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| THE KASM  COMMUNITY REINTEGRATION  AND  RECOVERY MODEL  Training manual |
| ***Using KASM to Transform Treatment Programs into Comprehensive Recovery Orientated Care Systems*** |
|  |
| ***Our best efforts have not lead to glaringly effective results. In fact dispositive results are the norm, and there seems to be two dominant factors of successful recovery: (1) person centered counseling and (2) community integration.*** |
|  |
| By Imam Hamzah Al-Ameen |
| 2/23/2010 |
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***Using KASM to Transform Treatment Programs into Comprehensive Recovery Orientated Care Systems***

**By Imam Hamzah Al-Ameen**

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# Let’s Start At the Beginning

Institutions tend to change their members, and sometimes adversely. Disabilities develop regardless of what or who are responsible and once deinstitutionalized these persons are entitled to be made whole and/or be provided with supportive resources and assistance. Frequently service providers do not have the knowledge base, the skill set, or the training to facilitate reentry. Large providers have set up data bases and counseling strategies to manage discharges and transfers. Our best efforts have not lead to glaringly effective results. In fact dispositive results are the norm, and there seems to be two dominant factors of successful recovery: (1) person centered counseling and (2) community integration ((DBH/MRS)).

# Factors of Institutionalization

Institutions are systems with inputs and outputs, conditions and consequences. The paradigms controlling the institutional policies are the basis of its objectives. Individuals within the system are affected by the implementation of institutional objectives, and the individual is conditioned and their ability to cope with the factors of institutionalization form either disabilities or strengths upon reentry or reintegration into community and society. Identifying these factors can help change agents (counselors) understand the difficult path related to community reintegration. Without knowledge of these factors counselors and helping professionals are themselves handicapped by disinformation. The following factors have been identified as being the controlling causal characteristics of institutionalization[[1]](#footnote-1):

1. Homogenization**:** There is intake, screening, numbers are issued, uniforms mandated, delousing, haircuts, ID cards, pictures and a plethora of procedures that strips individuality. A stamp is placed that identifies and often stigmatizes individuals, all because of institutional need to count and identify members. This factor is closely related to objectification.
2. Pauperization**:** Institutions charge fees, restrict earnings, or only supply services to poor persons. Institutions are economically driven or dependent. People’s earnings are regulated by taxes and sometimes they are forcibly prevented from acquiring economic freedoms.
3. Dependency**:** Prolonged institutionalization can produce decreased self direction, weakened ambition and self determination. Even short stays can produce dramatic levels of dependency as with DSS, hospitals, and prisons. Individuals may be unused to seeking resources and even expect and sometimes deserve resources to be totally provided.
4. Isolation**:** Detachment from regular social roles, geographically, psychosocially can lead to feelings of irrelevance, loss.
5. Docility**:** Will to challenge can be weakened, along with increased lethargy, and diminished interest in self and others.
6. Objectification**:**  Individuals lose autonomy, become dejected, and sometimes develop a loss of self esteem, which can culminate in apathy.
7. Desynchronization**:** Timing and sense of reality is often abrogated as individuals begin to adapt to the new system they find themselves in, they become out of phase with their previous settings. There are numerous reports that newly released individuals say things are moving fast literately, and express fears related to movement, distance and speed.

Some institutions impact their members more than others and some factors are often not apparent, in all cases whether it is a hospital stay, treatment center, military deployment, incarceration, or foster care, the above factoids are present to some degree.

Of all institutions prisons can be the most austere. The author has detailed 7 factors that cause serious mental and behavioral disorders in ex-offenders. The rougher the incarceration the more exacerbated the illnesses seem to be. Terence Gorski, is one of the leaders in this field of relapse prevention look at the relationship between his findings and the seven factors detailed by the author.

Gorski[[2]](#footnote-2) relates, The Post Incarceration Syndrome (PICS) is a serious problem that contributes to relapse in addicted and mentally ill offenders who are released from correctional institutions. Currently 60% of prisoners have been in prison before and there is growing evidence that the Post Incarceration Syndrome (PICS) is a contributing factor to this high rate of recidivism.

**Reasons to Be Concerned About PICS**

There is good reason to be concerned because about 40% of the total incarcerated population (currently 700,000 prisoners and growing) are released each year.  The number of prisoners being deprived of rehabilitation services, experiencing severely restrictive daily routines, being held in solitary confinement for prolonged periods of time, or being abused by other inmates or correctional staff is increasing.

The effect of releasing this number of prisoners with psychiatric damage from prolonged incarceration can have a number of devastating impacts upon American society including the further devastation of inner city communities and the destabilization of blue-collar and middle class districts unable to reabsorb returning prisoners who are less likely to get jobs, more likely to commit crimes, more likely to disrupt families.  This could turn many currently struggling lower middle class areas into slums.

As more prisoners are returned to the community, behavioral health providers can expect to see increases in patients admitted with the Post Incarceration Syndrome (Gorski).

**Gorski’s[[3]](#footnote-3) Symptoms of Post Incarceration Syndrome (PICS)**

**1.  Institutionalized Personality Traits**

Institutionalized Personality Traits are caused by living in an oppressive environment that demands: passive compliance to the demands of authority figures, passive acceptance of severely restricted acts of daily living, the repression of personal lifestyle preferences, the elimination of critical thinking and individual decision making, and internalized acceptance of severe restrictions on the honest self-expression thoughts and feelings.

**2.  Post Traumatic Stress Disorder (PTSD)**

Post Traumatic Stress Disorder (PTSD) is caused by both traumatic experiences before incarceration and institutional abuse during incarceration that includes the six clusters of symptoms:

(1) Intrusive memories and flashbacks to episodes of severe institutional abuse;

(2) Intense psychological distress and physiological reactivity when exposed to cues triggering memories of the institutional abuse;

(3) Episodes of dissociation, emotional numbing, and restricted affect;

(4) Chronic problems with mental functioning that include irritability, outbursts of anger, difficulty concentrating; sleep disturbances, and an exaggerated startle response.

(5) Persistent avoidance of anything that would trigger memories of the traumatic events;

(6) Hypervigilance, generalized paranoia, and reduced capacity to trust caused by constant fear of abuse from both correctional staff and other inmates that can be generalized to others after release.,

**3.  Antisocial Personality Traits**

Antisocial Personality Traits are developed both from preexisting symptoms and symptoms developed during incarceration as an institutional coping skill and psychological defense mechanism.  The primary antisocial personality traits involve the tendency to challenge authority, break rules, and victimize others.  In patients with PICS these tendencies are veiled by the passive aggressive style that is part of the institutionalized personality.  Patients with PICS tend to be duplicitous, acting in a compliant and passive aggressive manner with therapists and other perceived authority figures while being capable of direct threatening and aggressive behavior when alone with peers outside of the perceived control of those in authority.  This is a direct result of the internalized coping behavior required to survive in a harshly punitive correctional institution that has two set of survival rules:  passive aggression with the guards, and actively aggressive with predatory inmates.

**4.  Social-Sensory Deprivation Syndrome:**

The Social-Sensory Deprivation Syndrome is caused by the effects of prolonged solitary confinement that imposes both social isolation and sensory deprivation.  These symptoms include:

* Severe Chronic Headaches,
* Developmental Regression,
* Impaired Impulse Control,
* Dissociation,
* Inability To Concentrate,
* Repressed Rage,
* Inability To Control Primitive Drives And Instincts,
* Inability To Plan Beyond The Moment,
* Inability To Anticipate Logical Consequences Of Behavior,
* Out of Control Obsessive Thinking, And Borderline Personality Traits.

**5.  Reactive Substance Use Disorders**

Many inmates who experience PICS suffer from the symptoms of substance use disorders.

* Many of these inmates were addicted prior to incarceration, did not receive treatment during their imprisonment, and continued their addiction by securing drugs on the prison black market.
* Others developed their addiction in prison in an effort to cope with the PICS symptoms and the conditions causing them.
* Others relapse to substance abuse or develop substance use disorders as a result of using alcohol or other drugs in an effort to cope with PICS symptoms upon release from prison.

**Post Release Symptom Progression**

Prisoners experiencing PICS tend to experience a six stage *post release symptom progression leading to recidivism* and often are not qualified for social benefits needed to secure addiction, mental health, and occupation training services.

* ·        Stage 1 of this Post Release Syndrome is marked by Helplessness and hopelessness due to inability to develop a plan for community reentry, often complicated by the inability to secure funding for treatment or job training;
* ·        Stage 2 is marked by an intense immobilizing fear;
* ·        Stage 3 is marked by the emergence of intense free-floating anger and rage and the emergence of flashbacks and other symptoms of PTSD;
* ·        Stage 4 is marked by a tendency toward impulse violence upon minimal provocation;
* ·        Stage 5 is marked by an effort to avoid violence by severe isolation to avoid the triggers of violence;
* ·        Stage 6 is marked by the intensification of flashbacks, nightmares, sleep impairments, and impulse control problems caused by self-imposed isolation. (Gorski)[[4]](#footnote-4)

We understand now that reintegrating ex-offenders are most likely suffering from PICS, and PAWS (Post Acute Withdrawl Syndrome)[[5]](#footnote-5) and that there is a connection between PICS, PAWS, recidivism and relapse.

One-third to one-half of homeless people had severe psychiatric disorders, often co-occurring with [substance abuse](http://en.wikipedia.org/wiki/Substance_abuse) (McQuistion HL).[[6]](#footnote-6) The lack of independence and responsibility for patients within institutions, along with the "depressing" (Grob) and "dehumanizing" (Palmer) environment can make it difficult for clients to live and work independently. Individuals who have become psychologically "institutionalized" can face several kinds of difficulties upon returning to the community.

The experience of being in an institution may often have exacerbated individuals' illness: proponents of [Labeling Theory](http://en.wikipedia.org/wiki/Labeling_theory#The_.22mentally_ill.22) claim that individuals who are socially "labeled" as mentally ill suffer stigmatization and alienation that lead to psychological damage and a lessening of self-esteem, and thus that being placed in a mental health institution can actually cause individuals to become more mentally ill(Wright, Gronfein and Owens 2000) (Link, Cullen and Struening).

Currently clinicians and counselors require sufficient training that teaches how to position themselves as advisors and agents of change. Training that assist clients by empowering them with information, inspiration, and motivation. Training that empowers clients to drive their own recovery, and which helps clinicians render effective evidenced based treatments and recovery based supportive services.

Clients sometimes are unable to evaluate the effects of institutionalization. Clinicians are ill prepared and lack schema for the cause and effects of institutionalization. Counselors are unfairly challenged to reverse phenomena they have insufficient systemic knowledge of. Treatment plans need to transform into recovery plans.

Recovery and reintegration are issues directly related to addiction, behavior disorders and mental health issues. Organizations that provide services to people with behavior disorders and mental health issues supply coping strategies that should be comprehensive recovery orientated responses to person centered treatment values. Recovery and reintegration are related to addiction and mental illness. There is a direct link between institutionalization and reintegration and therefore the antithetical factors of institutionalization would obviously be the keys to community reintegration and recovery. In fact without such emphasis it is quite clearly possible that institutions will perpetuate the very ills they were erected to improve. Treatment is oftentimes condescending, paternalistic, and unrelated to client ambitions, and values. So we have a schema of seven competing causal characteristics of reintegration:

# Factors of Reintegration

1. Autonomy **- Clients have a right to individuality and free choice.**
2. Access **– Clients should have access to advice, and assistance in education, employment, and other supportive services.**
3. Self Determination **– Clients have a right to choose their own strategies and subsequent outcomes.**
4. Attachment **– Clients have a right to reacclimatize and reenter social roles, family and community.**
5. Recovery **– Clients have a right to choose what method of treatment is best for them.**
6. Subjectivity **– Clients have the right to be treated as human beings and not be stigmatized as consumers, inmates or patients after reentry.**
7. Synchronization **– Clients have a right to services that help efforts to resynchronize and reclaim new productive roles in society.**

# Stigmatization

The badge of shame that the people in recovery, mentally ill, and disabled are forced to wear upon reentry is unfair and totally debilitating. Here are some recommendations[[7]](#footnote-7):

* Real ID[[8]](#footnote-8)
* Life coaches
* Job coaching
* Parenting advocacy & training
* Self-esteem counseling
* Discrimination counseling
* Pastoral counseling
* Higher education
* Vocational counseling
* Expanded notification of consumer rights
* General health medicine
* Networking
* Support groups
* Advocacy

In addition to the authors therapeutic interventions listed above, Gorski has suggested political strategies aimed at the PICS, PAWS, phenomena:

**Reducing the Incidence of PICS**

Since PICS is created by criminal justice system policy and programming in our well intentioned but misguided attempt to stop crime, the epidemic can be prevented and public safety protected by changing the public policies that call for incarcerating more people, for longer periods of time, for less severe offenses, in more punitive environments that emphasize the use of solitary confinement, that eliminate or severely restrict prisoner access to educational, vocational, and rehabilitation programs while incarcerated.

The political antidote for PICS is to implement public policies that:

(1)       Fund the training and expansion of community based addiction and mental health programs staffed by professionals trained to meet the needs of criminal justice system clients diverted into treatment by court programs and released back to the community after incarceration;

(2)       Expand the role of drug and mental health courts that promote treatment alternatives to incarceration;

(3)       Convert 80% of our federal, state, and county correctional facilities into rehabilitation programs with daily involvement in educational, vocational, and rehabilitation programs;

(4)       Eliminate required long mandated minimum sentences;

(5)       Institute universal prerelease programs for all offenders with the goal of preparing them to transition into community based addiction and mental health programs;

(6)       Assuring that all released prisoners have access to publicly funded programs for addiction and mental health treatment upon release. (Gorski)[[9]](#footnote-9)

When a society institutionalizes an individual it has a duty to reintegrate the person into the social fabric. Clinicians who are aware of the schema can now make better assessments, render better support services and referrals. The schema for reintegration is the inverse of institutionalization.

Reintegration and recovery have rights (American with Disabilities Act (ADA))[[10]](#footnote-10) attached to them and clinicians and clients need be made aware of what they are.

# Community Integration is a Right

**Community integration is a right of persons in recovery from behavioral health issues. This right is embedded in the 1990 American with Disabilities Act (ADA) and the 1999 Supreme Court Olmstead decision in which it was determined that unnecessary Institutionalization of persons who could live in the community with the proper supports is a violation of the ADA. President Bush’s 2001 executive order in response to the Olmstead decision and the final report from the President’s Mental Health Commission in 2003 have reinforced the notion of community integration and recovery as major policy goals for the design and delivery of mental health care.[[11]](#footnote-11)**

## Community Integration Defined

**Community inclusion/opportunities: the focus is on nesting recovery in the person’s natural environment, integrating the individuals/families in recovery into the larger life of the community, tapping the support and hospitality of the larger community, developing recovery community resources; and encouraging service contributions from and to the larger community. Connection to the community is viewed as integral to long-term recovery.[[12]](#footnote-12)**

## Community integration Means Increased Opportunities in All Areas of One’s Life

Community integration is the opportunity to live in the community, and be valued for one's uniqueness and abilities, like everyone else. This means the opportunity to do all of the things below:

* Work;
* Go to school;
* Be housed in the community;
* Have friendships with peers in recovery and individuals who have not received supports in the behavioral health system;
* Have meaningful social roles, such as parenting, being married or otherwise; involved in intimate relationships, being a brother/sister, being a son/daughter,
* Engage in recreational and physical activities;
* Participate as a citizen, including volunteering, engaging in the political process, and other aspects of civic life;
* Engage in spiritual and religious activities;
* Make choices about treatment and in all other areas of one’s life to the same degree that other people can and do.[[13]](#footnote-13)

## Recovery Defined

***“Recovery is the process of pursuing a contributing and fulfilling life regardless of the difficulties one has faced. It involves not only the restoration, but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one’s community. It is facilitated by relationships and environments that promote hope, empowerment, choices and opportunities that promote people in reaching their full potential as individuals and community members.”[[14]](#footnote-14)***

# Using KASM as the Model to Transform Treatment Systems[[15]](#footnote-15)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| KASM | KNOWLEDGE | ACTION | SHARING | MAINTENANCE |
| CLIENTS  Are people with behavior and mental disorders, and have legally mandated civil rights. | Learn specific rights of disabled persons, and recovery information. | Implement reconnection with family, groups, employment. | With family, support groups, and other similarly situated persons. | Using resources and initiatives that prevent relapse and promote recovery |
| COUNSELORS  Agencies should consider restaffing and creating links with emphasis on pastoral counseling, educational specialists, community organizers, faith providers, chaplains, Imams , clergy, and support groups. | Transform into super charged social change agents that provide client centered and driven care; with empathy, advocacy, motivation, and advice based on current social settings and policies that clients are confronting. | Transform into programs that provide empathy, advocacy, motivation, and advice based on current social settings and policies that clients are confronting. | Link and broker service information and join initiatives with other providers. | Provide ongoing evaluation of service compliance continuing education and quality controls. |
| SYSTEMS  Become recovery orientated focusing on community reintegration. | Gather information that Super charges comprehensive recovery orientated care systems which provide client centered and driven recovery services that seek to reintegrate clients into the community. | Transform into programs that provide empathy, advocacy, motivation, and advice based on current social settings and policies that clients are confronting. | Link and broker service information and join initiatives with other providers. | Provide ongoing evaluation of service compliance continuing education and quality controls. |

# Comprehensive Recovery Orientated Care Systems

CROCS are providers of comprehensive recovery services, which do not just provide clients with cookie cutter, rubber stamped, recovery plans that merely protect funding, reduce work load, and unfortunately reduce a client’s chance of success in recovery. Services should not culminate in discharge plans that do not reflect holistically the ambitions, strategies, decisions, values, faith, culture and needs of clients. ((DBH/MRS))

The emphasis in CROCS should be client centered and driven recovery planning that is orientated around the fact they are dealing with persons with disabilities and that they are legally mandated to supply recovery services that respond to their client’s individual rehabilitory needs related to reintegration and prosperity (DBH/MRS). Clients are not all the same and are uniquely disabled and require individual, realistic, effective person centered spiritual recovery (Yusaf) and integration empowerment (Salzer). CROCS should provide linkages to (this is not an all inclusive list):

The stakeholders in attendance at SAMHSA/CSAT’s National Summit on Recovery held in 2005 identified elements of recovery-oriented systems of care as follows:

* Person-centered;
* Family and other ally involvement;
* Individualized and comprehensive services across the lifespan;
* Systems anchored in the community;
* Continuity of care (pretreatment, treatment, continuing care, and recovery support);
* Partnership-consultant relationship, focusing more on collaboration and less on hierarchy;
* Strengths-based (emphasis on individual strengths, assets, and resilience);
* Culturally responsive;
* Responsive to personal belief systems;
* Commitment to peer recovery support services;
* Inclusion of the voices of recovering individuals and their families;
* Integrated services;
* System-wide education and training;
* Ongoing monitoring and outreach;
* Outcomes-driven;
* Based on research; and
* Adequately and flexibly financed (CSAT, 2007, p. 12-13).[[16]](#footnote-16)

# Client Centered & Driven Systems of Recovery

Providers should respect faith choices, and the autonomy of consumers, and treat consumers in accordance with the above noted legal mandates.[[17]](#footnote-17) This will increase efforts in recovery and integration. Clients should be motivated through the counselor giving advice, and teaching consumers to benefit from their expert knowledge, of local community resources and therapeutic interventions, and how to maintain spiritual recovery.

# The Counselor as Empathetic Super Charged Change Agents

Our Prophet (as) said “faith increases and it decreases…,” So we are like spiritual batteries on either high or low charge. We know that faith is increased by doing right actions. So we all must maintain our faith, by the light of Al Quran, and the Sunnah, in it we have a firm handhold.

We have to be forgiving and empathetic so that we can have a clear heart to increase our good deeds, as Islamic counseling professionals what works for our clients is applied to ourselves and our community. KASM is just such a treatment.

We recommend the following: life coaching, peer networking, internet resourcing, making linkages with other providers and the private sector.

We as providers and counselors have to be super charged with the right information and the ability to deliver it to consumers.

# Pastoral Counseling and Chaplaincy

Clergy are responsible for 50% of all counseling of persons with mental health and behavior disorders (Osman M. Ali). This implies that regardless of what counseling skills clergy possess people rely on clergy for their counseling needs. There need to be linkages between clergy and mental health providers that support recovery. We recommend that providers recruit chaplains and that we teach Imams and Islamic Chaplains, KASM Therapy, a cognitive behavioral therapy (Elias) based in Al Asr (Q:103)[[18]](#footnote-18), and scientific evidence based treatment modalities[[19]](#footnote-19).

In a recent study of Imams, by Osman M. Ali, The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States, it was found that “few …had received formal counseling training.Their… congregants came to them most oftenfor religious or spiritual guidance and relationship or maritalconcerns.” Alarmingly, “Imams reported that since September 11, 2001, therehas been an increased need to counsel persons for discrimination (Osman M. Ali).

Islamic clergy are best suited to address these needs. In fact we are responsible as Muslims, and many of us know it is necessary that leaders address these communal needs. KASM program models are appropriate to address the therapeutic needs of our community.

The report concludes as follows: “An increased need to counsel persons who were discriminatedagainst was reported by all Imams with congregations in whicha majority are Arab American, 60 percent of Imams with congregationsin which a majority are South Asian American and 50 percentof Imams with congregations in which a majority are AfricanAmerican” (Osman M. Ali). Across the board in all Islamic sub groupings, and demography Imams reported these phenomena.[[20]](#footnote-20)

## Conclusion

Our hope is that service providers begin to realize that they can no longer do business along the same old standards, things have changed. I remember the days when to go to treatment required that the client be totally humiliated and shamed into wearing a dunce hat, and a baby pamper under the assumption that this will make a consumer not want to use drugs and alcohol, needless to say, people did not get well in fact it caused them to want to drink and drug even more. This type of quackery is reminiscent of Attica C.F.[[21]](#footnote-21), Willow Brook[[22]](#footnote-22), or even the asylums of the early 1900’s. We document that oftentimes Muslims seeking wellness entered the Masajid and our communities were at loss to understand and help them stop the suffering. Often Muslims were in church run programs and did not feel comfortable, and report, they felt like a fish out of water and that their faith was in conflict with their treatment.[[23]](#footnote-23)

KASM is the solution that links Islamic counseling clinical professionals to mental health skills and empowers Imams and Islamic chaplains with professional counseling and related skill development.

We pray, Oh Allah Most Gracious, Bless this KASM training, causing readers to know, and thereafter develop sincere desire and intention to take actions thereon, that will lead to KASM therapy being taught and shared with those in need of maintaining a blessed life in KASM Recovery, Insha Allah, Ameen.

Imam Hamzah Alameen

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# Client Reintegration & Recovery Resources

## Client Check List

SEE ATTACHED

## Provider Reintegration Recovery Resources

## Websites

*CENAPS.* [www.tgorski.com (http://www.tgorski.com/), www.cenaps.com (http://www.cenaps.com/), www.relapse.org (http://www.relapse.org/), www.relapse.net (http://www.relapse.net/)](file:///C:\Users\Hamzah\AppData\Roaming\Microsoft\Word\www.tgorski.com%20(http:\www.tgorski.com\),%20www.cenaps.com%20(http:\www.cenaps.com\),%20www.relapse.org%20(http:\www.relapse.org\),%20www.relapse.net%20(http:\www.relapse.net\))

University of Pennsylvania Collaborative on Community Integration

http://www.upennrrtc.org

Institute for Recovery and Community Integration

http://www.mhrecovery.org/

City Resources including job training programs and advocacy organizations

http://philadelphia.pa.networkofcare.org/mh/links/display\_links.cfm?id=85&topic=20

Supported Employment Consortium

www.worksupport.com

Association for Persons in Supported Employment (APSE)

www.apse.org

Recreation Therapy: resources and activities

http://www.recreationtherapy.com/tx/actindex.htm

CST Mental Health Resources page

<http://cstmont.com/resources.htm>

[www.Islamiccharities.org](http://www.Islamiccharities.org) (KASM Therapy and advocacy)

St. Francis Care, Clinical Pastoral Counseling

<Http://www.stfranciscare.org/body.cfm?id=983>

**CSAT’s National Summit on Recovery go to:**

<http://www.rcsp.samhsa.gov/resources/index.htm#summit>.

Association for Clinical Pastoral Education, Inc.

<http://www.acpe.edu/multicultural.htm>

For strategies involving CROC program implementation. **http://www.crisisprograms.com**

# Provider Check List

SEE ATTACHED

# Works Cited

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Haney, Craig. "The Effect of Incarceration and Reentry on Children, Families, and Communities." December 2001. The Psychological Impact of Incarceration:. 2010 <http://aspe.hhs.gov/hsp/prison2home02/Haney.htm>.

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Osman M. Ali, M.D., Glen Milstein, Ph.D. and Peter M. Marzuk, M.D. "The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States." Psychiatry Service February 2005 : 56:202-205.

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Shorter, Edward. A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. 1997. 22 Feburary 2010 <http://books.google.com/books?id=-Oybg\_APowMC>.

Williams, Stephen M. Environment and Mental Health. New York: John Wiley & Sons., 1994.

Wright, Eric R, William P Gronfein and Timothy J Owens. ""Deinstitutionalization, social rejection, and the self-esteem of former mental patients"." Journal of Health and Social Behavior 41 (1) 2000: 68–90.

Yusaf, Shehzi. "Spirituality in Clinical Practice: An Islamic Perspective." 2005.

1. The author has developed these factors based on qualitative research, interviewing dozens of professional counselors and human service providers who were also, in recovery, ex-felons and chronic recidivist. For support of these assumptions see Haney, Craig. "The Effect of Incarceration and Reentry on Children, Families, and Communities." *The Psychological Impact of Incarceration:.* December 2001. http://aspe.hhs.gov/hsp/prison2home02/Haney.htm (accessed 2010). [↑](#footnote-ref-1)
2. Terence T. Gorski (Gorski) [↑](#footnote-ref-2)
3. Terence T. Gorski, [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. See the KASM training manual for a discussion on Gorski’s PAWS; symptoms of PAWS can continue ten years into recovery. [↑](#footnote-ref-5)
6. McQuistion HL, Finnerty M, Hirschowitz J, Susser ES (May 2003). ["Challenges for psychiatry in serving homeless people with psychiatric disorders"](http://ps.psychiatryonline.org/cgi/pmidlookup?view=long&pmid=12719496). *Psychiatr Serv* **54** (5): 669–76. [doi](http://en.wikipedia.org/wiki/Digital_object_identifier):[10.1176/appi.ps.54.5.669](http://dx.doi.org/10.1176%2Fappi.ps.54.5.669) [↑](#footnote-ref-6)
7. The author recommends that providers seriously study local resources and consumer interest in programming should be priority. [↑](#footnote-ref-7)
8. A release ID need not divulge the name of the agency releasing consumer instead they should have a regular State ID like everyone else has. [↑](#footnote-ref-8)
9. It can be seen in current legislation that the Gorski recommendation were taken seriously and there are now funding and initiatives focusing on the problem, but are providers aware of the counseling needs of released inmates? [↑](#footnote-ref-9)
10. Olmstead decision and the final report from the President’s Mental Health Commission in 2003 have reinforced the notion of community integration and recovery as major policy goals for the design and delivery of mental health care. [↑](#footnote-ref-10)
11. See transformation tools: *Philadelphia Department of Behavioral Health/Mental Retardation Services (DBH/MRS, 2006)*. [↑](#footnote-ref-11)
12. (Blueprint for Change, Philadelphia DBH/MRS, 2006) [↑](#footnote-ref-12)
13. Salzer, M.S. (ed.). (2006). Psychiatric Rehabilitation Skills in Practice: A CPRP Preparation and Skills Workbook.

    Columbia, MD.: United States Psychiatric Rehabilitation Association. See Transformation Tools: Philadelphia Department of Behavioral Health/Mental Retardation Services (DBH/MRS, 2006) [↑](#footnote-ref-13)
14. Philadelphia Department of Behavioral Health/Mental Retardation Services (DBH/MRS, 2006) [↑](#footnote-ref-14)
15. (Al-Ameen) See training manual for fuller discussion of KASM Therapy. [↑](#footnote-ref-15)
16. **To access the complete report from CSAT’s National Summit on Recovery go to:**

    <http://www.rcsp.samhsa.gov/resources/index.htm#summit>. [↑](#footnote-ref-16)
17. [↑](#footnote-ref-17)
18. See our training manual. [↑](#footnote-ref-18)
19. For a full discussion see the training manual which details the Islamic schema of KASM Therapy, and which therapeutic strategies are utilized (CBT, DBT, REBT, among others, a multi-therapeutical approach). [↑](#footnote-ref-19)
20. Although Imams have little formal trainingin counseling, they are asked to help congregants who come tothem with mental health and social service issues.

    Imams needmore support from mental health professionals to fulfill a potentiallyvital role in improving access to services for minority Muslimcommunities in which there currently appear to be unmet psychosocialneeds.” (Osman M. Ali) [↑](#footnote-ref-20)
21. Attica, Correctional facility was the site of an inmate revolt against the cruel and unusual conditions that were allowed to exist there in the early 70’s. [↑](#footnote-ref-21)
22. Like Attica, Willow Brook mental hospital was found negligent and guilty of horrific abuses to the mentally ill, [↑](#footnote-ref-22)
23. Dr. Malik Badri is a supporter of CBT therapies for Muslims and he cautions clinicians that western therapy models cannot be totally used in the treatment of Muslims. [↑](#footnote-ref-23)