



Recovery Oriented Practice: The Road to Building Person-Centered Planning into Services

Webinar: Part 2

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Learning Objectives



Be able to:

- Describe what the fidelity to Person-Centered Planning looks like
- Explain how to improve documentation
- Describe the role of the county/tribe in ensuring quality services with contracted providers
- Understand Direct Support Staff's role in psychosocial rehabilitation in Community Based Residential Facility's (CBRF)

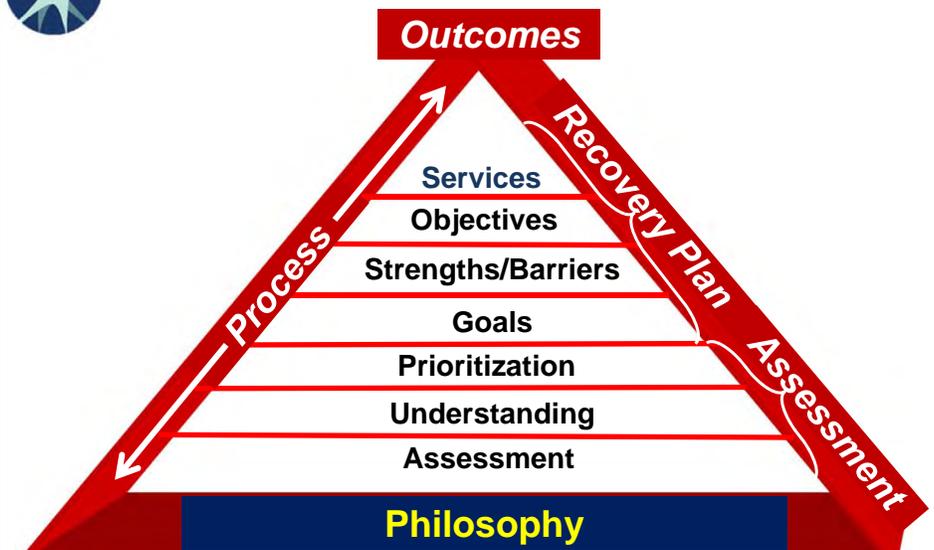


Fidelity Checklist Assignment

- How did you all do with this assignment?
- Did you see documentation that could be improved?
- Any areas of the PCP components that did not fit in with your organization's documentation?



PCP Components





Assessment: Common Mistakes

- Limited mention of the person's strengths (e.g., past success, interests, preferences)
- Limited mention of the barriers that are getting in the way
- Not sufficiently comprehensive
- Does not use all available information resources

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Clinical Summary: Common Mistakes

- Lacks adequate integration/understanding of the person
- Does not give both the provider's and individual's perspectives
- Does not pull out key areas that need to be addressed
- Unclear what the treatment recommendations are

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Goals: Common Mistakes

- Not global
- Not directed toward recovery
- Not consistent with assessment and clinical summary
- Too many
- Not responsive to need



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Goals: Common Mistakes

Example:

- “I want to go fishing more often.”

Is this a meaningful goal for this individual? Do you need to peel the onion?

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Goals: Use of OARS

Conversation (OARS)

- **Open-ended questions:** What would this mean to you to be able to go fishing? What's getting in the way of doing this?
- **Affirmation:** You really have tried hard to overcome the anxiety.
- **Reflections:** Seeing your friends at the fishing spot is really important to you and you feel stuck because of your anxiety.
- **Summary:** From what you said, you really want to be able to see your friends again at the fishing spot. There are things you have tried to get a handle on the anxiety but there are things you have not tried yet. You want to feel unstuck so you can get out again. What are some of your ideas to get over this hump? How can we help?

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Goals & Clinical Summary

Example:

- "I want to go fishing more often to see friends."

Clinical summary: Ed would like to be able to go fishing again so he can see his friends but has a significant amount of social anxiety. His increased anxiety has been a barrier for him to be able to go fishing and socialize with others outside the home. His mother passed away five months ago and his anxiety seems to have increased since then.

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Goals: Common Mistakes

Examples:

- I don't want to go back to the hospital.
- I don't want to be overwhelmed anymore.

Could these be reframed to move toward something desirable?

Examples:

- I want a cell phone.
- I want a car.

Are these life-changing, meaningful goals for the person?

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Goals: Common Mistakes

Examples:

- I don't know what my goal is
- I just want to be left alone
- I want to maintain my routine

How do you work through this? Use of motivational interviewing (e.g. pros/cons, working with ambivalence)

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Objectives: Common Mistakes

- Don't support the goal
- Not measurable or behavioral
- More of an intervention than objective
- Not time framed
- Too many simultaneous objectives
- Uses AND, hard to measure

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Objectives: Common Mistakes

Example 1:

- Mike will continue to clean his apartment **and** wash his dishes **and** clean along side staff once a week.

Is this objective Behavioral, Achievable, Measurable, Time-framed?

Are there mixed objectives and interventions?

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Objectives: Re-write

Objective:

- Within 3 months, Mike will spend 2 hrs/wk doing household chores as evidenced by self-report

Intervention:

- CBRF staff will prompt and train Mike in doing household chores 2 hrs/wk to improve Mike's cleaning skills.

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Interventions: Common Mistakes

- Combined activities a provider is doing
- There is no connection to the assessment and clinical summary (Is the service needed by the person?)
- Frequency, intensity, and duration not included
- Purpose not included
- Does not reflect multidisciplinary activity
- Does not include natural supports when they are available

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Interventions: Common Mistakes

Example (combined activities):

- CBRF staff will assist Lee with meal planning/preparation, personal hygiene, shopping, and household cleaning.

Name, Qualifications, Job Title, Modality, Frequency, Purpose

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Case Scenario 1

John: 45 yrs. old. Hx of schizoaffective disorder. John lives in a CBRF. Worked part-time two years ago but starting drinking more to manage his mood and was fired from his job in construction. John was hospitalized six months ago due to severe depression and hallucinations. He has been sober for the past four months. John is divorced, no children. John states, “I think I did better when I was working even though it was stressful.” John admits that he doesn’t always remember to take his medication, some days has trouble getting out of bed, and does not know how to cook for himself. John’s mother lives nearby but they do not always get along. John states he would like to have his own apartment, a computer, drive again, and get a girlfriend. John likes to watch sports, use technology, and socialize.

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John's Recovery Plan

Goal 1:

“I want to get a job back in construction”

Goal 2:

“I want my own apartment”



John's Recovery Plan

Barriers:

- Lacks skills in managing stress and mood
- Vulnerability to relapse
- Does not take his medication consistently
- Lacks individual adult daily living skills
- Does not take care of his personal hygiene



John's Recovery Plan

Strengths:

- Motivated to make changes
- Wants to maintain his abstinence from alcohol
- Has work experience
- Likes to socialize with others
- Aware of stress affecting his mood

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John's Recovery Plan

Goal 1: "I want to get a job back in construction"

Objectives (short-term goals):

- Within 2 months, John will complete a resume.
- Within 3 months, John will apply to 3 jobs as evidenced by self-report

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John's Recovery Plan

Goal 2: "I want my own apartment"

Objectives (short-term goals):

- Within 2 months, John will complete a WRAP plan
- Within 3 months, John will prepare at minimum three meals per week
- Within 3 months, John will ask CBRF staff for his medication 4x/week without prompting
- Within 6 months, John will get up in the morning independently 5x/week
- Within 6 months, John will use a stress management coping strategy 75% of the time when he is stressed

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John's Recovery Plan

Goal: "I want to get a job back in construction"

Interventions:

- Sue Smith, BA, Employment Specialist, will assist John in finding a job by meeting with him 4 hrs/wk to assist with developing a resume, identifying available jobs, visiting possible job locations, and practicing interviewing
- CBRF staff will remind John to attend to his personal hygiene, daily or as needed, in order for John to get used to attending to his hygiene.
- CBRF staff will monitor John daily for symptoms and side effects when he takes his psychotropic medication, and will prompt John on days he does not ask for the medication
- John will attend AA meetings 2x/wk to maintain his recovery from alcohol

Name, Qualifications, Job Title, Modality, Frequency, Purpose 24



John's Recovery Plan

Goal: "I want my own apartment"

Interventions:

- CBRF staff will assist John with emotional regulation skills 2 hrs/wk to better manage his mood and stress
- CBRF staff will prompt John to get up in the morning on days John does not get up on his own in order for John to have a consistent schedule
- CBRF staff will assist John with planning and preparing meals 4 hrs/wk in order to teach John cooking skills.
- Mike Jones, BA, Case Manager, will follow-up with John's providers 4 hrs/mo to ensure John receives quality services
- Ann Moore, CPS, Peer Specialist, will assist John in developing a WRAP plan and identifying coping strategies 3 hrs/wk to help John manage his stress and mood.
- CBRF staff will monitor John daily for symptoms and side effects when he takes his psychotropic medication, and will prompt John on days he does not ask for the medication

Name, Qualifications, Job Title, Modality, Frequency, Purpose

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Role of Counties/Tribes and Community Based Residential Facilities (CBRF) in Psychosocial Rehabilitation



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Psychosocial Rehabilitation: Counties/Tribes and Contracted Providers

- Counties/Tribes are ultimately responsible for the work performed by contracted providers
- Which means the Counties/Tribes are responsible for:
 - Training requirements
 - Outcomes/Measurements
 - Communication with contracted providers/CBRFs
 - Documentation
 - Quality and frequency of services



Psychosocial Rehabilitation: Case Manager's Role

From the functional screen to the assessment, plan, and services, the case manager is responsible for ensuring:

- Recovery/Service plan is cohesive and connects the plan to the functional screen, assessment and clinical summary through to outcomes and measurements
- Direct Support Staff's documentation is linked to the plan
- Services are being provided as listed in the plan
- Communicates expectations about services provided and the expected outcomes



Psychosocial Rehabilitation in a CBRF

Who is most important to outcomes? Direct Support Staff

Role:

- Know the person
- Understand what is important to the person
- Understand the person's communication style/non-verbal communication
- Have a trusting relationship with the person
- Support the person in different environments
- Is the individual the person turns to for assistance and support

Adapted from Person-Centered Planning: A Guide to Help Direct Support Professionals Understand Their Role in the Person Centered Planning Process 29



Psychosocial Rehabilitation in a CBRF

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Psychosocial Rehabilitation in a CBRF

Direct Support Staff's Job Within CRS

- Implementing the plan of service
- Need to be familiar with each person's plan in the home
- Know what the individual's goals and objectives are
- Know what the staff's responsibilities are to assist the individual in achieving the goals
- Work with the Home Manager and other staff to provide the psychosocial rehabilitation services as a team
- Help people learn to care for themselves and their home

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Psychosocial Rehabilitation in a CBRF

Direct Support Staff's Role in Pre-Planning

- Communicates with the case manager the progress the person has made on their short-term goals and any barriers that have gotten in the way
- Shares with other staff and with the case manager about the person's preferences, favorite activities, dislikes, challenges, strengths, wants
- The direct support staff could be asked by the person to join the recovery team

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Psychosocial Rehabilitation in a CBRF

House Manager's Role in Assessing Quality of Services:

- Do my staff know each person's hopes and dreams?
- Do staff know the goals in each person's plan?
- Have the residents made progress in reaching their short-term and long-term goals?
- Do staff overdo for residents or show/teach them how to do something for themselves?
- Do staff provide opportunities for residents to have choices?



Further Learning for Next Week

Ann: 60 yrs.old. Hx of schizophrenia. Never been married, no children. Ann lives in a CBRF. Ann has diabetes and high blood pressure. She has difficulty socializing with people but does see her sister occasionally and went to church. Ann had an incident (involving her psychosis) at church and is afraid to return. Ann likes to read, plant flowers, and watch movies. Ann says, "I want be able to keep my routine and go back to church." Ann's Christian faith and reading the bible is very important to her. Ann used to buy random items that she did not need and would run out of money. Her sister is now her payee. Ann does state she would like to have control of her money again. Ann is able to cook for herself but has difficulty with hygiene and managing her money, as well as, remembering to take her medication and going to her doctor's appointments.



Further Learning for Next Week

Create a recovery/service plan for Ann:

- Goals?
- Barriers?
- Strengths?
- Objectives?
- Interventions?



References and Resources

Person-Centered Planning: A Guide to Help Direct Support Professionals Understand Their Role in the Person Centered Planning Process

http://www.cmhcm.org/provider/centrain/Training_Units/PCP.pdf



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