

REHABILITATIVE INTERVENTIONS DAY 1 OF 2

Illinois DMH/DHS, Fall 2007

Presenters

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DMH

- Monica Bert, Contract Manager, Region 5
- Katherine A. Burson, Rehabilitation Services Chief
- Mary E. Jensen, Recovery Specialist, Region 2
- Rhonda Keck, Recovery Specialist, Region 5
- Nanette Larson, Director, RSDG
- Dan Wasmer, Director, Region 1 North
- Eldon Wigget, Recovery Specialist, Region 2

Parker, Dennison & Associates

- Lee Ann Slayton

Program Goals

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- Outline service delivery strategies for rehabilitation interventions that are part of new/revised Rule 132 services of ACT, Community Support, and PSR. (DAY ONE)
- Revise assessment, treatment planning and documentation process to support core rehabilitation practice for the new services. (DAY ONE)
- Outline key organizational structure and reporting tools that enhance the implementation of Community Support (Individual, Team & Group). (DAY TWO)
- Review staffing and supervisory models that meet the new requirements, while enhancing productivity, service quality, and compliance issues. (DAY TWO)

Day One Objectives

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- Identify specific skill-building interventions
- Develop skill-building sequences and plans
- Tie specific interventions to Rule 132 Services
- Modify treatment plans and assessments
- Identify and correct common documentation errors.

Evolving Mental Health Services in Illinois

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DOING FOR



**DOING WITH AND
TEACHING HOW**

“Doing For”

6

- Driving
- Shopping
- Cleaning
- Waiting
- On the phone
- Providing social & recreational opportunities
- Making appointments
- Doing paperwork
- Getting entitlements
- Responding to consumer crises
- Doing things for and on behalf of the consumer

How was the time spent?

7

Staff met Sally at her home and went with her to the bank to cash a check. Sally discussed that her daughter has been treating her better and is also talking to her more.

Met with John related to organization and management of his apartment. Since John has stacks and stacks of paper, worker brought a shredder and trash bags. Shredded papers throughout the visit.

“Doing With”: The Interventions

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- Support to Facilitate Recovery and Rehabilitation
- Teach How – Skill Building
- Develop Natural Supports

How was the time spent?

9

Jerry stated that he would like to see his family once a month but was worried about how that would work with his mother's schedule. Worker asked Jerry to develop a "script" for calling his mother and telling her that he would like to visit and asking her when it would be convenient. Jerry was able to come up with things he would say on the call, and write them down, but got anxious trying to say them aloud. Jerry will read over the script tonight and tomorrow, and then we will practice saying them aloud on the phone on Wednesday.

How time is spent when we “do with”

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- ❑ Teaching
- ❑ Coaching
- ❑ Helping consumers link with resources they need and want
- ❑ Helping consumers develop strategies to avoid crises
- ❑ Using documentation as an integral part of service delivery
- ❑ Engaging in ongoing functional assessment/ conversations with consumers
- ❑ Doing things with the consumer and helping the consumer do things for self

DOING FOR



DOING WITH AND TEACHING HOW

Worker spoke to Jane to say that worker planned to bring Jane's lease during the visit today, so Jane could sign it and to call Jane's mother to set up a time that Jane could see her daughters.

Reviewed with Jane who to call to set up an appointment to sign her lease. Jane identified a friend who could take her, and who could help her remember where to sign on the paper. Jane then called the landlord's office to set up a time and called her friend to take her. We will meet when Jane returns and review how it went, and practice how she will communicate with her mother about setting up a time to see her daughters.

DOING FOR



DOING WITH AND TEACHING HOW

Dave has run out of food and requested that worker pick some up from food bank. Worker took Dave to the food bank where we picked up food and took it back to his apartment and put it away.

Dave has run out of food again. Developed “food plan” and checklist with Dave with indicators of when he should get more food (before he runs out) and the hours and location of the local food bank. Dave rehearsed asking for food at food bank, and then coached Dave at food bank as he signed in and asked for two days of food. He stayed focused enough with gentle prompting to ask for food. Will review the food plan on each visit until he can accomplish it on his own.

Consumer Perspectives

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- Input into setting personal goals, and service priorities
- Input into the quality of services received
- Supported employment
- Benefits counseling & budgeting
- Flexible service hours & better access

Consumer Perspectives on Language

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- Person-first language is ‘clinically correct’
- Person-first language can be the first and most significant steps in recovery
- It can have a powerful impact and it is **FREE!**

Why Change?

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- Illinois consumers want change.
- Research supports change
- We have new and different tools/technologies
- DMH/DHS wants to purchase services based on this knowledge

Direction of Change

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Risk Management → Skill Building
Oversight → Coaching/Mentoring
Advocacy → Self-Advocacy
Staff Driven → Consumer Driven
MHC Life → Community Integration
Minimal Hope → Recovery

So how do we get from here to there?

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- Knowing the goal
- Taking small steps
- Build on what we learn
- Practice, Practice, Practice

Some Ground Rules

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- Rule 132 interventions must be tied to medical necessity.
- Please send all Rule 132 questions to dhsmh@dhs.state.il.us.
- We will not be talking about billing, coding or rates.

3 Broad Categories of Rehabilitation Interventions:

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1. Support to facilitate recovery
2. Skill Building
3. Developing Natural Supports

Support to facilitate recovery and rehabilitation

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- Role models, family, friends, and peers can give the hope needed to move toward recovery
- People need someone in their life who believes in them, who provides encouragement, validation and positive feedback
- Positive expectations, opportunities and challenges build hope, meaning and purpose, and engender recovery

Support to facilitate recovery and rehabilitation

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- Promote each individual's active participation in decision-making.
- Assist each individual to identify strengths and how to use them.
- Assist the individual to identify barriers and how to overcome them.
- Assure each individual's participation in the development and implementation of their treatment plan.

Support (continued)

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- Provide assistance with defining what recovery means to the individual.
- Assistance with recovery-based goal setting and attainment.
- Encouragement for trying new things
- Developing strategies to prevent relapse.
- Identifying strengths and risk factors

Support-to-Facilitate-Recovery Interventions

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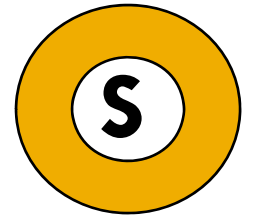
- Orienting to service(s)
- Peer Support
- WRAP & other planning processes
- Functional assessments that are “shared conversations” (e.g., CASIG, Strengths Assessment, COPM, LOCUS)
- Decision Making/Making Choices
- Consumer-driven crisis contingency planning

Support Interventions (cont.)

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- Motivational interviewing
- Recovery ownership
- Helping consumer assess their risks, and developing strategies that work for them to prevent relapse or decrease intensity/frequency of relapse
- Recruit and establish a personal recovery support team that includes natural supports
- Consumer-driven treatment planning and goal prioritization.

Example: Susan

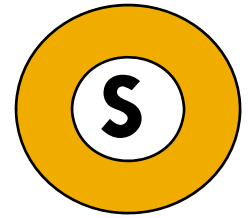


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Susan has lived in an agency residence for 7 years, has a family that lives about 45 miles away, but historically has only visited them if staff drive her. She claims her only friends are her case managers and counselors.

Q: What supportive interventions might help Susan sustain hope & stay engaged in the rehabilitation and recovery process?

Example: Josh



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- 13-year old Josh lives with his mom and 2 much younger sisters. He is frustrated easily and has frequent outbursts that can result in him hurting others as he lashes out. Josh has been in special education since he was 8, but is still failing at school and has no friends from school.

Josh's mother wants "things to be better" and wants help with handling his bad behavior. Josh wants to play basketball and other sports, but can't because his grades are too low and he is in trouble too much.

- **Q:** What supportive interventions might help Josh & his mother sustain hope & stay engaged in the rehabilitation & recovery process?

Skill Building

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- Observable - Can either see it or say it.
- Must be practiced to be mastered and maintained.
- Right ways and wrong ways.
- Done for a reason.
- Can be Generalized - Can be used in a variety of situations and/or locations.

Skill Building Steps

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- SAY
- SHOW
- PRACTICE
- Demonstrate AGAIN
- Have student DEMONSTRATE
- Provide feedback and correction
- Practice AGAIN
- At mastery, continue practice until over-learned
- Integration in a variety of “real” settings

More About Skill Building

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- Help the individual **link** various skills together
 - ▣ Link planning a menu with making a grocery list
- Help the individual **generalize** skills to other settings
 - ▣ *In vivo* practice
 - ▣ Providing review materials/tools
 - ▣ Modifying the environment
 - ▣ Enlist natural supports

Teaching and Coaching Strategies

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- Instructions
- Modeling
- Cueing (constructed and naturally occurring)
- Adapting
- Feedback
- Practice

Adaptation and Compensation Strategies

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- ❑ Checklists
- ❑ Modifying routines
- ❑ Modifying habits
- ❑ Cueing systems
- ❑ Organization and memory tools
- ❑ Modifying the environment
- ❑ Changing or simplifying how a task is done
- ❑ Energy conservation methods
- ❑ Supplemental Supports

Note: Occupational Therapists have expertise in this area.

Skill Building Hints

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- Use a variety of teaching/coaching strategies
- Link skills to goals they want to reach.
- May not be linear process (ups & downs)
- Pace of learning and retention are very individual
- Requires keeping fresh through:
 - ▣ retraining
 - ▣ ongoing practice
 - ▣ cueing strategies

Rehabilitation Interventions Happen on a Continuum

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**Interventions are the
"in-between" steps**

**Where is
consumer
now?**



**Where
does
consumer
want to
go?**

Sequencing

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- ❑ Skills can be broken into components
- ❑ Components can be taught separately
- ❑ Components can be linked
- ❑ Occupational therapists and other rehabilitation professionals have expertise in task analysis to help with this work.
- ❑ Sequencing provides foundation and adds to it.
- ❑ If steps are too large, they can be broken down

More About Skill Building

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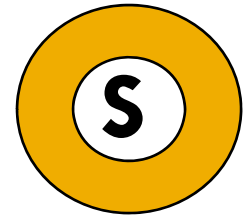
- Skills should build on each other
- Skills start with where consumer is functioning now and move toward where consumer ultimately wants to be functioning
- Skills are taught in context
 - What is behind the need for the skill?

A Note About Skill Building Groups

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- Ask each group member
 - ▣ What goal(s) are you working on?
 - ▣ How can this skill/group help you meet your goal?
- Role plays obviously relate to members' goals and life situations.
- Ask, "With whom and where can you practice this skill today/tomorrow?" Ask each person to write it down on their "to do" list.
- At the beginning of the next group session, ask each group member how the practice went. Ask how they know it went well or not so well.

Back to Susan & Josh



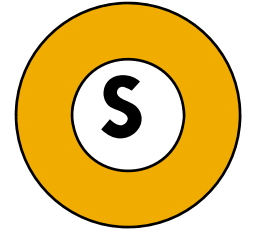
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SUSAN

- What skills might Susan need to accomplish her goal to visit family without the aid of her caseworker and given that she has no natural supports in place that can assist her?

JOSH

- What skills might Josh need to accomplish his goal of playing basketball? What skills might his mother need to help Josh achieve his goal?



- ▣ WHAT ARE SOME WAYS TO HELP SUSAN OR JOSH GAIN THAT SKILL(S)?

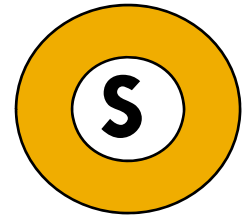
- ▣ WHAT ARE SOME OF THE STEPS TO THAT SKILL?

Learning to Access Resources

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- Some of the same steps as skill building apply:
 - ▣ Modeling
 - ▣ Explaining
 - ▣ Small steps (in the right direction)
 - ▣ Organizational tools (e.g. PDA, notebooks, labels, checklists, scripts, etc.)
- Knowledge and skills in:
 - ▣ Identifying resources
 - ▣ Accessing resources
 - ▣ Advocating for self
 - ▣ Asking for help and asking for advocacy

What might you do differently?







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- Spend down
- Re-eligibility
- Doctor's appointments
- Skill building and specific situations
- Recreation
- Socialization
- Medication monitoring
- Lack of socialization
- Lack of recreation
- Self care
- Decision making
- Recovery ownership

Example Changes

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- Recreational event at agency  host an event at own apartment.
- Weekly agency trip to the YMCA  small group of swimmers go pool on their own each week.
- Computer class at the agency  access the computer resources, help, and classes at the public library.
- Call to gather benefit information for person  teach this skill through modeling, role play, coaching, scripting, etc.

Thinking Bigger About Resources

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- ❑ More than food, money, clothing & entitlements
- ❑ Social and other supports
- ❑ Links to other systems/resources
- ❑ Community resources: libraries, health fairs, food banks, free classes
- ❑ Social institutions: churches, community centers, other nonprofits (not necessarily mental health)

Developing Natural Supports

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- Where can the person obtain this service or support that is not affiliated with our organization?
- Where do other people in our community go for this?
- Churches, social clubs, libraries, support groups, recreation centers, etc.

Developing Natural Supports

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- Establishing supportive relationships with nearby community members; e.g., neighbors, clergy, local store owners, librarian, boss, teacher, police officer, etc.
- Education and support designed to develop the family or others as a support system to help achieve the individual's goals.

Interventions to Build Natural Supports

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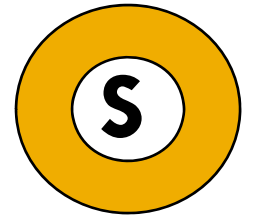
- Facilitating self-directed engagement in leisure, recreational, and community social activities.
 - ▣ Identifying and supporting connections with friends
 - ▣ Locating and trying out resources & locations for “fit.”

Building Natural Supports (cont)

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- Facilitating collaboration between the individual's network of natural supports
 - ▣ Introducing support network members to one another
 - ▣ Coordinating efforts between members, e.g., rotate activities, visits, rides, etc.
- Linking natural support development with skill building efforts.

Back to Susan and Josh



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- What might you consider to help Susan or Josh build a natural support network?
- How might you tie the building of natural supports to the skill building interventions you identified earlier?

Specific Interventions to Help With Service Changes

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- ❑ Education on the changes and the possibilities.
- ❑ Support in sorting through the pros and cons for them personally
- ❑ Validate their sense of loss (if necessary)
- ❑ Enlist Recovery Support Specialists and other consumers to share their recovery stories
- ❑ Talk about how the new services are designed to help them meet their recovery goals at their own pace.

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Key Processes to Support Rehabilitation Interventions

Assessment, Treatment Planning,
Documentation

CMS Proposed Regulations on Rehabilitation

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- All Rehab Services Incorporated: Physical as well as Psychiatric
- Clear Emphasis on Restoration (or improvement) of Function
- Requires Person-Centered Planning in Psychiatric Rehab
- Requires Progress; maintenance of effort not sufficient

CMS Proposed Rules on Rehabilitation Plan

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1. Based on comprehensive assessment
2. Qualified practitioner, input from consumer &/or family
3. Follow guidance from consumer
4. Rehab & recovery goals
5. Specify disorder being addressed
6. Identify medical & remedial services
7. Identify methods to be used
8. Specify anticipated outcomes
9. Frequency, amount & duration
10. Signatures
11. Anticipated providers
12. Timeline for re-evaluation
13. Be re-evaluated with individual
14. Evaluate goals & services
15. Document individual participated in development
16. Document that services are rehabilitative
17. Include history and coordination needs

This Means That the Assessment

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- Must include the standard diagnostic assessment
- Must include an assessment of functioning that ties the diagnostic issues to the functioning issues.
 - ▣ A functional deficit alone is not sufficient.

A Rehabilitation-Focused Assessment:

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- **Initiates helping relationships**
 - Ongoing process
- **Life Domain based**
- **Identifies strengths that can contribute to the rehabilitation**
 - abilities and past accomplishments
 - interests and aspirations
 - resources and assets
 - unique individual attributes
- **Specifies stage of recovery/change**
- **Ties Diagnosis to Life Functioning**
 - Some level of functional assessment

Assessing Function

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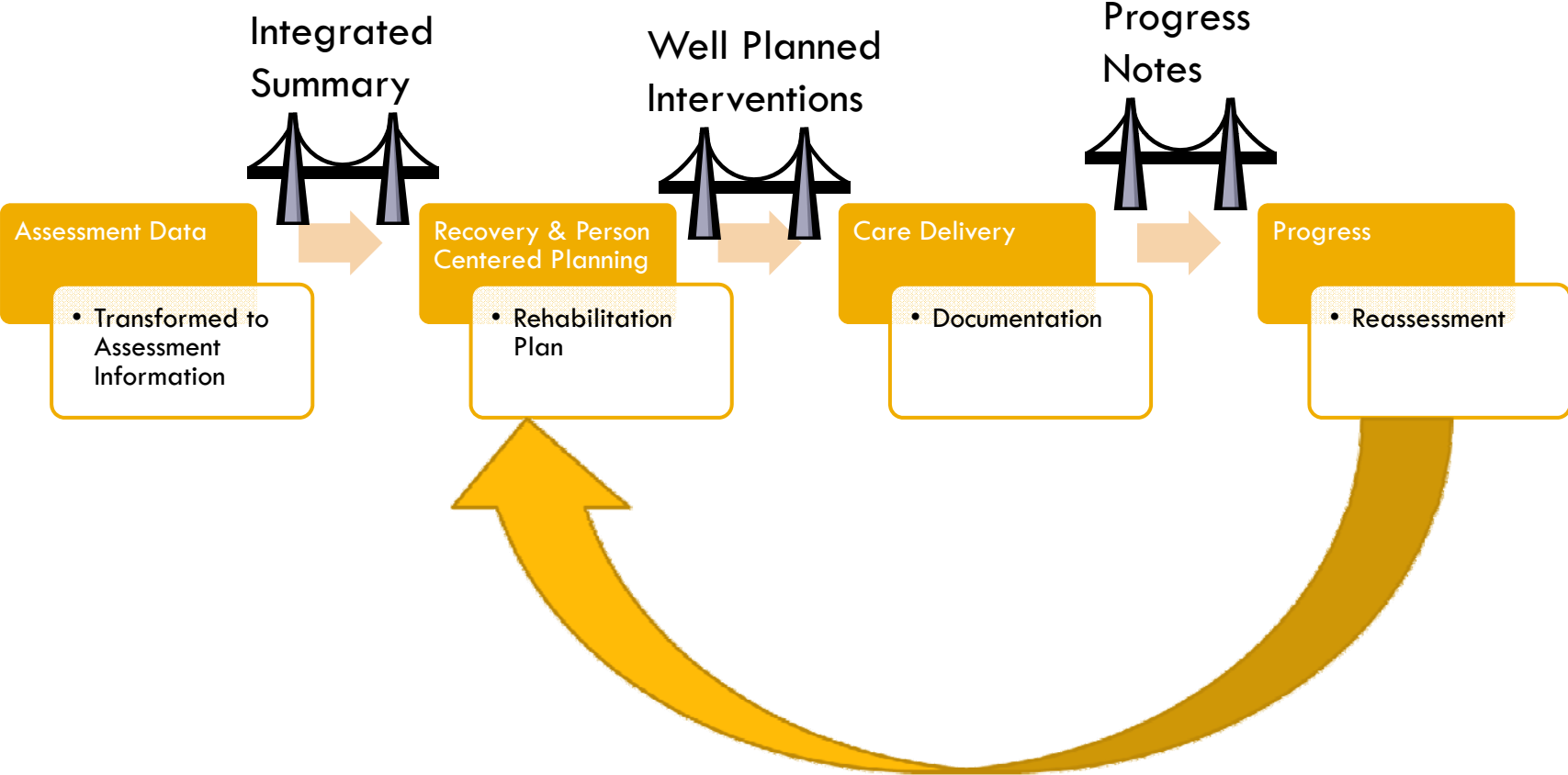
- Outlines how the consumer's illness is interfering with their functioning and their ability to achieve their "best possible functional level."
- As part of that, outlines functional deficits and functional strengths.
- Ties the functioning level to the illness AND to the consumer's recovery goals.

Functional Assessment Levels

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- Like clinical assessment, functional assessment is ongoing. But pay attention to specific uses:
 - ▣ To determine program/payor eligibility
 - ▣ To recommend Level of Care
 - LOCUS is example
 - ▣ To aid treatment & rehabilitation planning
 - Many tools, including CASIG, Strengths-Based, COPM (Canadian Occupational Performance Measure)
 - ▣ To assist in planning intervention sequences and adaptive strategies
 - Borrow from OT and MRDD

The Essential Bridges

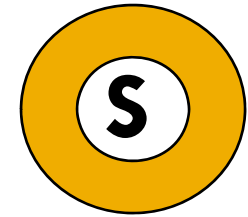


Interpretative Summary

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- Takes all the data and makes it meaningful
- References each dimension and impact on current consumer functioning
- Lists strengths, challenges and consumer goals
- Prioritizes needs not problems – Diagnoses are not “needs”
- Critical thinking that answers the questions “so what” and “what next” by using all your clinical skills and abilities
- Answers: Why is the consumer in treatment/what services can we provide related to the needs? Therefore, justifies the diagnosis and Level of Care (that consumer meets admission criteria).
- Identifies what outcomes we trying to achieve
- Recommends services/level of care

Interpretative Summary



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- ❑ Goes beyond just restating the consumer's history and data in abbreviated form is one of the most widespread documentation errors in behavioral health
- ❑ Individualized meanings and consequences are critical in a recovery model
- ❑ Include “So what” questions – so what does this mean, so what should we do, so what will show progress, so what should we do first?

If you don't get a good one from the diagnostic assessment, develop your own to help bridge to treatment plan.

Not so good

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- Janet, 58 years old, diagnosed with major depression, recurrent, with psychotic features, has spent the last 20 years institutionalized either in the hospital or a nursing home. She moved into an apartment last month. She has a complicated medical regimen because of high blood pressure, obesity, and cardiac insufficiency. She presents as clean but is disheveled and has on multiple layers of clothes on a hot summer day. Refer her to CST.

Better Integrated Summary

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- Janet is happy to be out of nursing home, eager to make friends and live more independently, but anxious because she has not been responsible for taking care of herself for a long time. This is her highest hope for help from Rehab. She is not yet connecting her needs with her illness, attributing them primarily to lack of services that the nursing home staff provided her. Her depression and sometimes tenuous reality testing make it difficult for her to learn complex skills and grasp complex concepts without extensive support and repetition. Rehab services can assist Janet by providing structure and support. Highest priority skill development areas include maintaining at least a minimal energy level through illness self-management, maintaining her physical health, developing basic food preparation and living space management skills, and developing recovery goals for her life outside of an institution.

Rehab Focused Strengths & “Barriers” ***

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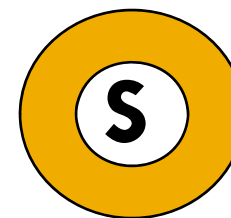
Traditional

- Strengths :
 - ▣ College education
 - ▣ Articulate
 - ▣ Pleasant
 - ▣ Tries hard
- Barriers
 - ▣ No family or social supports
 - ▣ Poor hygiene
 - ▣ Self-isolating

Rehabilitation & Recovery Focused

- Strengths :
 - ▣ Able to express and work toward rehabilitation goals
 - ▣ Motivated to have friends and establish herself in community
 - ▣ History of stability in housing, based on good money management
- Barriers
 - ▣ Does not have access to support network
 - ▣ Symptoms impact self-care skills

Look at existing assessments and ask:



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- What additional information do you want to guide these types of interventions?
 - ▣ Support to Facilitate Recovery and Rehabilitation
 - ▣ Teach How – Skill Building
 - ▣ Develop Natural Supports
- How might you obtain that information?
- How would you prioritize this work? Why?

Does it Answer the Admission Criteria Question?

63

- Assessment should point to the level of care (ACT/CST/CSI) and justify the questions implied in the admissions (or continuing stay criteria)
- If your assessment cannot answer those questions, you are not yet done!

Plan Development

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- **Acquired skill / Art form**
 - ▣ not often taught in professional training
 - ▣ often viewed as administrative burden and paper exercise
- **Opportunity for creative thinking**
- **Integrates clinical data**
 - ▣ derived from integrated summary and prioritization
 - ▣ information transformed to understanding
 - ▣ guides recovery

Examples of Recovery & Rehabilitation Goals

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I don't want to get sicker.	I will focus on staying well and getting better by managing my medication and symptoms.
I want my own apartment where no-one can tell me what to do.	I will achieve skills to live independently in community.
I want a girlfriend and lots of buddies to do things with.	I will develop a network of friends and social contacts for socialization and support.

Outcomes to Objectives

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Rehab Outcomes	Objectives
I will focus on staying well and getting better by managing my medication and symptoms.	<ul style="list-style-type: none"><input type="checkbox"/> Identify different medications and their uses<input type="checkbox"/> Identify at least one side effect of each medication
I will achieve skills to live independently in community.	<ul style="list-style-type: none"><input type="checkbox"/> Bathe 3x/week with minimal prompting<input type="checkbox"/> Close door when using bathroom in public places
I will develop a network of friends and social contacts for socialization and support	<ul style="list-style-type: none"><input type="checkbox"/> Make eye contact and say "hello" to one person a day<input type="checkbox"/> Respond in groups when asked questions

The Key to Good Plans: Goals & Objectives

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- Goals: Start with the consumer's Recovery Goals or consumer's Goals for Services.
 - ▣ These should be stated in consumer's own words
 - ▣ Can be short, intermediate, or long-range
 - ▣ May or may not change over time
 - May just become more refined

Rehabilitation Outcomes (Goals)

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- Intermediate to Long-Term
 - ▣ May not change over multiple treatment plan revisions
- Point to function that must be attained to assist consumer in meeting his/her recovery goals
- Often helpful for these to be broad statements
 - ▣ Allows for flexibility in covered interventions/objectives
 - ▣ Helps to keep consumer and staff pointed toward “vision of recovery” and not get lost in details of day-to-day activities
- Should be attainable and written in plain English
- Serve as ultimate outcomes of rehabilitation.

Good Goals Are Active

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- “Consumer will use tools and self-prompts to take meds regularly.”
- “Consumer will demonstrate ability to take meds on a regular and consistent basis.”
- “Consumer will participate with medication schedule in residential setting.”

Unhelpful Goals:

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- Describe the process of the intervention, not the outcome of the intervention.
 - ▣ See doctor once/month
 - ▣ See therapist
 - ▣ See community support specialist
 - ▣ Go to therapy

- Say what staff will do.
 - ▣ Monitor consumer's meds
 - ▣ Take consumer to doctor

- Use jargon and are hard to understand.

Good goals and objectives have the *consumer* as the subject

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- Goals, Outcomes & Objectives say what the consumer (or support system/family) will be able to do
- Interventions say what the staff will do

Objectives:

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- ❑ State what will be accomplished during this treatment/rehabilitation planning period.
- ❑ Serve as shorter-term outcomes
- ❑ Often are incremental steps to achieve the larger, more long-term goals.
- ❑ Can be measured – by consumer and staff. (Not artificial measurement.)
- ❑ Point to progress
- ❑ **Will** be changed with every rehab plan update.

Objectives

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- **Sequential and concurrent steps to attain the goals**
 - ▣ divide goals into manageable tasks and activities
 - ▣ provide time frames for assessing progress
 - ▣ maximum of three or four per goal
- **Essential features**
 - ▣ Measurable and observable
 - ▣ behavioral language
 - ▣ achievable/time limited
 - ▣ understandable to the person served

Objective Template

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At the end of this plan, the consumer will be able to:

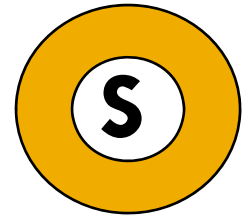
NOTE that the objective does *not* say what the staff is doing.

Common Mistakes

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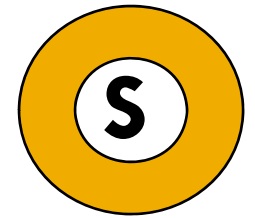
- ❑ Objectives not clearly related to goal attainment
- ❑ Objectives are not measurable or behavioral
- ❑ Interventions and objectives are confused
- ❑ Too many goals and objectives
- ❑ Interventions do not reflect consumer preferences and past treatment (if it did not work last time why will it this time?)
- ❑ No link between treatment plan and assessment
- ❑ Not focused on restoring/improving function

4 Core Questions for Notes



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- ❑ What goal/objective (from Treatment Plan) were you working on?
- ❑ What was the intervention?
- ❑ How did the consumer respond?
- ❑ What are the next steps?



Link Notes to the Service you Delivered*

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- Anyone should be able to tell what service you delivered by the narrative of the note.
- Take care to distinguish
 - ▣ Case management
 - ▣ Community support & ACT (any flavor)
 - ▣ Counseling
 - ▣ Medication Training
 - ▣ PSR
 - ▣ Community Support Group and PSR

*More on this tomorrow

Two Notes for John

Outcome: John will be able to plan and implement a healthy menu for himself within his budget.

Objective: John will be able to use a planning guide to identify and select “healthy meal” items.

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Picked up John to go to the grocery store. We picked up food for several meals and discussed need to budget. John does not like fruit. Discussed importance of eating balanced meals including fruit. John was uncomfortable in store and wanted to leave. Told him I would be by again on Thursday.

Coached John on selection of meals for the week using the checklist we had developed on Monday. John was able to pick appropriate foods in 4 of 6 categories. Reviewed alternatives to fruit including extra vegetables. John began to get anxious in store. Encouraged and modeled use of deep breathing and visual imaging of fishing with cousin. John attempted to practice these skills. Scheduled again for Thursday. John plans to use the checklist next week when he shops with his neighbor.

Two More Notes for John

Outcome: John will self-manage his medication effectively so that he can work toward his own business.

Objective: John will identify side effects of medication which could result in his stopping his medication.

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□ Asked John to identify medication name, purpose and dosage instructions. John stated his medication makes him feel tired and hungry and he is gaining weight and cannot fit into his clothes. Discussed why it is important to keep taking his medication to remain outside hospital.

□ John said his medication makes him feel tired and hungry and he is gaining weight and cannot fit into his clothes. Together, we reviewed the “Solutions for Wellness” section about avoiding weight gain through food selection, exercise, and alternative activities. Coached John on sugar-free food selection. Modeled easy exercises that John can do at home, even while watching TV. John practiced stretching and floor exercises, and agreed to try two exercises each of the next three days. We will use the “healthy food selections” list we developed last week when we go to the grocery store on Friday, with an emphasis on foods that will help John avoid weight gain.

And Two More Notes for John

Outcome: John will have an expanded network of friends and supports.

Objective: John will make eye contact while greeting strangers appropriately.

80

Took John to McDonalds to practice making friends and socializing. Ordered John's meal and reminded him to say thank you and make eye contact with the person taking his order. John was polite and greeted two food servers.

Reviewed "Making Friends" module with John and role played greeting wait staff at local fast food restaurants/ Asked John to assess his comfort level when speaking to know and unknown staff. John agreed to practice smiling and making eye contact with known staff. He was able to greet two staff at McDonald's appropriately and without discomfort. He agreed to practice greeting the cashier when he goes grocery shopping on Thursday.

Make Sure You Show Progress

81

- Not so Good: “John continues to make progress.”
- Better: “John is now able to initiate deep breathing and visual imaging of fishing with cousin 50% of the time without prompting when he becomes anxious at the grocery store.”
- Better: “John is correctly using his meal planning guide to select healthy foods with very little assistance. He asks me to check his work and I seldom find errors.”

Group Notes

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- Intervention can be same for everyone in group*
 - ▣ Name of group is NOT intervention
 - ▣ Individualize intervention for anyone where group is a setting for practice of other skills (see next)
 - ▣ Intervention can refer to a specific curriculum.
- Consumer's Response to Intervention *and* Next Steps must be individualized for each participant

Individualizing Group Notes

83

- “Juanita attended cooking group”
 - ▣ Juanita holds a job as a cook at Burger King.
 - ▣ Juanita does not have independent living skills on her treatment plan.
 - ▣ She does have anger management and social interaction skills on her treatment plan.
- Make sure that you write what Juanita practiced in this group – not interrupting, waiting her turn, and being supportive to others. The actual group was a context, not the event.

Resources

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- Extra Resources Available at www.ParkerDennison.com/IllinoisServicesWorkGroup.html
 - Excerpts from APS Clinical Resource Guide (GA) on rehab focused skills, goals, objectives
 - List of curricula focusing on skill building suitable for rehab use
- Pathways to Recovery workbook:
<http://www.socwel.ku.edu/projects/SEG/pathways/Pathways%20to%20Recovery%20Cover.pdf>

Tomorrow:

85

- Schedule 9 to 3:00
- Focus on Operations for Community Support (CSI, CST, CSG primarily but issues applicable to ACT and PSR staff)