

SAMHSA toolkit recognizes OSH Supported Education staff



Staff from OSH's Supported Education Department played a key role in the creation of a recently published toolkit by SAMHSA. Here, Eric Miller, Erika Gabbard, Barb Pfaltzgraff, Ashley Eason and Anita Cantrell display a binder containing one section of the toolkit.

By Robert Yde, Public Affairs Specialist

Although the onset of severe mental illness can occur at any point during a person's lifetime, often it emerges during late childhood or early adulthood. For many, this is the time when they are finishing high school or beginning college, and their mental illness can quickly derail their educational and career goals. Even after a successful recovery, the lack of a formal education can leave these individuals at a disadvantage as they try to rebuild their life.

While commonly used in community treatment, Supported Education programs have been a rarity in large, state-run psychiatric hospitals. Oregon State Hospital, however, has been an exception to this trend. For the past five years, teachers and staff at OSH have been developing a comprehensive Supported Education program from the ground up that has helped hundreds of patients gain the foundational knowledge

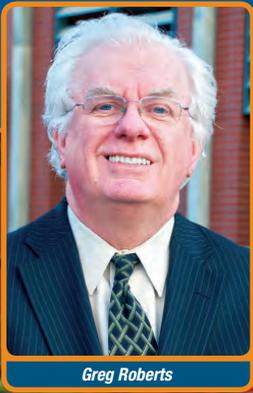
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OSH Recovery Times

is edited by Robert Yde. Contact him at 503-947-9982 with questions, comments or suggestions.



Greg Roberts

Message from the superintendent

Dear OSH Team:

Most of the time, I use my column in the *Recovery Times* to talk about significant initiatives going on within Oregon State Hospital, but for this issue, I would like to discuss some very important things that are going on with the statewide mental health system. These efforts have the potential to affect the hospital in a big way, both by helping people get the mental health services they need before ever coming to OSH and by making sure there are adequate services in the community to support recovery after patients leave our care.

Discussions began last year when the Governor released his 2013-2015 Governor's Balanced Budget, one of the early steps in the state's budget process. This budget has an impressive 43 percent increase in General Funds for Oregon's community mental health system, including an additional 471 beds in communities statewide.

Then, more recently, Senate President Peter Courtney called on Oregon legislators to increase funding for mental health services above and beyond the Governor's Balanced Budget. Courtney proposed budgeting \$285 million for adult community-based services and \$46 million for children and young adults. "If we're going to get serious about treating mental illness in our state, we have to get serious about funding mental health services in our state," Courtney said. "It's too important to put off any longer."

Both leaders recognize the imperative to create a robust network of services to meet the mental health needs of all Oregonians. Families, pediatricians and others who work with our children need tools and training to identify the early signs of mental illness and the interventions to prevent these illnesses from

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Message from the superintendent

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becoming chronic. Those who already are living with mental illness need access to the right level of treatment to meet their needs, from hospital level of care to independent community living.

The Legislature will make the final decision on the budget near the end of the 2013 session. We will do our best to keep you apprised as the legislative session continues.

Sincerely,

A handwritten signature in black ink, appearing to read "G Roberts", is centered below the word "Sincerely,".

Greg Roberts
Superintendent

Your furlough obligation

By *Patty Foster, Workforce/Recruitment Consultant*

As we head into the final five months of the 2011 – 2013 biennium, your Human Resources office would like to remind you to schedule any unused floating furlough time by March 31.

During this biennium, all state employees had furlough obligations of some type. Some of you had all floating furloughs and were able to work with your management team to schedule those days off. Others had a mix of agency closure (fixed) and floating furloughs days.

Staff must schedule and take all floating furlough time by March 31, 2013. After March 31, managers will be responsible for scheduling any remaining floating furloughs for their staff so that all days are taken by May 31, 2013.

No furloughs will be scheduled, approved or taken in the month of June. **Individuals who have not met their furlough obligation will have their July 1, 2013, paycheck reduced by the number of furlough days not taken.**

Please don't delay. Get your furloughs scheduled and taken before it's too late.

If you have any questions, please contact Human Resources at 503-945-2816.

In addition to any remaining floating furlough days you may have, there are two fixed furlough days remaining in the 2011-2013 biennium. Most state offices will be closed on the following days, so please plan accordingly:

Friday, April 19
Friday, May 24

The OSH staff fitness room is now open

By *Bernadette Murphy, Wellness Committee Chair*

For OSH employees, not having time to get to the gym is no longer an excuse for not keeping that New Year's resolution. The staff fitness room opened in Kirkbride last month and is available to all staff 24 hours a day, seven days a week for just \$5 a month through the end of June. Beginning July 1, the rate will increase to \$10 a month.

Located inside Kirkbride's second-floor lounge, the fitness room contains free weights, ellipticals, stair



The fitness room offers a variety of options for aerobic exercise.

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Spiritual Care staff provide support, encouragement to OSH patients, staff

By Todd Guevara, Chaplain



OSH Spiritual Care staff inside the Kirkbride Chapel. The department plays an active role in patient treatment, while also attending to the spiritual needs of both patients and staff.

While most people are familiar with what a chaplain is, many may not fully understand what a chaplain does. The mission of Oregon State Hospital's Spiritual Care Department is to support, encourage and provide resources for patients in accordance with their specific religious traditions and spiritual practices. To accomplish this, our chaplains lead treatment mall groups, conduct weekly chapel services, provide patient and staff consults, assist patients with community transition, and work with hundreds of community volunteers to help meet the ongoing needs of our diverse population. We also serve patients and staff as H.E.A.R.T responders, Ethics Committee members and IDT members.

Our goal is to offer spiritual care without exclusions in a professional and safe manner. All of our chaplains have considerable academic training, each holding at least a master's degree. At minimum, all staff and contract chaplains have completed a one-year residency in a Clinical Pastoral Education program prior to working

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Salem campus

- **Lisa Barnes**
Bridges and Trails;
- **Todd Guevara**
Harbors and the Cottages;
- **Sr. Mary Ann Okonkwo**
Bridges, Harbors, Springs, Trails and the Cottages;
- **Marjorie K. Oughton**
Springs;
- **Dennis Stahlnecker**
Trails and Bridges;
- **Luz Barela-Borst**
Supervisory Candidate, Clinical Pastoral Education program;
- **Melissa Bennet**
CPE intern, Butterfly 2;
- **Douglas Hollums**
CPE intern, Harbors; and
- **Sandy Vandagriff**
CPE intern, Bridges 1 and Leaf 2.

Portland campus

- **Greg Deli**
- **Ruth Worley-Rizk**

Recovering From Schizophrenia

By James Tse, Western University of Health Sciences

James Tse is a fourth-year medical student at Western University of Health Sciences. Last year, James performed his psychiatry clerkship, a requirement for psychiatric students designed to strengthen their clinical knowledge base and skills, at Oregon State Hospital under the guidance of Mario Chen, M.D. All names in this article have been altered to protect patient privacy.

I first met John halfway through my psychiatry clerkship at Oregon State Hospital. John suffers from schizophrenia, a chronic psychiatric disorder characterized by delusions, hallucinations and negative symptoms of alogia, anhedonia and avolition. According to the Diagnostic and Statistical Manual of Mental Disorders-IV-TR, these symptoms must be present for more than six months and cause significant impediments to social and behavioral functioning. Schizophrenia itself is subdivided into five subtypes — paranoid, disorganized, catatonic, residual and undifferentiated — with paranoid subtype being the most prevalent.

Schizophrenia usually begins manifesting itself during early adulthood, with a younger peak age of onset in males compared to females. John was no different. He was 25 when he had his first psychotic episode. At the time, his son had just been born, and he and his girlfriend had moved into a new home, eager to start a new chapter in their life. For reasons unknown, John began to drink heavily, and his alcohol use eventually led him to start experimenting with other drugs, including cocaine and methamphetamine. His combined use of both alcohol and stimulants eventually culminated in acute psychosis.

According to John's account, each episode of psychosis is a living and breathing nightmare. One of the hallmarks of paranoid schizophrenia is a preoccupation with one or more delusions.

Many of John's delusions stemmed from previous events in his life. In addition to his delusions, John's psychosis was often accompanied by physical pain, which he described as "someone taking a part of the brain and twisting it into a knot."

It has been six years since John was formally diagnosed with schizophrenia, and this was his third admission to the hospital. Each time he has been admitted, John has vowed to quit abusing drugs but has always relapsed back into a cycle of substance abuse. John's struggles with recovery parallel a commonly held view that schizophrenia is a chronic illness with little hope for sustained remission. However, recent studies have shown that recovery has a variable course.

One of the difficulties in treating schizophrenia is that, currently, there is no universally accepted definition for recovery. The definition often varies between clinicians and researchers, who often define recovery as an extended period of remission from psychotic symptoms with improvement in global functioning, and patients, who define recovery as the ability to rejoin society and function even in the face of persisting symptoms.

In a 2002 pilot study published in the "International Review of Psychiatry," Robert Liberman, M.D., and his team at the UCLA Psychiatric Rehabilitation Program defined recovery as a remission of psychiatric symptoms characterized by a rating of four or less on the Brief Psychiatric Rating Scale (BPRS) for a period of two years with a return to independent living, vocational functioning and relationships with peers. The study identified 10 factors associated with sustaining recovery: having a supportive family; absence of substance abuse; a short duration of untreated psychosis; a good initial response to neuroleptic medications; adherence to treatment; supportive therapy with a collaborative therapeutic alliance; good neurocognitive functioning; a good premorbid

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Recovering From Schizophrenia

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history; absence of the deficit syndrome; and access to comprehensive and continuous care.

Findings from additional studies have also supported a more positive view of recovery from schizophrenia. For example, a study led by psychiatrist Glynn Harrison at the University of Bristol (United Kingdom) compared schizophrenia mortality at the 15- and 25-year intervals and found that 48.1 percent of the patients identified themselves as recovered and had returned to normal functioning. Another cohort study by Martin Harrow, Ph.D., and a team from the University of Chicago found individuals with schizophrenia and schizophreniform disorder had recovery rates of 41 percent and 55 percent respectively during a one-year period.

Findings such as these provide hope for John that he has a good chance of finally breaking the cycle and sustaining recovery. When I spoke with him in the days leading up to his discharge, John reported that he had been very proactive in trying to get his life back together. He indicated that the past six years he had spent wrestling with schizophrenia were some of the darkest times in his life. John realized his continued drug use was causing him to spiral back into schizophrenia, and said he was committed to joining Narcotics Anonymous and was looking for a sponsor to help him stay clean. John had also gotten back in touch with his family and loved ones, hoping to gain their support, and contacted his previous employer to discuss employment opportunities.

While John may never live a symptom-free life, recent findings have suggested that it is very possible to live a meaningful and productive life with schizophrenia. I am optimistic for his recovery and hope that wherever he is, John is enjoying life to its fullest.

Reference

Bellack A. Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, and Implications. *Schizophr Bull*, 2006(32): 432-442.

Fischer BA, Buchanan RW. Schizophrenia: Clinical manifestations, course, assessment, and diagnosis. In: *UpToDate*, Basow, DS (Ed), *UpToDate*, Waltham, MA, 2012.

Harrison et al. Recovery from psychotic illness: a 15- and 25-year international follow-up study. *Br J Psychiatry*, 2001(178): 506-517.

Harrow M, Grossman LS, Jobe TH, Herbener ES. Do patients with schizophrenia ever show periods of recovery? A 15-year multi-follow-up study. *Schizophr Bull*, 2005(3): 723-734.

Liberman RP. Recovery from Schizophrenia: A concept in Search of Research. *Psychiatric Services*, 2005(56).

Liberman RP, Kopelowicz A, Ventura J, Gutkind D. Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, 2002(14): 256-272.

Team Recognition – December

By the Employee Recognition Committee

The Employee Recognition Committee would like to congratulate the December winner of the Team Recognition Award. Below is a description of the team's accomplishments.



The Forensic and Evaluation Services team with members of the Superintendent's Cabinet.

DECEMBER

Category: **Innovating**

Nominated by: **Arthur Tolan, Director of Forensic and Legal Services**

Forensic and Evaluation Services team

In recent months, the Forensic and Evaluation Services (FES) team has taken several notable steps that have improved its productivity. Using Lean tools, FES staff have streamlined the competency restoration and evaluation process, which has resulted in more evaluations being performed in less time. This means that they are able to provide evaluations to courts more quickly, which has led to .370 patients spending less time at the hospital.

In addition, the team has made efforts to simplify the very complex evaluation process by reaching out to and working more closely with the clinical staff responsible for treating .370 patients. The FES team has standardized the

format of its reports to clinical teams to make them more informative and user-friendly. This includes providing the reason the patient did not pass the evaluation, which helps the treating team focus on and work with the patient on specific issues and better prepare the patient to pass his or her next evaluation.

Congratulations to the FES team! Thank you for all of your hard work.

Next month, we will feature January's and February's winning teams. If you would like to nominate a team for the March category — supporting recovery — please submit your Team Recognition Form to Employee Recognition Committee Chair Sara Walker, M.D.

For more information on the Team Recognition Award, please contact **Dr. Walker** at sara.walker@state.or.us or **503-945-8872**.

Turn to page 16 to see a list of recognized staff from the FES team.

A Culture of Safety and the Six Core Strategies

From your Seclusion and Restraint Committee

This month, we wrap up our look at how data can be used to inform practices, which is the fifth strategy of the National Technical Advisory Council's (NTAC) Six Core Strategies for Reducing Seclusion and Restraint. As you know by now, we are using these strategies as the foundation for our Culture of Safety initiative at OSH. In particular, we will show how data is being used to help determine the best way to handle patient aggression.

On the surface, you may think that aggression is just aggression; however, digging deeper yields additional perspectives to consider. Research in recent years has identified the three types of aggression most commonly displayed by patients in a secure forensic setting. These are instrumental, reactive, and psychotic aggression. Each is best managed with a specific approach.

Instrumental aggression, also noted as organized premeditated aggression, occurs about 29 percent of the time. It is often associated with antisocial or psychopathic personality disorder and is difficult to treat. For the best results, patients must have a clear set of rules that are consistently applied in addition to cognitive behavioral approaches that address altering pro-criminal beliefs with interpersonal conflicts (Quanbeck et al., 2007). Such an approach would probably not work with the other two types of aggression.

Psychotic aggression occurs about 17 percent of the time, most frequently while a person is experiencing paranoid ideations. Although less common, psychotic aggression may indicate that a person is decompensating and is, to a degree, more unpredictable. Clinical



approaches for dealing with psychotic aggression include close monitoring of the patient for signs of decompensation and medication adherence.

The most routine type of aggression seen in in-patient forensic settings is reactive or impulsive aggression. According to Quanbeck, reactive aggression accounts for 54 percent of all incidents. **The way that staff handle these types of interactions can greatly influence the outcomes.** Last year, Standards and Compliance staff assembled and distributed a list of more than 90 tips on flashcards that line staff can use to de-escalate a situation. These tips were a combination of external best practices (Project BETA), evidence-informed practices, and the expertise and experience of staff at OSH. In fact, OSH staff contributed more than half of the tips, many of which were consistent with identified best practices. (If you would like another set of flash cards for

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A Culture of Safety and the Six Core Strategies

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your unit or department, please contact James “Doc” Campbell.)

No matter the type of aggression, the underlying theme that emerged from our research and de-escalation tips was that the best way to manage aggressive situations is to build and practice a variety of skills and approaches, and then keep refining them based on feedback from patients and staff.

With this approach in mind, OSH recently rolled out a new Safe Together Work Team Initiative (WTI) designed to provide staff with new pre-escalation and de-escalation skills, as well as the training opportunities to practice them.

Look for information in the coming months from the Safe Together WTI.

In the next two issues of *Recovery Times*, we will wrap up our ongoing look at NTAC’s Six Core Strategies with a discussion of the final strategy — the roles of consumers.

If you have suggestions, comments or observations for the Seclusion and Restraint Committee, please send them to **J.S. “Doc” Campbell**, CPHQ at James. CAMPBELL@state.or.us.

The six core strategies developed by the National Technical Assistance Center to Reduce the Use of Seclusion and Restraint:

- **Leadership’s roles;**
- **Work force development;**
- **Using data to inform practice;**
- **Using seclusion and restraint reduction tools;**
- **Consumer roles; and**
- **Debriefing techniques.**

Reference

Quanbeck, Cameron David; McDermott, Barbara E.; Lam, Jason; Eisenstark, Howard; Sokolov, Gregory; Scott, Charles L.: Categorization of Aggressive Acts Committed by Chronically Assaultive State Hospital Patients. *Psychiatric Services*, Vol. 58, No. 4: 521-528, April 1, 2007.

Workforce Management

API Time and Attendance

Last year, the first phase of the API workforce management system was introduced to address some of the staffing challenges common to a multi-shift, 24/7 operation like OSH. Today, using API's Staff Scheduling tool many of you enjoy more control over your schedules. Whether at home or at work, you can now easily view your schedule, trade shifts, request time off and more—helping you to better balance your personal and professional life.

In the coming months, OSH will launch the second phase of API, Time and Attendance. The Time and Attendance tool will eliminate the paper-based sign-in/-out logs many of you now use. Soon, by simply swiping your OSH ID badge at the beginning and end of your shift, you will be able to quickly and accurately record your time every day.

Time and Attendance rollout

- API's Time and Attendance tool will be rolled out in strategic and staggered phases.
- Phase one begins this spring with Food and Nutrition Services.
- Phase two is planned for this summer and will comprise all unit-based nursing staff.
- Phase three will focus on all remaining disciplines and departments. The order will be determined by highest need and complexity of the system design.
- Ultimately, all OSH staff will use the Time and Attendance tool to record their time.
- Departments will be able to use the Time and Attendance tool without having to use the Staff Scheduling tool.



OSH Workforce Management
Because Your Time Matters

Highlights

1. Staff will use their OSH ID badge to record their daily time.
2. Special badge readers will be placed at all primary entry/exit points.
3. Time recorded in API will be entered into the State Payroll Time Capture System (MCICS/Hummingbird).

For questions or information, email Technology Services at OSH.TSM@dhs.oregon.gov.



SAMHSA toolkit recognizes OSH Supported Education staff

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and skills they'll need for a successful future in the community.

As treatment philosophies continue to shift to a more person-centered, recovery-oriented approach, more providers have begun to recognize the important role education can play in maintaining recovery. Now, thanks in part to the expertise of OSH's Supported Education staff, providers have an additional resource to help them develop their own program.

Last year the Substance Abuse and Mental Health Services Administration (SAMHSA) published a new toolkit, "Supported Education: A Promising Practice," which details the effectiveness of Supported Education, shares best practices and offers guidance for establishing a successful program.

The toolkit, authored by Karen Unger, Ph.D., was based in part on research done at OSH. From 2007 to 2009, Unger, one of the nation's foremost experts on Supported Education, served as a consultant to OSH's Supported Education staff during the development of their department. In addition to offering her guidance, Unger also worked closely with hospital staff to collect data and information that would be used to create the toolkit. As a result, OSH teachers Anita Cantrell, Ashley Eason and Eric Miller were formally listed as contributors to the toolkit and Director of Rehabilitative Services Barb Pfaltzgraff was credited as a consultant.

"We tracked all kinds of measures that showed how our students progressed through the program, and Karen incorporated a lot of the data that came out of this into the SAMHSA toolkit," Pfaltzgraff explained. "In the end, a lot of the material that's in the toolkit looks very similar to what we're doing here at OSH."

For more than two years, Supported Education staff collected detailed data such as the most common classes students were taking, student completion rates,

student retention rates and attendance. The benefits of tracking this type of data go well beyond the toolkit, of course, as the knowledge gained has helped staff to continue to refine and improve OSH's Supported Education program, providing more patients with more educational opportunities.

Today, the department offers a range of education options to meet patients' individual needs, such as adult basic education (reading, math, general studies), computer literacy, English as a second language, GED preparation and college courses.

"I'm proud to have been part of this project, but I'm just as proud of the work we do every day," Eason said. "Education is a key determinant for success outside of the hospital. We want patients to build the scaffolding here so they can sustain it when they're back in the community."

For more information on OSH's Supported Education Program, please contact **Barb Pfaltzgraff** at **503-945-0991**.

Governor's State Employees

Food Drive!

January 28 – March 1, 2013

www.oregon.gov/fooddrive



RACE TO END HUNGER

Ways to participate:

- Make a payroll deduction
- Donate nonperishable food
- Participate in fundraisers
- Write a check
- Meet the Governor's Challenge



The OSH staff fitness room is now open

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Free weights were purchased thanks to a donation from SEIU.

steppers, treadmills, and exercise bikes, including one Schwinn AirDyne bike. For your convenience, there is also a small bank of lockers available (for single-visit use only), as well as showers and other restroom facilities.

The fitness room is entirely staff supported – no state funds were used to purchase equipment. Your monthly dues will help us maintain our current equipment and purchase new equipment in the future. In addition to your monthly dues, you will be asked to pay a one-time key deposit of \$10 (\$5 of which is refundable) when you join.

Planning and preparation for the fitness room took many months of hard work. The Wellness Committee would like to thank all staff that donated time and resources to this project. We would especially like to thank SEIU and OSH's current Aspiring Leaders cohort for their contributions

We hope you enjoy your new fitness room and look forward to seeing you there.

If you're interested in using the staff fitness room or would like more information, please contact Wellness Committee representatives **Bernadette Murphy** at 503-947-1021 or **Pat Davis-Salyer** at 503-945-9450.



For staff looking to "bulk up," a separate room is filled with weightlifting equipment.

Spiritual Care staff provide support, encouragement to OSH patients, staff

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at OSH, giving them considerable experience in hospital chaplaincy. In addition, staff chaplains are required to complete national board certification as chaplains — the most rigorous of all certifications in chaplaincy.

OSH's Clinical Pastoral Education program

Since 1956, more than 200 aspiring chaplains have received training at OSH through our Clinical Pastoral Education (CPE) program. The CPE program is an interfaith, graduate-level professional program that brings together theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) for supervised encounters with persons in crisis. It provides students with a unique experience to help them gain the skills and insight needed to work in the hospital environment.

Their intense involvement with people in need, as well as the feedback received from their peers and teachers, help students develop an enhanced awareness of themselves and the needs of those we serve. Through theological reflection on specific human situations, students gain new understandings of their ministries. Working as part of the interdisciplinary team, students learn to build interpersonal and inter-professional relationships.

Working with you

Our chaplains are honored to serve at OSH. We are committed to a whole-person approach and collaboration to provide an environment that fosters healing. Please feel free to contact our staff at any time. We look forward to seeing you on the units and getting to know you better.

For more information, please contact the Spiritual Care staff member assigned to your work area.

Spiritual Care staff offer a variety of treatment mall groups that are open to all patients. Current offerings include:

- Forgiveness;
- Exploring Prayer Practices;
- Greif and Loss;
- Songs of Our Being;
- Anger and Map Art; and
- My Story.

Service schedule

Salem campus

- Saturdays
 - » Jehovah's Witness service, 10:30 a.m., Kirkbride Chapel
- Sundays
 - » Catholic service, 9:15 a.m., Kirkbride Chapel;
 - » Protestant service, 9:15 a.m., Harbors Chapel;
 - » Catholic service, 10:15 a.m., Harbors Chapel; and
 - » Protestant service, 10:15 a.m., Kirkbride Chapel.
- We offer a Catholic service in the Springs Chapel every third Tuesday of the month at 3:45 p.m.
- We offer a Catholic Mass once a month, which we announce once it's scheduled.

Portland campus

- Sundays:
 - » Protestant service, 2:30 p.m.
 - » Catholic service, 4 p.m.

Team Recognition

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Congratulations to the December Team Recognition Award winners.

December: Improving quality

FES team:

Chris Corbett, Psy.D.

Mandy Davies, Psy.D.

Kathleen Forrest, Executive Assistant

Mariam Garuba, M.D. (forensic fellow)

Stephen James, Ph.D.

Christopher Lockey, M.D.

Alex Millkey, Psy.D.

James Peykanu, M.D. (rotating M.D.)

Dan Smith, Psy.D.

Cynthia Stokes, Psy.D.

Andy Stover, Psy.D.

Contractors:

Alex Duncan, Psy.D.

Gary Field, Ph.D.

Jerry Gordon, Ph.D.

Anne-Marie Smith, Ph.D.

February and March 2013 EDD events

The following is a list of classes being offered at the OSH Education and Development Department (EDD) during February and March. Classes are located at EDD unless otherwise noted. For more information about these classes, call 503-945-2876.

Avatar training for RN/LPN

Held in 310 Computer lab

Mar. 1 (8 a.m. to 5 p.m.)

Mar. 14 (8 a.m. to 5 p.m.)

Mar. 29 (8 a.m. to 5 p.m.)

Avatar group notes training

Held in 310 Computer lab

Mar. 11 (9 a.m. to 11 a.m.)

Avatar for non-clinical staff

Held in 310 Computer lab

Mar. 18 (9 a.m. to 11 a.m.)

Pro-ACT refresher

Held in 344 Integrity

Feb. 26 (8 a.m. to 5 p.m.) Day 1

Feb. 27 (8 a.m. to 12 p.m.) Day 2

Feb. 28 (8 a.m. to 5 p.m.) Day 1

Mar. 1 (8 a.m. to 12 p.m.) Day 2

Mar. 12 (8 a.m. to 5 p.m.) Day 1

Mar. 13 (8 a.m. to 12 p.m.) Day 2

Mar. 14 (8 a.m. to 5 p.m.) Day 1

Mar. 15 (8 a.m. to 12 p.m.) Day 2

Mar. 26 (8 a.m. to 5 p.m.) Day 1

Mar. 27 (8 a.m. to 12 p.m.) Day 2

Mar. 28 (8 a.m. to 5 p.m.) Day 1

Mar. 29 (8 a.m. to 12 p.m.) Day 2

Pro-ACT refresher for 13/20 staff

Held in 344 Integrity

Mar. 4 (7:30 a.m. to 9 p.m.)

Mar. 22 (7:30 a.m. to 9 p.m.)

Pro-ACT refresher for operations staff

Held in 344 Integrity

Mar. 8 (8 a.m. to 5 p.m.)

New employee orientation

Held in 342 Leadership

Feb. 25-26 (8 a.m. to 5 p.m.)

Day 5-6

Feb. 27 (8 a.m. to 5 p.m.) Day 7

(310 Computer lab)

Mar. 4-8 (8 a.m. to 5 p.m.) Day 1-5

Mar. 11 (8 a.m. to 5 p.m.) Day 6

Mar. 12 (8 a.m. to 5 p.m.) Day 7

(310 Computer lab)

Mar. 18-22 (8 a.m. to 5 p.m.)

Day 1-5

Mar. 25 (8 a.m. to 5 p.m.) Day 6

Mar. 26 (8 a.m. to 5 p.m.) Day 7

(310 Computer lab)

ED day

Held in 344 Integrity

Feb. 25 (8 a.m. to 12 p.m.)

Mar. 1 (1 p.m. to 5 p.m.)

ED day (continued)

Mar. 5 (8 a.m. to 12 p.m.)

Mar. 18 (8 a.m. to 12 p.m.)

Mar. 19 (8 a.m. to 12 p.m.)

FPS Nursing orientation

Held in 306 Service Excellence

Feb. 27 (8 a.m. to 5 p.m.)

Mar. 28 (8 a.m. to 5 p.m.)

Nursing orientation

Held in 306 Service Excellence

Mar. 13 (8 a.m. to 5 p.m.)

Mar. 27 (8 a.m. to 5 p.m.)

Motivational interviewing Step 1, Step 2 and Step 3

Held in 344 Integrity

Mar. 7 (8:30 a.m. to 3 p.m.)

Step 1

Mar. 21 (8:30 a.m. to 3 p.m.)

Step 2

Mar. 22 (1 p.m. to 5 p.m.)

Step 3

(Held in 306 Service Excellence)

CMA pharmacology

Held in 306 Service Excellence

Mar. 6 (8 a.m. to 12 p.m.)

Contraband/Room search

Held in 306 Service Excellence

Mar. 26 (8 a.m. to 12 p.m.)

Group facilitation basics

Held in 344 Integrity

Mar. 20 (1 p.m. to 5 p.m.)

Generations

Held in 344 Integrity

Mar. 27 (1 p.m. to 4:30 p.m.)

Attachment, Trauma and Emotional Regulations

Held in 306 Service Excellence

Feb. 25 (1 p.m. to 4:30 p.m.)

ASAM for ACP

Held in 344 Integrity

Mar. 11 (8:30 a.m. to 4:30 p.m.)

Forgiveness counseling

Held in 344 Integrity

Mar. 13 (1 p.m. to 5 p.m.)

Volunteer/Contractor orientation

Held in 308 Partnership

Mar. 14 (8:30 a.m. to 12 p.m.)