that he/she is making a commitment.

Sometimes you will develop what seems to be a realistic plan, but for one reason or another it appears to be unworkable. The plan you jointly develop should have a mechanism for evaluation. A "checkpoint" is necessary to monitor your plan. For example, in the situation with Sharon, a fourth step could be added to the plan:

- **Step 4**—After a week the instructor and Sharon will meet to see how successful the plan was in decreasing tardiness.
If a plan has been unsuccessful, a new plan should be developed. After the student makes a commitment to the first plan, excuses for not following that plan should not be accepted. If the plan has not been followed, it is either because the student did not take his/her commitment seriously or because the plan was unrealistic. The student, however, is still responsible for his/her behavior and cannot blame anyone else.

If the student offers an excuse, a new plan may need to be developed to eliminate the excuse rather than just offering the student another chance. Feeling sorry for the student or being lax about his/her excuses probably will not change any behaviors. Accepting excuses may be harmful because it may teach the student that excuses do work after all. For example, Sharon says she was late because she couldn’t get out of bed. The instructor and the student may add a new first step:

- **Step 1-A**—Sharon will put a sign in her room or on her door this afternoon to remind her to go to sleep a half-hour earlier (at 10:00 instead of 10:30). She will set her clock 20 minutes early.

When a student clearly demonstrates an effort to follow a plan and achieves a small step toward the clinical goals, that effort and success needs to be recognized. Encouragement should be a continual process.
MODULE 7: ALCOHOL AND OTHER DRUGS OF ABUSE (AODA)
Module 7: Overview

Student alcohol and drug use is one of the most difficult issues that staff members face on center. This module looks at the nature of adolescent alcohol and drug use and provides information about drug classification. It also includes an overview of commonly used drugs, discusses their psychological and physical effects, and dispels a number of myths concerning alcohol and marijuana, the two most commonly used drugs on center. Participants will have the opportunity to assess their own values concerning alcohol and drug use enforcement on center and to practice front-line communication, counseling, and problem-solving skills related to students’ alcohol and drug use.

The CMHC may want to expand this module to focus on center policy and the Trainee Employee Assistance Program’s (TEAP’s) intervention component, staff communication on alcohol and drug use issues, procedures and resources for handling drug emergencies, or staff values related to their own or students’ alcohol and drug use. 

TAG L: Trainee Employee Assistance Program (TEAP) and the following training modules: Module 2: Adolescent Development and Communication, and Module 4: Crisis Intervention, may be helpful resources.

Module 7: Objectives

At the close of this training session, participants will be able to:

- List substances in all five major drug categories
- Explain the physical and psychological effects of drugs in these categories
- Answer common questions about alcohol and marijuana
- Assist in strengthening or implementing center programs that can eliminate enabling behaviors by staff and diminish student alcohol and drug use

Module 7: Lecture and Discussion

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<td>Major Alcohol and Drug Categories and Their Psychological and Physical Effects</td>
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<td>Lecture/Exercise</td>
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1. Alcohol and Drug Use in Society and Job Corps (10 minutes)

During this session we will explore alcohol and drug use among students. However, before we consider student issues, it might be helpful to understand alcohol and drug use in the context of our total society. The majority of adults use alcohol and other drugs regularly. These drugs range from tobacco, alcohol, and caffeine products sold in the supermarkets to marijuana, cocaine, and heroin bought on the streets.

The daily bombardment of messages that encourage us to use drugs is so pervasive that we hardly notice them. They come from magazine and newspaper articles, television shows and commercials, musical lyrics, and the lifestyles of movie stars, sports figures, and media personalities. Messages also come from friends, relatives, and co-workers.

To a great extent, adolescent alcohol and drug use can be seen as a downward extension of the alcohol and drug related issues and problems in the adult population. Adolescents have to deal with alcohol and drug use during a crucial stage of psychological and social development. Adolescence is period of personal change, self-examination, and experimentation. In this society, experimentation often includes alcohol and drug use.

2. Major Alcohol and Drug Categories and Their Psychological and Physical Effects (35 minutes). This section includes the following lecture segments: Stimulants, Depressants, Hallucinogens, Narcotics, or Inhalants.

To feel comfortable discussing alcohol and drug issues with students and giving students accurate alcohol and drug information, you should know the basic psychological and physical effects of alcohol and drug use. The majority of adolescents do not understand these effects.

Exercise: Listing Drugs and Assessing Their Effects

Ask participants, either individually or in small groups, to list all of the legal and illegal drugs that they can think of in 2 minutes. Note that most drugs belong to one of the following categories: stimulants, depressants, hallucinogens, narcotics, or inhalants.

As an introduction to the physical and psychological effects of drug categories, ask participants to complete Handout 7.1, Self-Assessment: Effects of Alcohol and Drug Use. Allow 5 minutes for completion.
Stimulants

Stimulants increase alertness, decrease hunger, increase concentration, and generally speed up body functions, such as pulse and breathing. When abused, stimulants can produce restlessness, anxiety, paranoid thoughts, hallucinations, and, in extreme cases, convulsions.

Specific stimulants include nicotine (cigarettes), caffeine products (coffee, tea, cola, and chocolate), cocaine (slang terms include coke, snow, C), and amphetamines and methamphetamines, including Benzedrine, Dexedrine, and Methedrine (slang terms include bennies, dexties, speed, meth, hearts, lid poppers, orange crosses, black beauties, roses, and cartwheels).

A stimulant abuser generally shows the following symptoms:

- Excessive activity, irritability, argumentative, and nervousness; often has a hard time sitting still
- Dilated pupils
- Dry mouth and nose, chapped lips, bad breath, and may often lick lips and rub or scratch nose
- May go long periods without eating or sleeping

Example: Tobacco

Tobacco is considered a drug because it contains nicotine, a stimulant that increases heart rate and raises blood pressure. Nicotine is absorbed into the bloodstream when one smokes or chews tobacco. The stimulating effect of nicotine increases the risk of heart attack, and the tars and other substances in the smoke are associated with lung cancer and emphysema.
Adolescents smoke because of peer pressure, curiosity, media pressure, and imitation of adult behavior. Smoking, like drinking, is often viewed as a rite of passage into adulthood and it is illegal for some age groups. Adolescents who smoke usually go through three phases:

1. **Initiation phase**—The person will smoke occasionally, usually with a group of peers.

2. **Experimental phase**—Still with the peer group, the smoker is now up to five or six cigarettes a day.

3. **Addictive phase**—Usually 2 to 3 months after experimenting, the smoker feels the physical need to smoke and no longer needs peer group reinforcement.

It has been observed that many Job Corps students smoke. (Some Job Corps centers report that up to 90 percent of the students are smokers.) The addiction is very hard to kick and staff members have an obligation to help students make intelligent decisions regarding the use of tobacco.

**Discussion:**

Ask if anyone in the group can explain the elements of the center’s Tobacco Use Prevention Program (TUPP). If not, refer to the appropriate center operating procedure.

**Depressants**

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<td><strong>Physical Effects</strong></td>
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<tr>
<td>- Lack of coordination</td>
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<td>- Muscle relaxation</td>
</tr>
<tr>
<td>- Slurred speech</td>
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<tr>
<td>- Relief from physical pain</td>
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<tr>
<td>- Drowsiness</td>
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<tr>
<td><strong>Psychological Effects</strong></td>
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<tr>
<td>- Decreased anxiety</td>
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<td>- Decreased ability to reason, problem-solve</td>
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<td>- Sense of security</td>
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<td>- Difficulty judging distances</td>
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<td>- Amnesia (blackouts)</td>
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Depressants, commonly called "downers," have the opposite effect of stimulants. They act on the central nervous system to slow down bodily processes such as pulse, respiratory functions, blood pressure, and nerve activity. Thus, downers relieve body tension and mental anxiety, increase drowsiness, and cause the user to feel euphoric and relaxed. A large dose of a depressant, or continued depressant abuse, can result
in slurred speech, dizziness, staggering, impaired problem-solving ability, amnesia, and, in extreme cases, coma. Downers account for the majority of drug-related deaths.

Specific drugs in the depressant category include alcohol; barbiturates including Seconal, Amutal, Tuinal, and Nembutal (slang terms include blue devils, barbs, candy, peanuts, rainbows, red devils, and yellow jackets); minor tranquilizers including Valium, Librium, and Equanil; nonbarbiturate sedatives, including Methaqualone, Quaalude, and Noludar; and major tranquilizers, including Thorazine. Although it has hallucinogenic properties, PCP (Phencyclidine, "angel dust") is also chemically a depressant.

A depressant abuser generally shows the following symptoms:

- Appears intoxicated but has no odor of alcohol on the breath
- Staggers, stumbles, and appears disoriented
- Falls asleep in class or on the job
- Loses interest in normal activities

**Hallucinogens**

<table>
<thead>
<tr>
<th>Hallucinogens</th>
<th>Physical Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elevated temperature</td>
</tr>
<tr>
<td></td>
<td>Dilated pupils</td>
</tr>
<tr>
<td></td>
<td>Increased blood pressure</td>
</tr>
<tr>
<td></td>
<td>Increased salivation</td>
</tr>
</tbody>
</table>

Suggested Overhead 7.3
Dream-like Reactions

- Intensification and/or reversal of colors and sounds
- Apparent movement of inanimate objects
- Problems viewed from new perspective
- Perceived ability to think clearly
- Ordinary objects become unusual and beautiful
- Simple patterns become intricate geometric forms
- Sense of oneness, joy, peace, contentment

Adverse Reactions

- Increased anxiety and fear
- Feelings of depression and despair
- Loss of emotional control

Hallucinogens can cause users to sense time distortion, an increased sense of taste and smell, intensified colors and sounds, and wave-like movements of objects. The user may feel euphoric, creative, and have sense of oneness with the universe.

The possibility of a "bad trip" is a major drawback to using hallucinogenic drugs. Depending upon the person's history of alcohol and drug use, attitudes, or present emotional state and surroundings, hallucinogenic states may go from dreamlike to nightmarish. These bad experiences can be terrifying for the user, although they seldom have any long-term effects. Bad trips can happen to experienced and novice users alike. Because pure hallucinogens are often very hard to obtain, most street samples are cut with other substances (such as amphetamines, milk, sugar, PCP, nutmeg, or mace). This adulteration increases the probability of a bad trip. It is estimated that 80 percent of bad trips are caused by hallucinogens that are cut with other substances.

Drugs in the hallucinogenic category include: lysergic acid diethylamide (LSD), mescaline, dimethoxy-methamphetamine (STP, DOM), psilocybin (a mushroom), dimethyltryptamine (DMT), methylenedioxyamphetamine (MDA), and peyote. Some street names for these drugs are Christmas tress, windowpanes, and microdots. Marijuana is also considered an hallucinogen because it contains tetrahydrocannabinol (THC) which is a psychoactive ingredient.

A hallucinogen abuser generally shows the following symptoms:

- Often sits in a dreamlike or trancelike state
- May touch objects and examine things carefully for long periods of time
• Hallucinates
• Has an unrealistic perception of abilities
• On a bad trip, may be hysterical and claim that the body is distorted or that he/she cannot get back into the body

**Narcotics**

<table>
<thead>
<tr>
<th>Physical Effects</th>
<th>Psychological Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relief from physical pain</td>
<td>Aggressive desires dulled</td>
</tr>
<tr>
<td>Suppression of cardiovascular and</td>
<td>&quot;Fogged in&quot; or dreamlike state</td>
</tr>
<tr>
<td>respiratory systems</td>
<td>Reduction of anxiety</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Feelings of security and tranquility</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td></td>
</tr>
</tbody>
</table>

Narcotics are derived from the opium plant or synthetically made to have an opiate-like action. They include heroin, morphine, codeine, and paregoric. Their most common effects are a slowing down of bodily functions, relief from pain, a temporary state of euphoria, and sleepiness.

Individuals who use narcotics face a number of possible problems. First, the user may unintentionally overdose, take contaminated drugs, or contract infections from unsterile needles and syringes (e.g., hepatitis B, HIV virus). Second, the user may become involved in illegal activity to support the habit and thus face the danger of criminal charges. Third, withdrawing or "kicking the habit" is difficult and painful both physically and psychologically. Withdrawal symptoms include anxiety, sweating, sleeplessness, nausea, and hot and cold flashes. Withdrawal can last from 2 to 8 days.

A narcotic abuser may show the following symptoms:

• Red, raw nostrils, if sniffing
• Needle tracks on arms and legs (may often wear long-sleeved shirts)
• Lethargy and drowsiness
• Constricted pupils that fail to respond to light as they normally should
Inhalants

Inhalants

<table>
<thead>
<tr>
<th>Physical Effects</th>
<th>Psychological Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired judgment</td>
<td>Lightheadedness</td>
</tr>
<tr>
<td>Loss of muscle coordination</td>
<td>Giddiness</td>
</tr>
<tr>
<td>Slurred speech</td>
<td>Possible hallucinogenic effects</td>
</tr>
</tbody>
</table>

Commonly misused inhalants include a number of household or commercial products such as hair spray, nail polish, plastic cement, glue, gasoline, paint thinner, PAM, amyl nitrite, White Out (typing correction fluid) lacquers, and many aerosol products.

Also known as volatile solvents and "deliriants," inhalants can make the user feel lightheaded, giddy, uncoordinated, and drowsy. Because these drugs have a gaseous or liquid form, it is difficult to judge the dosage and, consequently, the effects. In some cases, inhaling too much of these substances has resulted in brain damage or death. Another danger in using inhalants is suffocation from the plastic bags used to concentrate the substance. Long-term dangers include hepatitis, lead poisoning, and permanent liver, bone, kidney, and brain damage.

An inhalant abuser generally shows the following symptoms:

- Odor of the inhaled substance on breath or clothes
- Excessive nasal secretions
- Watery eyes
- Drowsiness

To summarize, most drugs either slow down natural processes or speed them up. Depressants, narcotics, and inhalants make the individual feel relaxed and sleepy, more sociable, and less tense and worried. Stimulants and hallucinogens make individuals lightheaded, and leave individuals feeling that they can concentrate better and notice sights or sounds in a new way.

Because alcohol and marijuana are the drugs of choice for students and other adolescents, and because they are considered "gateway drugs" to the use of cocaine and opiates, in particular, they will receive special attention in this module.

Discussion:

Return to Handout 7.1 and go over the correct answers for the self-assessment.
3. Myths and Assumptions About Alcohol and Drugs (45 minutes). This section is divided into two segments: Alcohol and Drugs.

Alcohol Myths and Assumptions

Alcohol has always been the primary drug of choice among adolescents. Misinformation concerning its effects makes it difficult for youth to make informed decisions about alcohol's role in their lives. Students' false assumptions about alcohol should be challenged. Some current assumptions concerning alcohol use follow.

Discussion:

Write each of the following statements on an easel pad and ask participants whether they agree or disagree with the statement. Ask for volunteers to share the reasons for their position. Supply additional information, as needed, after the discussion of each statement.

- Alcohol is a stimulant, which tends to pep you up.
- Alcohol increases sexual performance.
- Everyone reacts in the same way to the same amount of alcohol.
- The fastest way to sober up is to drink black coffee.
- Some people can still drive competently after only a few drinks.
- There are ways to drink and not get drunk.
- Alcohol is not a drug. . . Beer isn't alcohol.

Assumptions about alcohol include the following:

- Alcohol is a stimulant, which tends to pep you up. Alcohol is a depressant. However, alcohol and other depressants may have a pseudo-stimulant effect in the initial phase of consumption. This paradoxical effect (e.g., the user appears to be excited, talkative, active, "high") is attributed to one part of the brain (reticular activating system) losing influence over other parts of the brain that control inhibitions. This effect fades quickly and the depressant symptoms appear as the user continues to drink.

- Alcohol increases sexual performance. This misconception is closely related to alcohol's perceived stimulant effect. Since the initial effect of alcohol is to decrease inhibition, lower anxiety, and make the user feel less uptight, one or two drinks may help an individual temporarily overcome a lack of confidence or feelings of guilt about sex/intimacy, and, thereby, facilitate sexual activity. However, alcohol research has shown conclusively that more than moderate doses of alcohol will frustrate sexual performance.
• **Everyone reacts in the same way to the same amount of alcohol.** Each individual's reaction to a given amount of alcohol will vary. The effects of alcohol are based on a number of physical, psychological, and social factors. Physical factors include body weight, body chemistry, fatigue level, type of beverage, amount of food ingested, and how fast the person drinks. Psychological factors include mood, attitudes about drinking, and past drinking effects. Social factors include the type of function and the type of people with whom the user is drinking.

• **The fastest way to sober up is to drink black coffee.** Time is the one and only factor that affects the sobering up process. Alcohol is metabolized through the liver at the rate of approximately 1/2 ounce (one beer, one glass of wine, one shot of liquor) per hour. A stimulant may help keep the drunk awake, but it will not improve judgment and coordination or sharpen reactions.

• **Some people can still drive competently after only a few drinks.** This misconception has had tragic results for tens of thousands of accident victims and especially adolescents since traffic fatalities are the number one cause of death in this age group. The majority of these accidents are alcohol-related.

• No one drives better after drinking. In fact, even one drink can affect a driver's judgment and may decrease alertness. Drinking three to five alcoholic beverages within a 2-hour period will seriously impair anyone's driving ability. Drinking more than this over a 2-hour period is likely to classify the driver as legally under the influence.

• Alcohol affects driving skills in number of ways. It reduces a driver's abilities to judge distances, speed, turns, and his/her own poor performance. Alcohol also heightens the driver's tendency to take risks by inspiring false confidence, while it impairs reflexes and slows reaction time. Drunk drivers are often forgetful and sleepy at the wheel.

• **There are ways to drink and not get drunk.** There are a number of physiological, psychological, and social factors that mediate the effects of alcohol. The fact is that many people use alcohol moderately without becoming drunk. Here are some of the rules of thumb for social drinking:
  - Drink only when relaxed and feeling well.
  - Eat before and while drinking, to slow the rate at which alcohol enters the bloodstream.
  - Sip drinks slowly, rather than gulping them down and jolting the central nervous system with a sudden rush of alcohol.

  \[3 \text{ drinks per hour} \times 2 \text{ hours} = +.10 \text{ alcohol blood level}\]
1 drink per hour X 6 hours = +.10 alcohol blood level

- Do not drink if using any sedative medications that can amplify the alcohol's effect.

- **Alcohol is not a drug . . . Beer isn't alcohol.** Two common comments made by adolescents require correcting. Alcohol is a depressant and the psychoactive active ingredient in beer is alcohol.

**Marijuana Myths and Assumptions**

Although alcohol is used by twice as many adolescents as marijuana, the majority of the 16 to 20 million marijuana users are in the 18- to 25-year old age bracket. Some current assumptions about marijuana follow.

**Discussion:**

Write each of the following statements on an ease pad and ask participants whether they agree or disagree with the statement. Ask for volunteers to share the reasons for their position. Supply additional information, as needed, after the discussion of each statement.

- The effects of marijuana depend on the quality of the substance used.
- Using marijuana leads to harder drug use, especially narcotics.
- It is safer to smoke marijuana and drive than to drink and drive.
- Research has proven that marijuana use is physically damaging to the human body.
- On the whole, marijuana is less harmful than alcohol.

- **The effects of marijuana depend on the quality of the substance used.** This statement is partially true. The percentage of the psychoactive ingredient, THC, in the marijuana plant can vary, depending on the crops and climate. The plants grown in the U.S. are usually significantly lower in THC than plants cultivated in other climates, especially Mexico, the Middle East, Southeast Asia, and India. However, users' reactions to marijuana are also highly related to factors such as past use experience, present mood, and situation.

- **Using marijuana leads to harder drug use, especially narcotics.** This "fact" was widely quoted in the early drug education classes. These scare tactics had the reverse effect on adolescents who knew better, and thus undermined the credibility of the entire drug education movement.

- There is nothing in marijuana that produces a need to use other drugs. The overwhelming majority of marijuana smokers do not progress to so-called "stronger"
drugs. However, some regular users have experimented with other drugs such as hashish, stimulants, and hallucinogens more than nonusers. Most regular users are also exposed to the user-pusher marketplace and to the culture of drug use, which may also affect use patterns.

- **It is safer to smoke marijuana and drive than to drink and drive.** There have been no studies to date that directly compare the relative hazards of driving under the influence of alcohol and driving under the influence of marijuana. However, several research studies have shown that marijuana use can significantly impair driving ability (even if the individual no longer feels high). The negative consequences include impaired judgment of distances, carelessness, and decreased concentration span and perceptual and motor abilities, particularly in adverse situations like bad weather or traffic. Comparisons between alcohol and marijuana influence on car accidents may be further blurred because some drivers use both drugs simultaneously.

- **Research has proven that marijuana use is physically damaging to the human body.** Research on the long-term effects of marijuana is just beginning, and conflicting studies coupled with sensational journalism add to the confusion. It is important that students understand that all the evidence on marijuana use is not yet in. Research is being conducted on the possible effects of marijuana on:
  - Male hormone levels
  - Throat and lung irritation
  - Cellular metabolism
  - The female reproductive system
  - Reducing pressure in the eyes caused by glaucoma
  - Reducing nausea in chemotherapy patients
  - Motivation in adolescents
  - Ability to learn new tasks
  - Ability to react in a different or dangerous situation
  - Memory loss
  - Body resistance to infection and disease
  - Chromosomes
  - Coordination and judgment

Research is ongoing, and it is projected that it will be 20 years before marijuana’s effects can be fully determined.

- **On the whole, marijuana is less harmful than alcohol.** This defensive attitude was one that adolescents often took in response to adult scare tactics about marijuana and other illicit drugs. In fact, long-term research and cultural experience have shown that alcohol use is physically, psychologically, and socially dangerous for millions of people. To date, there is simply not enough research information or
experience to estimate the long-term or adverse effects of marijuana use. However, it is important that young people learn how to make decisions about their own beliefs or values. Taking drugs can be an escape from adolescent "growing pains" and can increase the likelihood that the adolescent will never learn important decision-making skills.

4. Environmental Prevention (45 minutes)

The purpose of this discussion is to examine the center environment to determine which student programs, organization changes, or staff needs might reduce alcohol and drug use among students.

**Discussion:**

Distribute *Handout 7.2, Enabling Behavior*, to participants; have them read it and discuss any enabling behaviors they may have observed on center.

The single most important element in a successful TEAP is a staff that is sensitive to what are called "enabling" behaviors. There are very obvious and not so obvious ways staff can enable alcohol and drug use among students.

- **Obvious:** Actually bringing/providing alcohol and drugs to the students. This most obvious breach of ethical and legal behavior cannot be tolerated from a staff member for any reason.

- **Not so obvious:** The handout lists just a few of the not so obvious ways that staff enable students in their alcohol and drug use. The staff must become sensitive to any behavior or message that would allow the student to think that any alcohol or drug use is acceptable. In Job Corps, we use the concept of "zero tolerance" of alcohol and drug use. That does not mean we will terminate any student who is caught using but rather that all references and behaviors related to alcohol and drug use will be addressed and consistently managed by staff.

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**Categories for Center Action Plan**

- General programs for students
- Future alcohol and drug-related training
- The center's TEAP program
- Organizational changes related to alcohol and drug use

Previous Job Corps surveys have suggested general organizational areas that can affect student alcohol and drug use. These include:
• **General Programs for Students**—Suggestions for creating, expanding, or maintaining center programs that may decrease student alcohol and drug use. Examples might include developing a stronger student government, training students in peer counseling and communication skills, offering new incentives/rewards for a broader range of student achievements, and implementing a big brother/big sister plan for orientation.

• **Future Alcohol and Drug Use Training**—Recommendations regarding future training for students and/or staff on alcohol and drug-related issues. Recommendations might include improving staff skills in communication, using community resources for education training, and training new staff in drug identification and alcohol- and drug-related suspicious behavior.

• **TEAP**—Suggestions toward developing, changing, or strengthening the TEAP program. Examples might include pushing for center-wide support for a drug-free workplace, activities to heighten awareness of health and life effects, and support for a ban on tobacco use.

• **Organizational Changes Related to Alcohol and Drug Use**—Recommendations concerning policy, personnel, or physical environment changes. Recommendations might include stopping all tobacco sales on center, developing consistent and strong communication lines to all personnel regarding rules, involving students in the design and operation of alcohol and drug educational activities, and developing a more concrete and specific referral system, and increasing communication between departments regarding students’ alcohol and drug use.

---

**Exercise: Action Plan**

Distribute *Handout 7.3, Action Plan* and divide participants into four groups and have them appoint a recorder and spokesperson. Ask them to examine at least one center program which, if improved/strengthened, might curb alcohol and drug use and to make recommendations for new elements of existing programs. Ask them to fill out an action plan form for each recommendation. Have each group report their results.
**Handout 7.1**

**Self-Assessment: Effects Of Alcohol And Drug Use**

**Instructions:** Match each physical and/or psychological effect with the correct drug category by placing the letter(s) of the correct category beside each statement. Some effects may be caused by several categories.

<table>
<thead>
<tr>
<th>Physical/Psychological Effects</th>
<th>Drug Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increased body tension</td>
<td>A. Stimulant</td>
</tr>
<tr>
<td>2. Slurred speech</td>
<td>B. Depressant</td>
</tr>
<tr>
<td>3. Sense of security</td>
<td>C. Hallucinogen</td>
</tr>
<tr>
<td>4. Dilated pupils</td>
<td>D. Narcotic</td>
</tr>
<tr>
<td>5. Apparent movement of</td>
<td>E. Inhalant</td>
</tr>
<tr>
<td>inanimate objects</td>
<td></td>
</tr>
<tr>
<td>6. Lack of coordination</td>
<td></td>
</tr>
<tr>
<td>7. Decreased appetite</td>
<td></td>
</tr>
<tr>
<td>8. Giddiness/lightheadedness</td>
<td></td>
</tr>
<tr>
<td>9. Increased sense of ambition</td>
<td></td>
</tr>
<tr>
<td>10. Relief form physical pain</td>
<td></td>
</tr>
</tbody>
</table>

**REMOVE KEY FROM PARTICIPANT HANDOUT**

**KEY:**

1. A  
2. B,E  
3. B,D  
4. A,C  
5. C  
6. B  
7. A,D  
8. E  
9. A  
10. B,D
Handout 7.2

Enabling Behavior

Staff members may enable students' alcohol and drug use when they allow students to continue use without confrontation. Enabling behaviors may include:

Rationalizing the student's use—“I was a user when I was in high school.” “Job Corps is so stressful.”

Avoiding the issue—“What's the big deal?”

Denying there's a problem—“I use and I can still work.”

Protecting the student—“He's such a nice kid and he really needs Job Corps.”

Protecting the student's family—“I know his mother; it would hurt her if she knew.”

Enduring the behavior—“Maybe she'll grow out of this phase.”

Becoming dependent on students' friendships—“I just want our dorm to get along.”
### Action Plan

<table>
<thead>
<tr>
<th>Steps to be Taken</th>
<th>Resources</th>
<th>Any Barriers?</th>
<th>Strategies to Overcome Barriers</th>
<th>Who is Involved?</th>
<th>How Long?</th>
<th>By Whom?</th>
</tr>
</thead>
<tbody>
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MODULE 8: SUPERVISION
Module 8: Overview

Supervisory personnel at Job Corps centers are expected to monitor, counsel, coach, evaluate, discipline, and motivate their staff members. This module is designed to help supervisors better understand the theory and dimensions of their role. The module relies on management styles theories. Through discussions and role plays, participants will have an opportunity to examine supervisory styles for productivity and stress levels, job motivational techniques, feedback systems, and strategies for constructive evaluations. Additionally, participants will practice a model for solving work unit problems.

Module 8: Objectives

At the close of this training module, participants will be able to:

- Recount three types of leadership styles
- List three characteristics of each supervisor and employee response style
- Recognize one positive and one negative consequence of using a specific supervisory style
- Demonstrate a supervisory intervention in response to a staff or student behavior problem

Module 8: Lecture and Discussion

<table>
<thead>
<tr>
<th>Content</th>
<th>Process</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision in Job Corps</td>
<td>Lecture</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Leadership Styles</td>
<td>Lecture/Handout</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Supervisor and Employee Response Styles</td>
<td>Lecture/Discussion/Role Play Exercise</td>
<td>35 minutes</td>
</tr>
<tr>
<td>Guidelines for Supervisor Interventions</td>
<td>Lecture/Small Group Exercise</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

1. Supervision in Job Corps (5 minutes)

Supervision can be defined as the set of activities that motivate and channel employees' energy toward individual and organizational goals. The supervisor is an important element of any organization since he/she has the responsibility to help transform human potential into human achievement. The supervisor has the power to encourage individual ability, creativity, and cooperation, or to condone self-indulgence, isolation, and conformity.
Supervisors fill a large role in the Job Corps setting, which has a number of management levels and provides many services. Since the goal of Job Corps is to produce vocationally competent and self-sufficient young adults, almost every staff member on center has some supervisory functions. Supervisors must continually monitor, analyze, and help those working under them so that they can adapt to issues such as a new administrative directive, a change in physical plant maintenance priorities, or the effects of new food service schedules. Supervision is a stressful task in any organization; in Job Corps, it is an especially demanding and diverse one.

During this session, we will examine the influence of certain supervisory styles on staff and students. At the middle management level, supervisors can facilitate the development of new work skills by providing employees with job-related experiences that allow for achievement, recognition, increased responsibility, and advancement. Front-line student supervisors (residential advisors, recreation staff, etc.) can also be catalysts for successful student growth. Supervisory skills that promote sharing some adult responsibilities with students, guiding without controlling students, and giving students the opportunity to make mistakes allow adolescent students to develop independence.

2. Leadership Styles (10 minutes)

Certain leadership styles can either encourage independent action or reinforce conformity and dependency. A number of supervisor/adult leadership styles are listed in Handout 8.1, Leadership Styles. We will examine three major categories of leadership styles (autocratic-authoritarian, permissive, and democratic) and how these affect an adolescent's productivity and mental health.

<table>
<thead>
<tr>
<th>Leadership Styles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autocratic-Authoritarian</td>
</tr>
<tr>
<td>Permissive</td>
</tr>
<tr>
<td>Democratic</td>
</tr>
</tbody>
</table>

**Autocratic-Authoritarian**

- Adolescents describe authoritarian parents as the least happy group of parents.
- In task situations, subordinates with autocratic leaders have the lowest production rate when the leader is absent. Scapegoating and absenteeism is the highest for this group.
- Adolescents in an authoritarian environment feel the least conflict and are the most dependent on others' rules.
**Permissive**

- Adolescents from permissive environments have greater confidence in their decision-making ability than adolescents from authoritarian environments.
- These youth are also more likely to be irresponsible and avoid leadership roles than their peers from a democratic setting.

**Democratic**

- Workers in democratic environments have the highest sense of group cohesion and personal security.
- Adolescents’ sense of confidence and independence is highest in a democratic environment.
- Cooperation among adolescents is highest in a democratic environment.
- Adolescents display the highest level of originality and creativity in problem-solving situations, which are prevalent in democratic environments.
- Self-esteem is highest among people in democratic environments.
- When workers are involved in the creation of a product, they show the highest degree of satisfaction with their work.
- In military studies, individual morale is highest in democratic units that stress involvement, support, and officer/peer cohesion.

Several factors help to explain these results. First, subordinates with a democratic supervisor are more likely to identify positively with the individual and want to emulate him/her. In terms of an adolescent’s development, democratic adults provide models of independence that an adolescent can easily practice in a democratic environment. Finally, democratic supervisors give workers more opportunity to control the work environment and, therefore, to become more confident in their decision-making abilities.

3. **Supervisors and Employee Response Styles (35 minutes)**

There are supervisor initiation styles that parallel leadership roles. As we explore these supervisor initiator roles and employee response styles, it is important to note that we are presenting stereotypes and ideal forms. Each category represents an exaggeration since no individual is purely authoritarian or democratic in all situations. However, a supervisor’s predominant mode of interaction with employees can affect the group’s growth and cohesion, and the supervisor’s ability to teach others how to supervise.
Discussion:

Distribute *Handout 8.2, Three Supervisory Styles*, and *Handout 8.3, Three Employee Roles*. Allow time to read over the handouts and ask participants to identify other characteristics of individuals who are authoritarian, egalitarian, or eclectic supervisors and rejector, acceptor, and eclectic employees.

Exercise: Leadership Styles

Divide participants into small groups. Ask each group to create a scenario in which a supervisor (RA, teacher) is dealing with a conflict occurring among staff members or between students and staff members. Have participants focus on the interactions between supervisor/employee styles by developing scenarios involving:

- An authoritarian supervisor and eclectic employees
- An egalitarian supervisor and rejector employees
- An eclectic supervisor and acceptor employees

Have participants refer to Handouts 8.2 and 8.3 to develop their scenarios. Ask each group to act out their scenes. Identify and discuss the perceived supervisor/employee factors that helped or hindered the resolution of conflict in each scene.

While most research has focused on the supervisor's influence on the group, it is clear that an employee’s behavior can often determine a supervisor's behavior.

4. Guidelines for Supervisor Interventions (45 minutes)

Any appropriate supervision style not only embodies work relationship values such as cooperation and mutual problem solving but also presents practical guidelines for assisting employees in changing their behavior. Supervisors routinely help their workers to change interpersonal behavior or work habits when (1) workers are doing something that negatively affects departmental or center goals, or (2) workers need to learn new and/or more appropriate work skills.
Guidelines for changing behavior are:

- **Initiate the communication**—Supervisors are responsible for starting the change process but should encourage the employees to share in deciding where and when the intervention will take place.

- **State your concern**—When addressing workers, be descriptive and include a statement on your feelings about the issues. Indicate why intervention is necessary at this time.

- **Involve employees in the solution**—Statements or questions that involve workers in the solution increase the chances that the proposed solution will be implemented. Individuals are significantly more likely to change behavior permanently when they feel involved in the decision-making process.

- **Ensure that you are satisfied with the solution**—While you should enter into the negotiation phase with an open mind, it is equally important that the outcome of the negotiation is satisfactory. Be aware of the minimum change you expect beforehand. If the worker cannot or will not define a mutually acceptable solution, be prepared to carry your intervention to its logical consequences.

- **If employees resist, shift to active listening**—Active listening and other positive communication skills show workers that they are being heard and that you are considerate of the feelings associated with the issue. Once the worker has expressed these feelings and believes that the supervisor has heard him/her, problem solving is easier. Eventually, however, the supervisor and the employee(s) must find a solution that is satisfactory to the supervisor.

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3 This unit can be expanded with a demonstration or exercise on positive communication skills, especially active listening.
**Exercise: Supervisor Intervention Case Studies**

Divide participants into two small groups and assign one supervisor intervention scenario from *Handout 8.4, Supervisor Intervention Case Studies*, to each group. Each group should develop an action plan to address the behavior. Have each group select a reporter who will record the detailed action plan and report to all participants. Allow approximately 35 minutes for this exercise—20 minutes for group brainstorming, and 15 minutes for reporting results.

**Discussion and Wrap-Up:**

Review the sessions’ objectives and ask participants if they have any questions or comments.
## Handout 8.1

### Leadership Styles

<table>
<thead>
<tr>
<th>Style</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Autocratic</strong></td>
<td>No allowance is made for employees to express their views on a subject or to assert leadership or self-initiative.</td>
</tr>
<tr>
<td><strong>Authoritarian</strong></td>
<td>Although employees are allowed to suggest solutions to problems, the supervisor always decides issues according to his/her own judgment.</td>
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<tr>
<td><strong>Democratic</strong></td>
<td>Employees contribute freely to discussion of issues relevant to their roles, and may even make their own decisions; however, the final decisions are either formulated by the supervisor or meets his/her approval.</td>
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<tr>
<td><strong>Egalitarian</strong></td>
<td>This type of structure represents minimal role differentiation. Supervisors and employees are equally involved in making decisions pertaining to the employee’s tasks.</td>
</tr>
<tr>
<td><strong>Permissive</strong></td>
<td>Employees assume a more active and influential position in formulating decisions that concern them than does the supervisor.</td>
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<tr>
<td><strong>Laissez-faire</strong></td>
<td>The employee’s position in relation to their supervisor in decision-making is clearly more differentiated in terms of power and activity. In this type of relationship, employees have the option of either subscribing to or disregarding the supervisor's wishes in making their decisions.</td>
</tr>
<tr>
<td><strong>Ignoring</strong></td>
<td>In this style of supervision (if it can be called a style), the supervisor has become divorced from directing the employee’s behavior.</td>
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</table>
Three Supervisory Styles

Authoritarian Supervisor—Authoritarian supervisors assume that they are primarily responsible for making sure forms are completed, deadlines are met, and the organization runs smoothly. They view employees as human tools for helping them get their tasks done. They do not actively interact with their workers; rather, they direct, order, and require employees to perform tasks. To force compliance to their will, they do not hesitate to point out weaknesses, failures, or deficiencies of their workers, even in the presence of others. Some authoritarian supervisors wear their authority as a threat and routinely coerce or humiliate employees who fail to meet their standards. Other authoritarian supervisors use their status to invoke special access to top management decisions to gather special knowledge of an organization's policy as a means of dictating their employees' behavior.

Egalitarian Supervisor—Egalitarian supervisors are sensitive and aware of the problems faced by their employees. They put themselves in the employee's place and seek to be a source of companionship, advice, and support for their workers. The egalitarian supervisor often works with employees as equals getting them to help him/her complete a task. The egalitarian supervisor will often take responsibility for finishing a given group or individual task. Employees come to the egalitarian supervisor for advice or assistance in many areas of their lives. Egalitarian supervisors will protect and support their workers even if it means covering up and/or violating organizational regulations. They may behave according to the perceived peer group value system rather than the organization's official policy.

Eclectic Supervisor—The eclectic supervisor is fundamentally concerned with getting his/her job done. When required, he/she is firm and directive. At other times, he/she is a listener and advisor. The eclectic supervisor is systematic, objective, and candid, and assumes that employees are neither servants to be directed nor friends to be protected. The eclectic supervisor relates to employees using different approaches in various settings while helping them with goal setting, situational problems, training needs, and other employee duties.
Handout 8.3

Three Employee Roles

**Rejector Employee**—These are employees who alone, or in groups, take actions and adopt attitudes that reject the authority of the supervisor and the rules and regulations of the organization. They often fail to perform necessary tasks, and tasks that are completed are done reluctantly and require continuous supervision. Many rejecters are argumentative. When in groups, they do not actively oppose supervisors but simply fail to do what is required and withdraw from participating in group meetings or one-to-one sessions.

**Acceptor Employee**—These employees seek to comply with the rules of the organization, but more often try to satisfy the supervisors, and in general actively try to conform to the authority of the staff. Acceptors seek to avoid conflict with supervisors and will seek to justify rules, policies, and decisions of supervisors, even rules, policies, and decisions, that seem to have no obvious purpose for justification.

**Eclectic Employee**—Eclectic employees are neither acceptors nor rejecters. They try to get along with supervisors while maintaining good relationships with both acceptors and rejectors. Eclectics are usually goal-oriented, emotionally mature, and get the job done. They avoid situations that can lead to hostility or conflict whenever possible.
Supervisor Intervention Case Studies

Scenario 1

You are meeting with one of your employees who has arrived late to work 6 days in the last 3 weeks (between 15 and 20 minutes). Based on the guidelines for supervisor intervention, describe your action plan; include the rationale for addressing this behavior.

Scenario 2

You are a recreation specialist and basketball team coach and are meeting with a student who continually initiates an argument with other team members. This behavior is disruptive to the basketball team. Based on the guidelines for supervisor intervention, describe your action plan; include the rationale for addressing this behavior.
MODULE 9: MENTAL HEALTH STANDING ORDERS
Module 9: Overview

Mental health standing orders are an integral part of a center’s mental health problem prevention strategy and maintenance of employability and wellness. These standing orders allow nonhealth staff to recognize the primary signals of psychological distress, to distinguish between non-urgent, urgent, and emergency mental health situations, and to take appropriate courses of action.

This is an advanced session designed for nonhealth staff who have received previous standing orders training. Participants will have the opportunity to review and practice using the Standing Order NH 18: "The Management of Possible Mental Health Problems," and Standing Order NH 26: "The Management of Alcohol and Other Drug Use" and to discuss center policy and procedures for referral and documentation of mental health (including alcohol and drug use) problems.

Module 9: Objectives

At the close of this training module, participants will be able to:

- Describe the key elements of technical standing orders
- Demonstrate their ability to use Standing Orders NH 18 and NH 26
- Describe the center’s policy for referral and record keeping concerning possible mental health problems

Module 9: Lecture and Discussion

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<td>Lecture/Discussion/ Exercise/Feedback</td>
<td>45 minutes</td>
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<tr>
<td>Record System</td>
<td>Lecture/Discussion/ Exercise</td>
<td>45 minutes</td>
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1. Review of Technical Orders (45 minutes)

As you know through experience, standing orders are an integral part of the center's preventive health program. Today we will examine the Standing Order NH 18: "Management of Possible Mental Health Problems" and NH 26: "The Management of Alcohol and Other Drug Use," which were developed for nonhealth staff. These orders will help you recognize the primary signs of psychological distress and alcohol and drug use. These orders can be found in Technical Assistance Guide (TAG) Q: Standing Orders.

Before we consider the specific content and procedures outlined in NH 18 and NH 26 (Handouts 9.1 and 9.2), let's review briefly the general characteristics of all technical orders using NH 18 as an example. Technical standing orders take the form of an
algorithm with accompanying narrative notes. (An algorithm is a step-by-step diagrammed method for addressing a problem.) Symptoms are organized according to level of severity and range from the most severe symptoms requiring emergency (immediate) action to those symptoms that can be simply handled by the nonhealth staff within 24 to 48 hours (routines or non-urgent).

**Discussion:**

Ask participants to refer to the NH 18 and NH 26 algorithm format as you describe the key elements of a standing order. Ask participants to look at the specifics of the algorithms and their accompanying narrative as you lead them through emergency, urgent, and non-urgent situations. Invite questions concerning the NH 18 and NH 26 algorithm format and narratives. Refer to NH 5: "Referral of Students to Nurse, Physician, Hospital, or Consultant" for guidelines to follow when a student is sent to the emergency room (Handout 9.3).

Key elements in algorithm format including the following:

- The title appears in bold type in a solid-line box.
- The name of the Job Corps center is entered in the blank space at the top.
- Questions concerning the most serious symptoms and signs begin at the top of the algorithm. Questions concerning less serious symptoms are toward the bottom of the algorithm.
- With a "No" answer to these questions, movement continues down the left side.
- With a "Yes" answer, movement crosses the page toward the right side.
- Each situation is labeled as an emergency, an urgent problem, or a non-urgent problem. If there is no label, consider the situation non-urgent.
- Disposition boxes list, in order of priority, the way to handle an emergency, urgent problem, or non-urgent problem. Follow the steps in order.
- Whenever a student is sent to the emergency room, refer to the guidelines described in NH 5, "Referral of Students to Nurse, Physician, Hospital, or Consultant."
- Further details about how to recognize a symptom or take a specific action are described in the accompanying narrative and are identified by a lower case letter (a, b, c, etc.) beside the symptom question or action in the disposition box.
• In the lower right margin is a space for the date and the signature of the center physician, dentist, or mental health consultant who reviews and approves the order for center use.

Standing Order NH 18 is a technical order for nonhealth staff that summarizes possible mental health problems and corresponds to H 18 a-b-c, which is a technical order for health staff on possible mental health problems. NH 26 summarizes problems related to alcohol and drug use and corresponds to H 26, which is a technical order for health staff on possible alcohol and drug use problems.

**Exercise: Using Standing Orders/Discussion**

Conduct role play exercises based on NH 18 and NH 26. Ask for two volunteers to depict a psychiatric emergency, two volunteers to simulate an urgent (but not emergency mental health problem) and two volunteers to simulate a non-urgent mental health problem and two volunteers to work through some drug-related behavior. Volunteers should develop a role-play scenario using symptoms addressed in NH 18.

After processing the role plays, elicit participants' experiences in using standing orders and focus the discussion on the points below:

• The need for all nonhealth staff to know center policy and procedures as they relate to this standing order, especially center policy concerning emergency room procedures, transportation, logistics, dispensary hours, etc.

• The need to be familiar with the orders so that decisions can be made without reading in front of the student

• The need to listen to what the student is saying and to observe student body language (verbal and nonverbal communication)

• The process of referral and communication to the health staff (having copies of the center's forms related to referral for biochemical testing, incident reports, counseling referrals, etc. is recommended)

• The importance of writing accurate records and maintaining these records in the student's health folder
2. Record System (45 minutes)

To afford continuity and quality of care for students, the health staff should be made aware of all student health problems addressed by the nonhealth staff. This information should be forwarded to the health staff and included in the health record. To accomplish this, all responsible persons must adhere to a system for recording all health encounters.

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<tr>
<td>Communication/Documentation System</td>
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<td>Five Basic Elements</td>
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<td>• Consistency</td>
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<td>• Promptness</td>
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<td>• Confidentiality</td>
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<td>• Written Documentation</td>
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<td>• Periodic Review</td>
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The basic elements of a communication/documentation system are:

- **Consistency**—All staff should use the same system.

- **Promptness**—Information should be transmitted to the health staff within 12 to 24 hours (immediately for emergency situation).

- **Confidentiality**—The system for documentation and transmission of information must ensure confidentiality so that uninvolved staff and other students do not have access to this information.

- **Written Documentation**—To ensure that health problems are accurately identified and followed, all encounters must be entered in the health record. It is recommended that the nonhealth staff member describe the encounter to a health staff who will then enter the information into the medical record using the S.O.A.P. note format. Nonhealth staff should not make notes directly into the health record to help maintain confidentiality.

- **Periodic Review**—Health records should be reviewed periodically to ensure the provision of comprehensive care (necessary services provided at appropriate intervals, follow-up activities conducted when indicated, appropriate referrals made, and action taken as requested by specialists).

Health staff should document information in S.O.A.P. note format. It is also helpful for nonhealth staff to learn about S.O.A.P. notes in order to help communicate important information to health staff.
S.O.A.P. NOTES

Subjective
Objective
Assessment
Plan

- **Subjective**—The "S" stands for subjective reports, that is, what the student tells you about the history of the present illness. For example: Where does it hurt and for how long? How did it happen? What makes it feel better?

- **Objective**—The "O" stands for objective observations that is, what you can see or measure. For example: What is the student's blood pressure or temperature? Does the student have redness, swelling, stiffness, etc.? Does the student appear withdrawn, depressed, angry, irritable etc.

- **Assessment**—The "A" stands for assessment, that is, how you analyze the subjective and objective observations, after consulting the appropriate standing order. For example, does the student appear suicidal, anxious, or depressed or under the influence of drugs or alcohol.

- **Plan**—The "P" stands for plan, that is, what you intend to do about it. For example, you can obtain additional information, recommend treatment, or educate the patient. For nonhealth staff it might be a plan of who you will notify, when, and how the notification will take place.

While this record system is recommended for Job Corps use, other systems are acceptable as long as they are used consistently by all the staff and allow for prompt communications, written documentation, and confidentiality. The use of standing orders by the health and nonhealth staff will facilitate consistency in health problem assessment and treatment. Documentation and communication of all health encounters will ensure continuity in the provision of health care.

**Exercise: S.O.A.P. Notes**

Distribute *Handout 9.4, S.O.A.P. Notes*. With participants, complete a S.O.A.P. note based on information in NH 18. Stress that, in addition to a telephone call to the health and wellness manager, this S.O.A.P. note provides written documentation by the residential advisor of the situation that the nurse can incorporate in the permanent health record.
Handout 9.1

Note to CMHC: Reproduce Standing Order NH 18: "The Management of Possible Mental Health Problems" from TAG Q: Standing Orders, and distribute to participants.

Handout 9.2

Note to CMHC: Reproduce Standing Order NH 26: "The Management of Alcohol and Other Drug Use" from TAG Q: Standing Orders, and distribute to participants.

Handout 9.3

Note to CMHC: Reproduce Standing Order NH 5: "Referral of Students to Nurse, Physician, Hospital or Consultant" from TAG Q: Standing Orders, and distribute to participants.
Handout 9.4

S.O.A.P. NOTES

Instructions: Refer to Standing Order NH 18 to complete the S.O.A.P. notes.

Scene: RA is called in the night to see a student whose behavior, according to roommates, is very strange.

S: Student says, "There is no sense in continuing here...nothing is right...nothing has been right since my brother was killed."

O: RA observes that student is crying and appears very agitated.

A: 

P: 

Signature _______________________________   Date_________________
MODULE 10: SEXUALITY AND SAFER SEX PRACTICES
Module 10: Overview

Since sexuality is one of the predominant issues in adolescent development, it is important that staff be aware of their own values and feelings about sexuality and student sexual attitudes and behaviors. Without such staff awareness, students may lose a vital opportunity to understand their own sexuality, to tolerate different sexual styles, to take responsibility for their own sexual conduct, and to practice safer sex practices.

This module highlights the physiological and psychological factors related to sexual development in adolescents and young adults. The presentation encourages participants to rediscover and discuss their own early sexual feelings. Participants will examine their attitudes and center policy on issues such as public sexual behavior, sexual assault, masturbation, homosexuality, bisexuality, promiscuity, HIV-infected students, and safer sex practices.

Module 10: Objectives

At the close of this training module, participants will be able to:

- Recognize their personal sexual development and how their individual experiences relate to their views of students' sexual behavior
- List helpful hints for making the discussion of safer sex practices easier
- Relate Job Corps center policy concerning student sexual behavior to students

Module 10: Lecture and Discussion

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<th>Time</th>
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<td>Introduction</td>
<td>Lecture/Guided Group Exercise</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Student Sexual Behavior</td>
<td>Value Statement Exercise</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Talking To Students About Safer Sex Practices</td>
<td>Lecture/Brainstorm/Demonstration</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Job Corps Policy</td>
<td>Discussion</td>
<td>15 minutes</td>
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</tbody>
</table>

1. Introduction (20 minutes)

Sexuality is probably the most talked about feature of adolescent development. Youth are sometimes confused and often excited by it. Males and females go through hormonal changes, begin to feel new sensations, and experience physical changes such as genital development, menstruation, and ejaculation. In this session we will examine sexual attitudes and discuss some aspects of student sexual behavior on
center. However, at this point it might be helpful to review some of our own adolescent feelings about sexuality.

**Exercise: Adolescent Sexuality**

Instruct the participants to lean back, adjust their sitting positions, and become as relaxed as possible. Ask them to close their eyes and recall their own adolescence.

Suggest a few topics and ask participants to recall (silently) what they thought about these topics when they were adolescents. Give them a minute or two to recall their feelings about each of the following topics:

- The opposite sex
- Their own bodies
- What parents told them about sex
- Seeing their parents show affection for each other

Instruct the participants to open their eyes and ask for volunteers to state what word associations or thoughts they were aware of for each topic. List the words on an easel pad.

In summarizing, note the contrast between the intensity of their sexual feelings during adolescence and lack of modeling and positive sex information that they received from their parents.

2. Student Sexual Behavior *(25 minutes)*

We all have views and attitudes laden with values that guide our own sexual behavior. As staff, we must recognize that we may communicate our values to students in a way that clashes with their own values. Therefore, each encounter with a student regarding these values must be carefully managed. The first step in learning how to manage these encounters is to examine some value-laden statements about sexual behavior and discuss our reactions to them.
**Exercise: Student Sexual Behavior**

Divide participants into six groups. Ask each group to discuss their reactions to one of the six pairs of statements from a “pro” and “con” perspective. Give examples of how holding values could both help or hurt a student by the way it is communicated. Ask each group to choose a recorder who will report the main issues of their discussion to the entire group. Allow for total group discussion of each topic.

1. "My church teaches that extramarital sex is sinful."
   
   "We have to be realistic; they’re going do it anyway so it’s better if they know enough to protect themselves."

2. "It’s our responsibility to teach these kids self-discipline—and that includes sex."
   
   "I don’t care what they do as long as I don’t catch them!"

3. "I caught this kid masturbating!"
   
   "That’s none of your business."

4. "The rule says no sex acts on center. If I catch them at it, they’ll be terminated."
   
   "I think the rules have to bend a bit; it might be pretty hard not to slip once in a while."

5. "We can't allow homosexuality on this center!"
   
   "Hey, sexual preference is a person’s private choice and right."

6. "I’m angry that HIV-infected students are allowed in Job Corps."
   
   "HIV-infected students can live many years and they need job training to work and pay taxes."

3. **Talking To Students About Safer Sex Practices (30 minutes)**

In an era of STDs, AIDS, and hepatitis B, all staff need to encourage safer sex practices. Yet not all staff may be comfortable enough to teach safer sex practices. Suggestions for making discussions with students easier include the following:

- Know/ask what the student calls body parts and sexual practices.
• Help the student learn the correct names of body parts and sexual practices.

• Have a supply of unlubricated condoms in your desk drawer for demonstration purposes.

• Have a supply of good-quality, latex, lubricated (nonoxynol-9) condoms available for free distribution, no questions asked. (Distribute unlubricated condoms for oral sex.)

• Have a supply of latex gloves available for free distribution (for genital stimulation).

• Make sure both male and female students understand that (1) they must avoid all contact with their partners body fluids—semen, blood and vaginal fluids—and that the safest practice is to abstain from all sexual contact.

**Exercise: Brainstorm**

Ask participants to:

• List street/student names for body parts.
• List street/student names for sexual practices.
• List the correct names next to the street/student names. Be sure to cover intercourse, male and female genitalia, oral sex, heterosexual sex, and homosexual sex.
• Practice saying the words together as a group.

**Demonstration:**

Pass out a nonlubricated condom to each staff member and have them open the package, stretch the condom, try to break it, and generally become familiar with it. A dildo (obtainable from adult book stores) can be used to demonstrate correct condom placement. Make the following points about using a condom:

• Put a condom on a firm, erect penis—this can be part of foreplay.
• Roll the condom all the way down to the base of the penis leaving room at the top end for the semen during ejaculation.
• Withdraw the penis soon after ejaculation, holding onto the bottom end of the condom to prevent leakage.
• After the condom is removed, tie it off, and dispose of it.
• Only use a condom one time.
Discussion and Wrap Up:

As a final activity, ask participants to spend time examining and evaluating the Job Corps policy concerning student sexual behavior. Ask them to review Handout 10.1.

During the discussion, highlight recommendations which are especially relevant to center concerns or staff-student dynamics. At this point, participants should be encouraged to question, discuss, or comment on any conflicts between their private values and the Job Corps policy that they are being asked to implement.

As a final exercise, participants should identify those policies that are not being implemented on center and make specific recommendations for implementation.
Handout 10.1

Adolescent Sexuality
Suggested Practices and Guidelines

- Make latex condoms and gloves available to students for free from health services.
- Be fair and open-minded, even when it stretches your own personal value system.
- Ideally, rules and regulations should assure that behavior is acceptable and comfortable for students, staff, and the community. To achieve this ideal, a thoughtful program built upon the cooperation of all staff is necessary. It will not just happen.
- Not all of us are equally able to discuss sexuality effectively with others. The ability of all staff should be upgraded through staff training in sexuality and counseling skills. This training is particularly important for RAs, career counselors, health education instructors, recreational supervisors, and health and wellness service personnel.
- Counseling should not be moralistic or judgmental. It should include a free sharing of opinions, attitudes, and information.
- Staff and student training should include use of outside resources and speakers who deal with such topics as developing communication skills, sexuality, homosexuality, bisexuality, rape, STDs, AIDS, contraception, abortion, and pregnancy.
- Student education should provide the students with an opportunity to understand their own sexuality and to learn about the variety of sexual lifestyles. It should also encourage tolerance for the diversity of sexual lifestyles. Student education on sexuality should be a part of the Health Education Program, the Cultural Diversity Program, and dormitory rap sessions.
- Students have the right to choose their sexual lifestyles and must learn to express those lifestyles in a manner that allows them to live and work successfully within the community.
- Each center must formulate rules that set guidelines for acceptable behavior. The following guidelines for developing rules are recommended:
  - Rules and the consequences for breaking them should be clearly and accurately stated so all concerned can understand them.
  - Rules should be the same for heterosexual and homosexual activities.
  - Staff members should agree on what constitutes a rule violation so that the same actions are encouraged, discouraged, or punished by all staff.
  - In general, rules should be designed with the broadest possible definition of responsible sexual behavior in mind. That is, are those involved consenting, aware of, and willing to accept the consequences, and respectful of the rights of others around them?
MODULE 11: CONFLICT MANAGEMENT
Module 11: Overview

This module addresses physical and verbal violence. Unfortunately, verbal and physical fighting appear to be an inevitable part of social and interpersonal behavior. Thus, it is important that people learn to manage conflict in a productive, positive manner and that the more destructive and negative forms of conflict be prevented or redirected.

This module will introduce participants to a problem-solving model for conflict management. The model explores intervention in physical fights, and repeated verbal arguments, and include a discussion of conflict mediation. Although the focus is on conflict between students, many of the skills can be applied to student-staff conflict or staff-staff conflict.

Module 11: Objectives

At the close of this training module, participants will be able to:

- Describe four major steps for conflict intervention
- Recommend strategies for conflict prevention on center

Module 11: Lecture and Discussion

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<td>10 minutes</td>
</tr>
<tr>
<td>Conflict Intervention Model</td>
<td>Lecture/Role Play Exercise/Discussion</td>
<td>35 minutes</td>
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<tr>
<td>Conflict Prevention</td>
<td>Discussion/Action Plan Exercise</td>
<td>45 minutes</td>
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1. Seeds of Conflict *(10 minutes)*

The source of much conflict lies in the perception of a threat, or the frustration of unmet needs or expectations. Some of the behaviors you might see on center that reflect a source of conflict include:

Suggested Overhead 11.1

**Student Behaviors: Sources Of Conflicts**

- Manipulating
- Stereotyping
- Humiliating
- Segregating
- Scapegoating
- Coercing
- Fighting
Manipulating Students—"Setting up" other students; making someone look foolish, stupid, or ignorant; duping someone into behaving in ways not in his/her best interest; giving misleading or partially incorrect information

Stereotyping Other Students—Putting or keeping other students in an unfavorable position by use of stereotypes and negative labels

Humiliating Other Students—Talking down to other students; belittling their accomplishments; acting superior, making fun, "bad-mouthing," or criticizing

Segregating Other Students—Ignoring other students; isolating or refusing to include them in activities based on characteristics such as sex, class, race, ability, interest, etc.

Scapegoating Other Students—Blaming a particular student or group of students for all the problems experienced; letting a particular student "own" all of the unacceptable thoughts and feelings of the group

Coercion of Other Students—Interacting with other students using threats, browbeating, "shaking down," or intimidation

Fighting with Other Students—Engaging in heated verbal arguments or physical fights.

Discussion:
All of these behaviors are conflicts in and of themselves. Those that do not involve physical aggression can become the source of physical aggression. Ask participants if there any other triggers which might commonly lead to student violence?

2. Conflict Intervention Model (35 minutes)

The conflict intervention model begins with intervention in a physical fight or heated verbal argument and moves through conflict mediation. Not all parts of the model will apply to all situations. At the end of the presentation of the model, we will discuss some techniques you might use.
### Conflict Intervention Model

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**CONSIDER**
- Assess the safety of the situation. Decide on action.

**ACT**
- Intervene to separate the combatants.

**LISTEN**
- Find out the facts. Cool students down.

**MEDIATE**
- Help to resolve the cause of the conflict.

### Step I: Consider

1. Consider the seriousness of the situation. Is it a violent fight or a heated argument?

2. Determine the safety of the situation. Are there weapons? How many students are involved?

3. Decide if you need help in approaching the situation and the best source of that help. Do you need help from other staff, other students, or security?

In deciding whether you can handle it alone, you might need to consider your role and degree of authority, credibility, and rapport with the students who are fighting.

### Step II: Act

1. Approach the students and separate them.

2. Use a calm, firm manner and voice.

3. Do not use unnecessary force or verbal abuse.

4. Avoid language that would lower the students’ dignity or self-pride or cause them to lose face.

5. Get medical attention if necessary.

6. Disperse any crowd.
7. Place fighting students out of each other’s sight and hearing.

**Step III: Listen**

1. Calm the students down. They may need to express their feelings and to calm down emotionally and/or physically.

2. Do not take personal offense at what is said. (The person is temporarily out of control.)

3. Determine the cause of the dispute. What are the real issues?

4. Determine what each person contributed to the dispute.

5. Find out if there is a history of conflict between the disputants.

6. Determine whether or not you should mediate the dispute. Are the issues really between the two students or is it a case of misplaced anger? What are the consequences of not working it out? Do the combatants wish to work it out? What would constitute resolution for each combatant? If the determination is to mediate, bring the two sides together.

**Step IV: Mediate**

1. Let each student state what he/she sees as the basic issue and its effect on him/her.

2. Check for underlying feelings. Allow students to express their feelings but make certain that their anger is under control.

3. Have students describe their behavior. Do not allow them to make judgments or to blame/label the other person.

4. Have the students describe the outcome they want. What do they want from the other student, from the situation?

5. Ask each student what he/she is willing to do to help resolve the conflict.

6. Together, develop alternative solutions.

7. Choose the best alternative and have students contract with you and each other.

8. Make a plan for what will happen if the contract is broken.

In incidents where the students have no previous history of fighting and are not likely to argue again, there may not be a need for mediation. In these cases, Step IV will be
"Move On," rather than "Mediate." For disagreements where Steps I and II are not necessary, you can start with Steps III and IV.

Remember that when dealing with angry people their perceptions are often inappropriate. Anything a staff member says is likely to be distorted, so be patient. Be aware of some of the underlying reasons for overt anger, such as frustration of a need or goal.

**Exercise: Intervention and Mediation**

Divide participants into two groups. Ask each group to design and perform a hypothetical intervention and mediation for one of the two role-play scenarios in *Handout 11.1, Role Play Scenarios*. Following the role plays, process the presentations by posing the following questions:

- How was the situation handled?
- What were the important crisis management or mediation issues?
- How would other staff members have handled the situation?
- At what point could the situation have deteriorated?
- Should a referral have been made?
- What about followup care?

3. **Conflict Prevention (45 minutes)**

It is unrealistic to think that all forms of destructive or negative conflict can be eliminated on center. However, substituting more acceptable strategies for managing conflict can reduce the number and severity of destructive encounters. The strategies may be implemented through floor/dorm meetings, leadership programs, buddy systems (big sister/big brother), group counseling sessions, student government, etc.

**Discussion:**

Ask participants to recommend strategies that might prevent or reduce the conflict situation in the previous two role-play scenarios. Pass out list of strategies in *Handout 11.2, Conflict Prevention Strategies*. 
**Exercise: Action Plan**

Ask participants to come to a consensus about one or two strategies from *Handout 11.2, Conflict Prevention Strategies* to be implemented or expanded on center and, as a group, develop an action plan (*Handout 11.3, Action Plan*) for implementation of the strategies.
Handout 11.1

Role Play Scenarios

Scenario I

A residential staff member confronts a moderately drunk student who is disturbing other students just prior to lights out.

Scenario II

A staff member (RA, career counselor, recreation specialist, etc.) has learned that the leaders of two antagonistic student groups are planning to fight it out on the playing field later that evening. The staff member brings the opposing students together in his/her office.
Handout 11.2

Conflict Prevention Strategies

- Involve students in developing ways to reduce and manage conflict.
- Find ways to substitute discussion sessions for physical encounters.
- Hold training sessions to help students acquire the necessary skills and competencies to manage their own conflicts.
- Arrange student rap sessions on problems, causes of tension, and frustrations that lead to conflict.
- Use mutually accepted peers in mediating disputes between students.
- Arrange routine and ongoing discussions of racial, ethnic, and sexual differences among students.
- Develop a program for helping students to become aware of the impact of their behavior on others.
## Action Plan

<table>
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<tr>
<th>Strategies to be Implemented or Expanded</th>
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<th>Any Barriers?</th>
<th>Strategies to Overcome Barriers</th>
<th>Who is Involved?</th>
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MODULE 12: LIFE TRAUMA
Module 12: Overview

Death, chronic illness, and major injuries are naturally occurring events that touch the lives of most adults either directly or through the experiences of family and friends. These traumas also affect a significant number of students either before or during their stay at Job Corps. Unlike adults, students often do not have the experience, personal resources, or coping skills to work through these crises effectively. This presentation identifies the potential effects that these events can have on students’ mental health and emotional development. Participants will explore the stages of the coping process and the role that staff members can play in helping students through these transition periods.

Module 12: Objectives

At the close of this training session, participants will be able to:

- Describe three phases of crisis resolution
- Recognize four types of grieving patterns
- List four staff member functions which can help a student resolve a crisis situation

Module 12: Lecture and Discussion

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1. From Crisis to Resolution (30 minutes). This section includes 2 lecture segments: Phases of Grieving and Grieving Patterns.

Individuals who are trying to cope with unexpected crises such as traumatic injury, rape, terminal illness, or death often experience loneliness and alienation. This module will examine how to help students in the aftermath of a life trauma. Many of the reaction phases and staff interventions outlined below apply to students who have suffered a recent disability or sexual assault, or whose friends/family members suffer from a terminal illness.

Dealing with a student who has lost someone close to him/her may be one of the most difficult tasks facing a crisis intervener. Sources of this difficulty may range from the fear of re-triggering feelings from your own past losses, feelings of helplessness, and a general reluctance to come to terms with issues of death, dying, and other life trauma.

To assist a student in dealing with the death of someone close, it is important to understand normal grieving reactions and to be able to assist the student in
understanding, accepting, and managing those reactions. It is important to remember that students’ reactions are colored by individual and cultural characteristics, and that not all individuals will experience all reactions.

**Phases of Grieving**

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<th>Phases of Grieving</th>
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<tr>
<td>Avoidance</td>
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<td>Reestablishment</td>
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- **The Avoidance Phase**—This phase is characteristically a desire to avoid acknowledging that the person who was loved is now gone. Depending on the nature and meaning of the loss to the individual, he/she is overwhelmed by the impact. Just as the human body goes into shock after a large enough injury, so too the human psyche goes into shock when confronted with an important loss. It is the natural reaction to the impact of such a blow. During this period, the individual may be confused and dazed and unable to comprehend what has happened.

  As recognition starts to seep in and shock starts slowly wearing off, denial immediately crops up. It is only natural for the individual to deny that such a terrible event has occurred. At this initial phase, denial is therapeutic. It functions as a buffer by allowing the individual to absorb the reality of the loss a little at a time and prevents him/her from being completely overwhelmed.

  Disbelief and a need to know "Why?" may also appear at this time. There may be an explosion of emotion from a more outgoing individual, or withdrawal or depersonalization from a more introverted mourner.

- **The Confrontational Phase**—During this highly emotional phase, grief is experienced most intensely. The shock has worn off to a great degree, and the individual recognizes that there is a loss. Denial and disbelief may still occur, but a host of new reactions arise as the individual conforms to the loss and its implications.

  Anger is a natural reaction that occurs when an individual loses someone or something that is valued. Unfortunately, our society does not deal very well with anger and frequently the mourner and those trying to console the mourner have difficulty acknowledging and accepting this very natural and expected emotion. This anger is often displaced onto other people, often without the griever's conscious knowledge or intent. This anger may be vented at God, the doctors, the person who died, others who have not sustained the loss, and/or the bereaved self. Anger at oneself may also be the result of guilt, loss of control, or frustration.
Guilt feelings usually follow a loss. Because our relationships always contain some measure of ambivalence (i.e., some degree of negative as well as positive feelings), guilt is always a natural concomitant to loss. The griever commonly thinks about what could or should have been done.

Ambiguity is also a natural reaction to loss. In other cultures and earlier in our own society, mourning behavior was often scripted in a clear manner—wearing black clothing and avoiding social engagements for certain time periods. Today there are fewer clearly prescribed roles for mourners. This makes it difficult for the mourners to know how he/she should act or feel. This ambiguity adds more stress to an already stressful situation, and may contribute to the mourner's feelings of losing control and "going crazy."

- **The Reestablishment Phase**—This phase constitutes a gradual decline of grief and marks the beginning of the emotional and social re-entry into the everyday world. The mourner learns to live with the loss and reinvests his/her emotional energy into new persons, activities, and ideas. The old loss is not forgotten but merely put in a special place that allows it to be remembered and frees the mourner to go onto new attachments without being pathologically tied to the old.

None of the phases have a well-defined beginning or end. This third phase waxes and wanes during the latter period of the confrontation phase and continues thereafter. Guilt often accompanies the early reestablishment phase as the mourner copes with the fact that she/he must continue to live and can experience happiness in spite of the loss. For those grieving a death, this is a particularly thorny issue, as they may feel that they betray the lost loved one if they enjoy life without that person.

**Grieving Patterns**

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<td>Grieving Patterns</td>
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<tr>
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- **Normal Grief**—a stereotyped set of psychological and physiological reactions in which there are a number of responses that fit under the three general phases of avoidance, confrontation, and reestablishment.

- **Exaggerated Grief**—An abnormal prolonged grief reaction, frequently with an intensification of one or more of the manifestations of normal grief. Neurotic
features, such as undue guilt and identification symptoms, are often associated with this form of grief.

- **Abbreviated Grief**—A short-lived but genuine grief reaction due to an immediate replacement of the lost object (e.g., remarrying immediately after a spouse dies) or due to an incomplete attachment to the lost object (e.g., the individual was never really that attached to the deceased in the first place).

- **Inhibited Grief**—A lasting inhibition of many of the manifestations of normal grief, with the appearance of other symptoms (e.g., somatic complaints) in their place.

- **Delayed Grief**—Normal or exaggerated grief may be delayed for an extended period of time (up to years) especially if there are pressing responsibilities to occupy the bereaved. A full grief reaction may eventually be initiated by some event unrelated to the original loss (e.g., a pet's death can trigger a grief response for a loved one who died years earlier, but who had never been mourned because the griever felt he had to be strong to take care of other family members). In the meantime, only an inhibited form of grief may be observed.

**Discussion:**

Invite participants to briefly mention the reactions that they or other family members have had in response to the death of someone important to them. When possible, focus attention on the types and sources of support that helped the individual through this difficult period. Note especially any adolescent reactions that might differ from that of adults, (i.e., How do you think you would have reacted to your friend's death if you had been an adolescent? How do you think a student should respond in a similar situation?)

2. **Guidelines for Staff Support (45 minutes)**

As in other stressful situations, individual students will vary in how and when they respond to crises. Some students may be completely overwhelmed by the death of a significant person in their lives, while others may pass through the crisis period and show no adverse reactions. However, if the student remains on center, there are several staff interventions that should be considered alone or as part of an overall mental health management plan.

- **Active Availability**—Staff members should not wait until the student in crisis asks for help. Acute crisis are self-limiting with only a short time available to help the student positively resolve the crisis situation and learn crisis management skills. Although Job Corps promotes the development of student independence, these life
Trauma crises demand that staff members seek out and encourage the student to accept the support and help of others.

Staff members should lend practical and emotional support to the student. Staff can assist the student with logistical issues, such as travel arrangements, temporary leaves, contacting other friends or relatives as requested, and mobilization of the center mental health resources. Throughout the phases of avoidance, denial, anger, and resolution, it is essential that staff members be responsive and empathetic by initiating frequent and meaningful contacts with the student.

- **Permission to Grieve**—Adolescents are often unsure about how they should react to the death of someone important to them. This confusion is coupled with an adolescent’s tendency to be more open to suggestions during a crisis period. A staff member can facilitate the student’s progress toward resolution by encouraging the student to talk about his/her recurring feelings of confusion, pain, or helplessness. Staff support may be the catalyst that allows the student to develop new insights, behavior, and coping techniques.

- **Promotion of Peer Support**—During a crisis period, other students also may be unsure about how to relate to the student in crisis. Peer group support can help the distressed student feel less isolated and lonely.

  The residential staff can allay other students’ fears by meeting with the student and his/her roommate or residential group to share feelings about similar losses in their past or to express sympathy for the distressed student. This meeting is an important opportunity for students to learn how to give support and to better understand their own reaction to crises. The distressed student should not be pressured to speak about the incident or discuss his/her feelings beyond what is absolutely comfortable.

- **Acknowledgment of Crisis Anniversary**—For many, the anniversary of the death of a loved one can reintroduce the feelings of sadness, anger, helplessness, and loss. Often these feelings may be more intense than they were immediately after the event. Because time has elapsed since the acute crisis period, the individuals also may be less aware of the cause of their distress. In these cases, staff should be sensitive to students who may mention in passing that an anniversary of the death of a friend or family member is approaching.
Exercise: Case Studies

Divide participants into small groups and have them appoint a recorder and a spokesperson. Ask them to discuss the case studies in Handout 12.1, Case Studies on Grieving. Allow 15 minutes for each group to prepare their findings and 5 minutes to report out. In processing the case studies, ask participants to focus on the subtle symptoms of the grieving process and the interventions that would be appropriate to support students through this process.
Case Studies On Grieving

Case Study #1

The welding instructor notices that student J is frequently late for shop and appears to have little interest in his trade. He knows that the student J's mother died 2 months ago but that J wasn't very close to her and did not appear to be upset about her death.

Based upon the reactions to grief described in the lecture, formulate a list of possible reasons for student J's behavior and recommend an appropriate course of action.

Case Study #2

The center director just announced that the shop instructor was killed in an automobile accident over the weekend. What student behaviors might be anticipated?

Based upon the information on reactions to grief, what actions could the center staff take to alleviate students' grief reactions?

Case Study #3

The security guard received a call in the night from the RA, saying that student X was very combative and she was afraid that he would hurt himself or someone else. Student X had just learned that his girlfriend was killed.

Based upon the information on grief reactions, is student X's behavior a normal response? Recommend the appropriate response to his behavior.
MODULE 13: INTERGROUP RELATIONS
Module 13: Overview

For Job Corps staff, intergroup awareness means more than understanding the cultural differences between student ethnic/racial groups such as African-Americans, Whites, Native Americans, Asian-Americans, and Hispanics. It also means that staff must be sensitive to the myths, prejudices, and behaviors that adversely affect the human rights of all minority groups on center. These groups include women, homosexuals, people with disabilities, and individuals from disadvantaged areas of a city or a region.

This module provides participants with a theory of intergroup prejudice and the steps involved in the stereotyping process. Participants will examine common intergroup prejudice and adolescent development. Participants will also learn skills to decrease disharmony on center.

Module 13: Objectives

At the close of this training session, participants will be able to:

- Define the terms commonly used in intergroup relations
- Describe four causes of prejudice
- Recount three effects of discrimination
- Demonstrate sensitivity in dealing with discrimination on center
- Describe six intervention strategies that can help decrease prejudice on center

Module 13: Lecture and Discussion

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<tr>
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<td>Discussions/Group Brainstorm Exercise Lecture/Discussion</td>
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<tr>
<td>Prejudice and Discrimination on Center/Action Guidelines</td>
<td>Role Play/Exercise/Lecture</td>
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1. Terminology/Staff Experiences

Being female, an ethnic minority member, and/or homosexual imposes social pressures that can determine feelings students have about their own identity and the identity of the group to which they belong. The prejudice and discrimination, which accompany racism and sexism, are problems that have not been remedied in this country. These issues have deep roots in our history and are learned by many of us at a very early age. Yet because the concepts of racism, sexism, and other forms of prejudice are learned, they can be unlearned.
In this module, we will examine the causes of prejudice, the effects that discrimination can have on students’ development, and staff guidelines that can help students increase their understanding and tolerance of different minority groups.

**Terminology**

- **Stereotype**: Fixed mental picture of racial or ethnic group regardless of individual qualities or characteristics
- **Prejudice**: An unfavorable opinion or attitude toward a certain racial, religious, or ethnic group
- **Discrimination**: To make distinctions in treatment of people based on prejudice against them

Most people use the words prejudice and discrimination interchangeably. While the two words are closely related, there is an important difference between them. Prejudice has to do with the way you feel. Discrimination has to do with the way you act.

Prejudice is an unfavorable opinion that is formed without much thought or reason. Here are some examples of statements that show the speaker to be prejudiced:

- "I can't train her to do the job because women aren't smart enough for this work."
- "I don't like that store because it's owned by a Greek."
- "You can't expect him to know how to behave. After all, he is Mexican."

Each of these statements contains a judgment. In all three cases, however, the judgment has nothing to do with the person. It is related to the group to which the person belongs and is based on a stereotype.

A stereotype is a fixed mental picture that ignores the individual differences among members of a group. We stereotype when we assign certain qualities and reduce complicated human beings to just a few clear-cut, oversimplified personality traits. When we believe or feel that stereotypes of whole groups of people are accurate, we are being prejudiced.
Exercise: Awareness of Prejudice

Pose the following questions to participants, and have them silently recall their childhood memories on these topics. Give them a minute or two to think about each topic. Suggest that they close their eyes during this exercise to help them focused.

- What were the circumstances in which you first realized that you were from a different ethnic group than some other children?
- In your family, what were the differences that were emphasized between you and people of other ethnic groups?
- When you were growing up, what were three adjectives that described how girls should be? What were three adjectives that described how boys should be?
- In your community, what were Whites allowed to do that African-Americans or other minority groups were not allowed to do?

After the exercise, ask for volunteers to share associations, thoughts, and feelings that may have been aroused.

Discussion:

Ask participants to discuss their theories about why people are prejudiced and discriminate against others. The final list should include some aspects of the following four basic causes.

2. Causes of Prejudice, Stereotypes, Effects of Prejudice (30 minutes). This section includes three lecture segments: Causes of Prejudice, Stereotypes, and Effects of Prejudice.

Causes of Prejudice

- Economic Competition—When resources are limited, the dominant group may attempt to gain an advantage over the minority group by stereotyping that group and justifying their isolation from the economic benefits. Prejudicial attitudes tend to increase when the political and economic climate is tense and competition for jobs increases.

- Scapegoating—Aggression toward others is in part based on frustration, pain, or boredom. In the typical case, a frustrated individual feels unable to strike back directly (e.g., at a boss, at a teacher, or at the state of the economy) and chooses a
more vulnerable target to attack. The targets are usually people who appear even more helpless and powerless than the frustrated individual. Historical examples include Jews in Europe, African-Americans in this country, and Catholics in Northern Ireland.

- **Personality Needs**—A major step in childhood development includes the process of imitating and positively identifying with one's parents. If a child feels that his/her parent's love is based on the child conforming to parental prejudices, the child is likely to do so and to hold on to those prejudices into adult life.

- **Conformity to Society's Norms**—Prejudice as a result of conformity can extend beyond the family. Once begun within a society, prejudicial attitudes are difficult to change. Individuals have a great need to be accepted and supported by others. If a community norm is prejudicial toward African-Americans, Asians, homosexuals, etc., it can be difficult for an individual to openly disagree with these prejudices.

**Discussion:**

To open the second discussion on the causes of prejudice, ask participants to answer the following questions. If the group is large, divide participants into small groups and give each group one question.

- Do you think competition for jobs is related to prejudice against ethnic minorities and women? Do you have any direct knowledge or experience of this type of discrimination?

- Is scapegoating a major reason for prejudice? Do you think that scapegoating may at least partly account for some of the conflicts between ethnic groups?

- Is there any particular prejudice that you learned from your family or friends and have subsequently had to unlearn?

- Are there particular characters or programs on television that you believe demean certain minorities and promote prejudicial thinking? Are there stereotypical portrayals of minorities?

**Stereotypes**

The term stereotypes refers to the process of attributing identical characteristics to any person in a group regardless of the individual's personal qualities. To the extent that our stereotypes are based upon our actual experience, they may be helpful in dealing with the world. Unfortunately, prejudice is bred not by actual contact between
individuals but through hearsay, myths, and images created by television, movies, advertising, etc. The stereotyping process blinds us to individual differences and justifies our discrimination and cruelty toward others.

**Exercise: Stereotypes**

Divide participants into four groups. Ask each group to choose a recorder. Request that each group make a list of stereotypical characteristics for women, African-Americans, homosexuals, or Hispanics and report this listing to the larger group. Examine the characteristics of each minority group, possible social explanations for specific characteristics, and exceptions to these attributes.

**The Effects of Prejudice**

Prejudice and discrimination carry a heavy price. For society as a whole, the result is intense social conflict and loss of civic unity. Individual victims of discrimination and prejudice suffer both personal and social losses. They may be denied jobs, promotions, a good education, or decent housing.

The victims of prejudice and discrimination may come to think less of themselves. They may come to believe also the stereotypes that others have of them. This is especially true if they have suffered from prejudice and discrimination all their lives. They may often feel insecure, frustrated, and angry as a result of the treatment they have received in society.

Victims, however, are not the only ones who are hurt by prejudice and discrimination. The perpetrators may feel afraid and angry, and their prejudices limit their understanding of others.

Discrimination can be especially painful for the adolescent student who is attempting to grow emotionally and develop his/her intellectual and economic potential. The feelings of helplessness and powerlessness often lead to a diminution of self-esteem. Adolescent girls may bitterly realize for the first time that the traditional female role that they were taught during childhood has left them unprepared to enter more self-filling and economically rewarding jobs. Finally, some minority group individuals who do achieve a positive self-image in spite of repeated discrimination are likely to have a sense of mistrust of the larger society in which they live.
**Discussion:**

Ask participants to identify any instances and effects of discrimination that they have observed on center.

### 3. Prejudice and Discrimination on Center/Action Guidelines (45 minutes)

As a staff member, you have a rare opportunity to confront discrimination directly in the classroom, on the recreational field, and in the residential setting. Through your intervention, students can become aware of their own responses to being discriminated against. Without sensitive adult modeling and attention to these problems, the cycles of prejudice and discrimination will continue for another generation leaving psychological scars on an ever-widening number of minority group members. Let's examine several instances of center discrimination.

**Exercise: Center Discrimination**

Ask for four volunteers to act out the two scenarios found in Handout 13.1. In processing the large group discussion, participants should explore:

- The types of stereotypes that were used to justify the discrimination toward the student
- The student's feelings about being discriminated against
- The types of responses that the student used when reacting to the discrimination

**Action Guidelines**

Usually, individuals cannot change their prejudicial attitudes simply because they receive more accurate information. Because prejudices are seldom based on facts, new facts have very little impact on attitude changes. However, prejudice and discrimination can be significantly lowered when individuals have an opportunity to be in contact with members of a different minority group, if the members of each group have equal status. This arrangement is possible on a Job Corps center.

Prejudice is also reduced when individuals of different groups believe they must depend on each other to accomplish their goals. This mutual interdependence should be basic to the Job Corps living concept. Dorm cleanliness, residential activity planning, and conflict resolution among roommates should focus on mutual responsibility and participation. The staff members must take a major role in designing center duties and planning activities to reflect this mutual interdependence in order to enhance contributions and interpersonal contacts between different minority groups on center.
Staff Guidelines For Decreasing Prejudice

- Stop Name Calling
- Prevent Rumors
- Prevent Violence
- Discourage Cliques
- Encourage Cooperation
- Don't Let Group Pride Turn Into Ethnocentrism
- Accept Other Views
- Don't Lecture or Sermonize

There are other guidelines for staff that can help increase understanding and lower prejudice:

- **Stop Name Calling**—Name-calling is based on stereotypes, and even when done in fun, it can be harmful. Discourage name calling any time it occurs.

- **Prevent Rumors**—Intergroup hostilities and suspicion are frequently spread by rumors. Attempt to stop rumors from starting and spreading. Find out if there is any truth to a rumor; don't let a rumor go unchecked.

- **Prevent Violence**—Violence between students may stem from prejudice and minority group discrimination. Any outbreak or near outbreak of violence must be stopped immediately. Find out what prompted the violence and take action to change the conditions.

- **Discourage Cliques**—One of the Job Corps goals is to help students get along and work with one another. Any kind of segregated grouping will interfere with this goal. Try to prevent cliques in classrooms and dormitories by assigning seats and beds. Center-sponsored clubs should never be segregated.

However, there is a distinction between segregation in classroom seating and dormitory assignments and a preference for friends in cafeteria seating or leisure activities. Some ethnic grouping may provide peer support and help students adapt to center life. For example, Spanish-speaking students who have difficulty communicating in English may prefer to associate with each other. A good way to assess the progress of intergroup relations at the center is to check, from time to time, and see whether preferences are drawn according to strict ethnic and racial lines.

- **Encourage Cooperation**—Real respect for another group involves helping that group when necessary. If one group of students is gaining at the expense of another, step in.
• **Don't Let Group Pride Turn Into Ethnocentrism**—Members of any minority group should be able to keep their separate identity; at the same time, they should come to see that other groups have much to offer. Group pride should not lead to feelings of hostility toward other groups.

• **Accept Other Views**—In order to be effective and helpful to students, accept points of view that are different from your own.

• **Don't Lecture or Sermonize**—Simply saying that prejudice and discrimination are wrong does not eliminate problems or assuage tensions. A better starting point is to show students that both parties suffer from prejudice and discrimination.

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**Discussion and Wrap-Up:**

Review the sessions’ objectives and ask participants if they have any questions or comments.
Handout 13.1

Role Play Scenarios

Scenario 1

This is an initial interview between a vocational instructor or career counselor and a new student who has signed up for the auto mechanics class. The instructor tries to subtly discourage her from taking this course.

Scenario 2

An African-American student is called into a meeting with a White residential adviser to discuss the continued lack of cleanliness in the residential area. After getting "the facts," the staff member implies that the reason the living area is messy is that African-Americans never learn good cleanliness habits at home or in their neighborhood.