

**Community Support
Training:
Skill Building Language**

DMHAS

December 2, 2010

DMHAS CSP/RP – General Info

COMMUNITY SUPPORT PROGRAM/RECOVERY PATHWAYS:

- 22 AGENCIES – 6 STATE, 16 PNP_s
- Opportunity to enhance & re-align MH Case Management services to Community Support Program/Recovery Pathways (CSP/RP).
- CSP/RP services focus on building & maintaining a therapeutic relationship with the individual while delivering rehabilitative, skill building interventions & activities.

DMHAS CSP/RP – General Info

- Every agency has a CSP/RP Champion & DMHAS staff have been meeting with them since 8/5/10 – every other Thursday – alternating between – in person meetings and conference calls.
- Champions have access to email address to post questions, if they cannot be answered at the agency level.
- DMHAS WEBSITE - www.ct.gov/dmhas
Major Initiatives - Community Support Program (CSP) Initiative

Service Definition

- CSP: a Team Service with a mixture of staff who focus on **Rehabilitation, Restoration and Recovery**
- This may mean building support and assistance along with defining what recovery means to the client by:
 - Establishing goals that help clients **build the capacity to reach recovery and independence**, while always trying to show/demonstrate their progress and the types of assistance & support provided.
 - Eventually **reduce the duration and intensity of care to the least intrusive level** that will sustain health.

The Switch: Rehab for Clinicians

- Justification for services is based on the medical necessity for assistance as the result of the psychiatric illness & how it impacts the individual's daily living which is assessed by the use of a functional assessment which in turn helps to define and inform the provision of restoration or improvement of functioning.
- Symptom reduction is not the focus, symptom and disability self management are.
- Focus is on teaching, cueing, reminding, training and overcoming barriers.

The Switch: Rehab for Clinicians

Focus is not medical or clinical, but Rehabilitative Skill building and support for Activities of Daily Living, including:

- Teaching, coaching and assisting with daily living and self-care skills such as; the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
- Other skill development activities directed at enhancing self-management skills and coping strategies to achieve independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the Recovery Plan;
- Teaching recovery skills in order to prevent relapse such as; symptom recognition, coping with symptoms/substance use triggers, emotional management, relaxation skills, self administration and appropriate use of medications, and preparation of illness related advance directives;

The Switch: Rehab for Clinicians

- Development of self-advocacy skills for the purpose of accessing natural supports, self-help, Health and wellness education and other advocacy resources and
- Education, support, and consultation to family members and significant others identified by the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant;
- Participation in Recovery Plan development and update; give person in recovery a copy of their recovery plan;
- Skills Training Groups, involving not more than six (6) persons who must be at similar cognitive levels and have comparable rehabilitation goals focusing on any of the activities listed in items above; and
- Documentation of all services must be maintained and meet federal, state and DMHAS requirements. Each client contact will be recorded in a medical record. Progress/Encounter notes shall relate back to goals identified in the recovery plan, describe concretely and objectively in behavioral terms client response to interventions, next steps, date, time, service duration, location of activity, practitioner name and credentials.

Working as a member of a Community Support Program, you will need to know and understand *specific Person Centered Skill Building Language*
Such as....

1. What “Assistance” means.
2. What the different “Levels of Assistance” are.
3. What are the “different types of “Assistive Techniques” for providing assistance to CSP participants.
4. How to use “Skill Building Language” in Documentation

Interventions = Assistance

Assistance is providing the step by step physical, verbal, written and visual directions/demonstrations (through cueing and prompting/coaching) that aid, enable and/or assist an individual in performing skills/tasks. There are different Levels of Assistance:

- **MAXIMUM ASSISTANCE:** Unable to meet minimal standards of behavior or functioning in order to participate in daily living activities or performance of basic tasks approx. 75% of the time. **Cue** – Step by step physical gestures, pointing and demonstrations **Prompts/Coaching** - Step by step physical demonstrations with visual and verbal directions that prompt the participant to perform the skills and/or tasks.
- **MODERATE ASSISTANCE** – Needs constant cognitive assistance such as 1:1 cueing, prompting/coaching or demonstrations to sustain or complete simple, repetitive activities or tasks safely and accurately approx. 50% of time. **Cues** - Hints to help organize thoughts. **Prompts/Coaching** – Step by step verbal directions.
- **MINIMUM ASSISTANCE** – Needs periodic cognitive assistance (cueing and/or prompting/coaching) to correct mistakes, check for safety and/or solve problems approx. 25% of time. **Cues** -Hints related to the task. **Prompts/Coaching** – Step by step written and/or verbal directions.
- **STANDBY ASSISTANCE:** Supervision by one person is needed to enable the individual to perform new procedures for safe and effective performance. **Cues** – Visual demonstrations related to the task. **Prompts/Coaching** – Visual and physical directions that prompt the participant to perform the skills and/or tasks.
- **INDEPENDENT:** No physical or cognitive assistance needed to perform activities or tasks.
- **UNABLE TO ASSESS** – Individual refuses or has chosen to not actively participate in providing any evidence of skills and/or abilities or demonstrating any skills and/or abilities for this assessment

The Different Types Of Assistive Techniques: Cues & Prompts/Coaching

Cueing and **Prompting/Coaching** are techniques that are used to teach skills, give information or instructions along with focusing and/or refocusing an individual's attention on a given task and/or skill.

Cueing and **Prompting/Coaching** can be done in four different ways or in a combination of two or more of these:

- Written information
- Spoken information
- Physical information
- Visual Demonstration

Written information

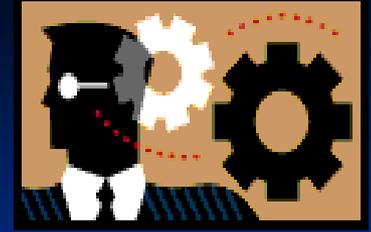


Written cues are often key words or lists used to remind and to focus and/or refocus attention on a given skill/task.

Written prompting/coaching are step by step instructions used to promote memory, organization skills and retrieval or acquisition of skills. Written cues and prompting/coaching may take several forms including:

- **Reminder words or notes**
- **Lists of tasks**
- **A daily schedule or chart**
- **A calendar to use for appointments**
- **Written step by step directions**

Spoken information



The difference between **Verbal Cues** and **Verbal Prompting/Coaching** are both determined by the amount of information given and the specificity of the spoken information.

Verbal Cue “Do you remember what to do first?” Or “Can you tell me how you would do?” (verbal hints)

Verbal Prompting/Coaching: “First, why don’t you do/try this...Or “I’ll describe/explain what you might do first and then we’ll go from there.” (These are examples of verbal directions)”

Physical information



The difference between Physical cues and Physical prompting/coaching *is a matter of degree.*

- **Physical Cue:** You may point to a cue card, a list, a reminder note, an object etc. to assist an individual to follow and remember the steps of the skill/task. (hints)
- **Physical Prompting/Coaching:** The individual is preparing to do his/her laundry. You explain & demonstrate each step in the process of loading the machine and selecting the settings in order for the individual to learn the skills independently. (directions)

Visual Demonstration



Some individuals learn primarily visual demonstrations re: Role-playing and modeling. These are effective ways to demonstrate needed skills and/or tasks to be learned and to **Visually cue** and/or **prompt/coach** the individual.

- **Visual Cues:** (*nodding, “OK” hand signals, etc.*) along with repeated practice and experience are an effective way for participants to learn and remember skills. (Visual “hints”)
- **Visual Prompt/Coaching:** Role-plays are most effective when the skill and/or task is *demonstrated* first by the Recovery Assistant with an opportunity for the individual to ask questions and then perform the steps of the skill and/or task. (think of it as “Visual directions”)

And All Of These Skill Building Techniques Need To Utilize Your Knowledge Of

- Positive, Person Centered, Recovery Oriented Communication Skills
- Motivational Interviewing Skills
- Understanding the Stages of Change and utilizing strategies to assist the individual in terms of where they are in their recovery process.
- An awareness of any Psychiatric Illness including trauma which may have resulted in lasting effects.

Positive Person Centered, Recovery Oriented Communication

Skills

Clients may have difficulty adjusting to the different ways that you are interacting with them as “teacher/treatment provider” versus the role of TCM case manager. Here are some simple guidelines:

- Get to the point
- Clearly state the area that you will be working on
- Use direct, simple language
- Keep it brief
- Speak in a calm voice
- Use praise whenever possible
- Tell client specifically what he or she did that pleased you
- Avoid long sentences and introductions to topics
- Make direct requests that tell clients exactly what you want to do with them



*Adapted from Bellack, Mueser, Gingerich, Agesta Social Skills Training for Schizophrenia Guilford Press, 1997

Examples of Positive Person Centered, Recovery Oriented Communication Skills

Listen Carefully: Check with the individual to find out what they think and feel. Check with them to see if you are correctly understanding how they are feeling.

- **Example:** “What I hear you saying is that you’re tired now, but you don’t mind if I ask you again to attend activities, is that right?”

Show Understanding: Actual or “perceived” changes to living situations, services, medications, etc. are stressful for all of us and is an adjustment. Showing support by acknowledging the difficulty of “change” is helpful. No one is ever “unmotivated”. There’s a reason behind a decision not to make change. Also, no one ever makes the “wrong” decision; all decisions are based on what serves our personal needs.

- **Example:** Asking questions like “How are you doing with the changes?”, or making comments like “It must be difficult for you to go through these changes” can be helpful.

Examples of Positive Person Centered, Recovery Oriented Communication Skills

Identifying Strengths: You can help people to identify strengths by asking about things that they like to do, or looking for things that they do successfully and commenting on it .

- **Example:** "Your apartment is so nice and neat, you must be a good housekeeper" or "You seem like such a friendly person" or even "You seem a little shy, but I sense that once people get to know you that they will find a very nice person".

Offering Hope: Ambivalence is normal. Help the individual acknowledge and discuss their feelings in a way that respects his/her choice.

- **Example:** "I think you will be successful here once you get used to it".

Generous Positive Feedback: Look for positives and let the person know about them. "You seem to have figured out the routine here, you are always on time for lunch".

- **Example:** "I liked the way you handled Mrs. Smith, you were very nice to her". "You have a great sense of humor".

Examples of Positive Person Centered, Recovery Oriented Communication Skills

What if someone doesn't want to participate?

- Allow for reluctance (stages of change).

Understand that Recovery is fluid and someone might be pre-contemplative or in the “relapse” stage in terms of their rehabilitation

- Use modeling instead of role-plays and get the individual's feedback...and **LISTEN**
- Use Motivational Interviewing and Engagement techniques and approaches
- Have an awareness of any Psychiatric Trauma which may have resulted in lasting mental and physical effects

Break into Groups

Case Example #1

Geraldo is 40 and lives in a fairly large city. He goes to a Clubhouse 5 days a week where he receives lunch. He is able to walk there. Other than that, he relies on his case manager to provide him with transportation to the grocery store, doctors' appointments, etc. He appears to be comfortable with this arrangement and he states that he would like to get a job. He has a high school diploma, although he attended some Special Education classes. Geraldo periodically complains of hearing voices that disturb him and it is very hard for him to concentrate. He is compliant with his medication regime. Geraldo seems to have to concentrate all his attention on whatever he is trying to do. He is constantly looking for approval and can get easily frustrated when others tell him what to do. Recently, Geraldo has expressed that he is interested in learning to do things on his own, such as cleaning his apartment and cooking. His hygiene is not the best. His bathing is irregular and it seems that he does not always wash his hair, shave, brush his teeth or wear clean clothes.

Using Skill Building

Practice Example #1 - Geraldo: Personal Care

Geraldo's first Goal is (stated in client's own words) "I want to get a job". His initial FA determined that in the **Domain of Personal Care** he was functioning at an **LOA of MINIMUM ASSISTANCE** (Needs periodic cognitive assistance (cueing and/or prompting/coaching) to correct mistakes, check for safety and/or solve problems approximately 25% of time. **Cues** – Hints related to the task. **Prompts/Coaching** – Step by step written and/or verbal directions.

As a group come up with a minimum of 5 "**skill building techniques**" that you would use to work with "Geraldo" in order to teach him to learn how to improve or gain new skills around his "**Personal Care Skills**" Use your knowledge, skills & training in Motivational Interviewing, Stages of Change & the Person Centered Approach.

***REMEMBER:** The different skills need to be observable & measurable.

Using The Functional Assessment To Inform The Development Of A Person Centered Recovery Plan “GERALDO”

Goal: (in client's own words) “I want to get a job”

Objective 1: Geraldo will work on developing health hygiene skills in order to help him get a job.

Skills/Interventions:

- Educate Geraldo on appropriate hygiene procedures
- Have Geraldo list what items are needed in his home so he could promote good hygiene
- Teach Geraldo to use the bus to get to the store to buy hygiene items
- Develop a daily routine for good hygiene (create a list with morning, afternoon and evening hygiene tasks with Geraldo)
- Create a weekly chart for Geraldo to check off when he completed his hygiene routine

Case Example #2

Mabel is 48 years old, does not have many friends and her behavior is continually getting her in trouble. She has recently been caught by one of the staff in her supervised apartment smoking pot behind the bushes on the property. She knows that this is against the policies of the agency who owns the property. She received a written notice stating that if this occurs again she will be evicted. Mabel has also told you that she likes to drink wine. She claims that she only does this occasionally (1x per week). You suspect that is more frequent. Mabel's psychiatrist has diagnosed Mabel with bipolar disorder. He has suggested that she take her medication as prescribed and go to the mental health center to receive services. Mabel doesn't think there is anything wrong and she doesn't want to take the medication because it "inhibits her creative ability." She can't understand what all the fuss is about and wishes that people would just leave her alone to do what she wants to do.

Using Skill Building

Practice Example #2 - Mabel

Mabel has a Recovery Goal of “I want to have more friends”. Mabel’s functional assessment indicated that she is **Independent** (No physical or cognitive assistance needed to perform activities or tasks) in most areas of her life.

As a group come up with a minimum of 5 “**skill building approaches/techniques**” that you would use with “Mabel” in order to assist her in accomplishing her stated goal. Use your knowledge, skills & training in Motivational Interviewing, Stages of Change & the Person Centered Approach.

***REMEMBER:** The different skills need to be observable & measurable.

General Documentation Guidelines: Recovery/Treatment Plans

- Should have a goal in **consumer's own words** which is then restated in a “treatment goal” which includes;
- **Medical Necessity** that is clearly stated and is written by Qualified Practitioner.
- Objectives should be **outcome focused, measurable and observable and designed to improve functioning and symptoms or prevent their worsening.**
- Interventions need to be **skills focused – the specific skills in a step by step process that an individual needs to learn in order to reach/obtain their goals & objectives.**

General Documentation Guidelines: Recovery/Treatment Plans

- Prioritizes problems and needs
- Stating goals which will facilitate achievement of stated hopes, preferences and desired outcomes
- Selecting measurable services and interventions of the right duration, intensity and frequency to best accomplish these objectives
- Identifying the qualified staff responsible for the provision of services and documentation
- Defining outcomes, discharge criteria and desired changes in levels of functioning and quality of life by which to objectively measure progress.

Documentation Language

The “Common CSP & RP Documentation Terms” sheet is available on the

DMHAS WEBSITE - www.ct.gov/dmhas

**Major Initiatives - Community Support
Program (CSP) Initiative**

General Documentation Guidelines: Progress/Encounter Notes

The progress/encounter note is an integral part of the consumer's written legal record.

- The **content** in progress note documentation should provide all the necessary supporting evidence to justify the need for the services based on medical necessity criteria & support all requirements for the service.
- The **purpose** of progress note documentation is to accurately describe the actual delivery of services and the actual impact of the services in such a matter as to provide the client, provider, and other appropriate stakeholders with sufficient information to determine each of the following (next slide):

General Documentation Guidelines: Progress/Encounter Notes

Progress notes need to demonstrate the following:

- Who - The name, qualifications and/or title of the qualified staff providing the service or intervention.
 - What – What was done, the specific interventions/skills training services provided.
 - Where – The physical site where were the services provided (office, client's home, etc.).
 - When – Date, length of service (in 15 min. units or time) and time of day.
 - Why – Why were the services done. The intended goal, objective and outcome related to the interventions/skills training services.
 - How – How the skills training was done (concrete, measurable & descriptive) along with the consumer's response and progress.
- * Also need to include the plan for next steps – Homework and/or any needed modifications or changes to the Skills training/interventions.

General Documentation Guidelines: Progress/Encounter Notes

There are numerous acceptable formats for best practice progress note documentation. Among many others, these formats may include the following acronyms. Definitions of these formats stand for:

- *S-O-A-P*: Subjective, Objective, Assessment and Plan
- *P-I-R*: Problem(s)-Intervention(s)-Response(s)
- *G-I-O*: Goal(s), Intervention(s), Objective(s)
- *G-I-R-P*: Goal(s), Intervention(s), Response(s), Plan

The GIRP model best lends itself to “best practice” for CSP progress note documentation.

G-I-R-P: Goal(s), Intervention(s), Response(s), Plan **Progress Notes**

G - Goal(s) - Describes the individualized goals and objectives of services and issues related to the reason why the consumer is participating in this particular service at this particular time.

- This is reflected on the consumer's Recovery Plan.
- The Consumer's hopes, preferences and desired outcomes specific to this particular setting, level and service of care are included.
- It is a statement of why the Consumer is in this program.
- It is expected that the information will answer the question why the Consumer needs these service(s).

G-I-R-P: Goal(s), Intervention(s), Response(s), Plan **Progress Notes**

I - Intervention(s) - Describes the services, interventions and modalities planned and provided in sufficient detail to clarify to all readers (including auditors for billing):

- **What was provided**
- **Why it was provided**
- **When it was provided**
- **Where it was provided**
- **With what intensity & for what duration it was provided**
- **Who provided it**
- **and How it was provided**

It is expected that the information will answer the question about what specifically is being done for the consumer.

G-I-R-P: Goal(s), Intervention(s), Response(s), Plan
Progress Notes

R- Response(s)- Should illustrate two types of responses:

- One is the consumer response to the intervention and related progress or non-progress.
- Two is the response of the service provider(s) and related services decisions to continue with the same planned interventions or to modify, add, delete or completely alter interventions.

G-I-R-P: Goal(s), Intervention(s), Response(s), Plan
Progress Notes

P- Plan- Should summarize the plan for continued services and describe what if any modifications need to be made and whether any referrals or new services are recommended. It is expected that the information will answer the questions:

- What has happened
- What is next

FA Questions

What happens to individuals who don't want this model, e.g. those who need immediate help for basic services (e.g. discharged from a hospital with no housing or benefits), but who are not currently interested in making any changes?

It is important to use the LOCUS to determine the appropriate level of care. It is common for the beginning of services to include a focus on basic needs/services, and attention to these needs often enhances the therapeutic relationship, leading to interest in working on additional rehabilitation goals in other areas of their lives. Some agencies are also offering drop-in case management services (e.g., 1.5 hours/week), in their clubhouse program or other part of their agency, to assist individuals who do not need the CSP/RP levels of care and have only a one-time need for assistance. Recovery support specialists (i.e., individuals in recovery) can be especially helpful in the engagement phase and working with individuals to develop personal goals.

FA Questions

Skills Teaching Groups in office setting. Are they still considered acceptable CSP service because they occur in an office setting?

This is acceptable CSP service time. Please also explore the potential for holding skills teaching groups in community settings. Groups in the office should not compose the majority of a person's CSP/RP hours.

If services are provided in the Clubhouse, is that considered “in the community”?

Yes, but remember we are looking for the education to occur in the client's natural environment. Having routine services in the clubhouses on a frequent basis may not always work.

FA Questions

Do encounter notes require documentation of a specific percentage of improvement?

No. Please see the CSP/RP website for a sample encounter note.

Can we receive samples of good chart documentation?

Yes. Your Technical Assistance Team is available to provide samples and we will post some on the CSP website. We are also developing a web-based module on CSP/RP Documentation.

FA Questions

Regarding the need for an integrated Recovery Plan, could, for example, one of the overall goals on the master treatment plan be ‘increase socialization’, and then a separate but attached Recovery Plan could expand, i.e., ‘use CSP skill building model to increase opportunities for socialization’?

In agencies that provide both clinical and CSP/RP rehabilitation services, we would like to see the overall goals and the CSP interventions in one Comprehensive Recovery Treatment Plan that contains the Clinical and Rehabilitation goals and interventions in one document which is accessible and referenced by all staff working with the individual.

FA Questions

Based on the recovery/treatment plan template, does the “90 day review” require the full completion of a new recovery/treatment plan?

No, it can be a recovery/treatment plan update, which would also include a FA update.

How do we have an integrated clinical/rehabilitation treatment/recovery plan, if our agency does not provide the clinical services?

The chart at your agency should contain a copy of the clinical treatment plan generated at the other agency. Your rehabilitation plans should reference and be consistent with the clinical plan; the clinical agency should have a copy of your rehabilitation plans and their clinical plans should reference/be consistent with the rehab plans.

Other Questions?

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