## **Primer for Psychosocial Rehabilitation Treatment Planning**

- A treatment plan may have one goal or, when clinically appropriate, more than one. As the
  provider, you must use clinical judgment about whether or not it's realistic for the plan to
  include more than one goal. Usually, participants have only one or two goals when they seek
  treatment.
- Each goal may have more than one objective. Generally speaking, if a goal has more than three objectives associated with it, the goal may appear insurmountable and the participant may become discouraged or never "own" the plan.
- The entire treatment plan shouldn't contain more than five objectives and most should only
  contain three. A large, extensive plan *could* be developed at the initial meeting, but each
  objective needs to have a clear, individualized timeline associated with it. A plan with a lot of
  goals and objectives but only one timeline is not realistic or helpful.
- If the plan has multiple goals, it's important for the participant to understand in what order the goals must be accomplished (this goal first, that goal second, the last goal after goals 1 and 2 are accomplished). The participant might be able to work on some goals simultaneously, depending on the presenting situation, but it's your responsibility to keep the participant interested, motivated, and hopeful that recovery is possible.
- The participant (or guardian, as appropriate) must identify personal recovery goals, but it's your responsibility to make sure the treatment plan "fits" the participant. You might ask a participant to repeat the plan goals (without looking at the plan) to make sure the participant understands what the plan says and ensure it's a good fit. Generally speaking, if participants can't remember what they're working on, they're probably not working on it and you may be wasting their time, your time, and other valuable resources. However, it's important to remember that, depending on the mental disorder, there are exceptions.
- When you and the participant (or guardian, as appropriate) agree that an area on the treatment plan needs to be addressed, it's up to you, as the provider, to identify whether or not the participant is a good candidate for skill training or if the participant would benefit more from support (community reintegration).
- If you decide the participant can benefit from skill training, that should be the main focus of the
  treatment plan. Given that, we know that the course of serious persistent mental illness (SPMI)
  isn't a straight line. So, even if you intend the main focus to be skill training, you should be
  sensitive to the participant's type of mental disorder and recognize that the participant may not
  be able to do skill training on a given day because of an exacerbated disorder, <u>but would</u>
  <u>benefit from support.</u>
- Although the main focus of the treatment plan is skill training, you should incorporate into the
  plan design the *opportunity* to provide support on unpredictable, but necessary, occassions (if
  all goes well the support would never have to be used).

- If the participant is overwhelmed with symptoms and just needs support (instead of training), then you should provide the support and not force skill training.
- If the participant continues to have bad days (e.g., starts decompensating), then the main
  focus of the plan may switch from training to support. You may need to consider amendments
  if the clinical picture warrants it, although amendments may not be necessary depending on
  the design of the treatment plan.
- When the participant is stable again, you should switch back to providing training. This is how
  providers have always interacted with participants, but now Medicaid labels the services
  distinctly as "skill training" and "support".

## Children/Adolescents-Specific Issues

- Support (community reintegration) looks different for children and adolescents than for adults.
   Serious emotional disturbance (SED) runs a different course than SPMI. A person with SPMI may have ups and downs and may, at times, appear to be in remission. A child with SED has a smaller fund of knowledge and experience on which to rely for coping and making sense of thoughts, feelings, and symptoms. A child in the full throes of emotional disturbance will behave and react consistently across situations that present the same stressors.
- Psychosocial rehabilitation (PSR) services (skill training and community reintegration) for children and adolescents are forms of active treatment directed at <u>restoring the participant's</u> <u>emotional stability</u> so the participant can continue to grow and develop according to established, developmental milestones.
- PSR services for children and adolescents aren't a substitute for the responsibilities of parents, the school system, or the corrections system.
- PSR skill training should focus on helping children develop skills so they can use them to be successful across settings. Thus, the intervention wouldn't be to teach the child to sit at a desk without disturbing the classroom. The intervention would be to teach the child how to act in group settings in order to benefit from being in a group experience. The child can then apply those skills to school, church, a movie theater, a family dinner, or the playground. If the focus of the intervention is just to get the child to stay at a desk, how will the child understand the bigger principles or the skill set needed to function in all group settings?
- Similarly, PSR skill training doesn't specifically involve the participant doing homework but, more generally, would teach the participant how to manage time responsibly, focus on the tasks at hand, and finish tasks once they're started. In this way, the participant can apply such skills to complete homework, complete chores within the family setting, take care of a pet, etc.
- It's crucial that all skill training interventions match the participant's developmental level. For
  example, expecting a small child to "reflect on his/her feelings" when the child hasn't
  developed abstraction skills yet is not productive or a good use of resources and can be
  frustrating and discouraging for the child.

- All skill training interventions must have meaning in the real world for the child or adolescent.
   An intervention that's meant to "teach the participant to get along with others" is too vague and has no real meaning for the participant. It's necessary to specifically describe what's intended such as, "take turns", "share", "ask permission", etc.
- Because children and adolescents are still developing, growing, and changing rapidly, community reintegration is intended to be provided in the context of the child's natural supports (family) whether the child is "up" or "down". Its purpose is to help the participant promote integration and functioning in the family so that the time spent with you, the worker, is not a one-dimensional "lesson" that the guardian must later figure out how to apply.
- Thus, you should provide the support service in an encounter with both the participant and the
  participant's guardian so the guardian, who's a significant player in the participant's success or
  failure in treatment, gets to be directly involved.
- It's crucial to involve the child or adolescent's guardian in the delivery of services. However, the child or adolescent must always be the focus of intervention. One way to achieve this is to have the guardian present for the skill training encounter. You can follow the skill training episode with a supportive episode (community reintegration) where you review with the participant and guardian the key elements of the training that you just delivered and clarify with them the intent of the training, the anticipated impact, and the work or action that should occur between them within the natural setting when the worker isn't present.
- If the guardian wasn't present to witness the skill training, there's no mechanism within the benefit package to involve the guardian in the delivery of PSR except the collateral contact. A collateral contact is a vital communication, from you to the guardian, about the participant's condition. Collateral contact is important communication the guardian might need in order to complete a specific action with the participant. It's different from community reintegration because it's not an active intervention. Community reintegration, on the other hand, is an active intervention you provide to the participant following a skill training episode in which the guardian was present.
- Community reintegration isn't a substitute for caretaking or supervision that a guardian or designated educator should provide, nor is it parenting education or training.

## Incorporating the Above Principles Into the Treatment Plan

- Providers sometimes structure treatment plans using the various functional areas identified in IDAPA as headings with a goal and objective under each heading. This is "old school" and it's not recommended (although you may continue with this approach, if you choose). It imposes a structure that doesn't add anything administratively or clinically to the treatment plan, but does force the scope of individual issues into silos and fragments the treatment approach.
- On all treatment plans, you should describe the skill training task after you identify an objective.
   Be sure to list the amount and duration of the skill training for that task. If the objective is for the participant to demonstrate non-violent adaptive responses when provoked by others, then

- Anticipating that the adult participant may not be able to participate in training on every single occasion, you should also build into the plan a support task. Describe the support task just below the skill training task. Again, you should describe how frequently and for how long sessions are to occur. Since the support is meant to occur only as a substitute when the participant can't benefit from skill training, the amount and duration listed on the plan needs to match the skill training task. In actuality, while there's no way to predict the exact amount and duration of the support that will be needed since the participant's "down" time isn't scheduled, it's expected that the provider will achieve the supportive intervention in the same amount of time or less than the skill training since, frequently, a supportive task doesn't involve the numerous steps that skill training involves. Somewhere on the plan (below the support task is a good place), the provider should note: "Community Reintegration to be provided instead of Skill Training on this objective only in the event of participant's decompensation and need for support" (or some such sentence).
- You can communicate the same intention as above by listing the skill training task, listing the supportive task, and then indicating the following (in whatever words you choose), "Sessions addressing this objective will occur 3 x week, 45 minutes per session in the form of skill training. When the participant is unable to participate in skill training (H02017) the session will be in the form of support (H0036)." If you're going to write the task in this way and you acknowledge that the support component may not take as long as skill training would, then you should indicate the amount and duration you anticipate for the supportive service (e.g., 3 x week, 30 minutes per session).
- If the life of the treatment plan starts when the adult participant's disorder is exacerbated or the participant is chronically unstable, then the plan's main focus would be support and you wouldn't include any skill training initially. However, there must be the potential for the participant to recover in order to participant in PSR to begin with. Therefore, a treatment plan that's just supportive and not training-oriented should be for a shorter duration, anticipating that the participant is going to stabilize and will be able to benefit from skill training, or otherwise benefit from psychotherapy, after receiving the support for a brief time.
- In such cases as described above, you may choose to design a plan in which the amount and duration of the support sessions is described as, "3 x week for 45 minutes each session for 12 weeks". If this design is chosen, you can add a skill-training task for the same objective when the initial plan is written and indicate something to the effect of, "After 12 weeks of support on this objective, if the participant is able to benefit from skill training, then skill training sessions will commence 3 x week for 45 minutes each session for 12 weeks."
- In the case of an adult participant who starts out needing support but stabilizes and is ready for training, it would be acceptable to write, "Sessions addressing this objective will occur 3 x week, 45 minutes per session in the form of skill training. When the participant is unable to participate in skill training (H02017,) the session will be in the form of support (H0036)."

- It may also be appropriate to design the plan so that it incorporates the skill training on a slower schedule. In this case, you should indicate something like, "After 12 weeks of support on this objective, if the participant is able to benefit from skill training, then skill training sessions will occur in place of support sessions 1 x week for 45 minutes each session for the first 2 weeks, 2 x week for 45 minutes each session for the following 6 weeks, and 3 x week for 45 minutes each session for the final 4 weeks. Support sessions will occur the first 8 weeks alternating with training sessions, for a total of 3 sessions per week for 45 minutes each session." This reflects a more structured approach, which for some mental disorders is more appropriate.
- Each objective on the treatment plan should follow the format described in the above paragraphs.
- If you judge that the participant won't need any support during the course of skill training interventions, you're not required to add support tasks to the plan. You can't <u>force</u> skill training, however. In such cases, there's a risk that the participant might have a "bad day" and can't participate in training. If there are no support services in the participant's treatment plan, this "bad day" may not satisfy the test of being a "crisis" and no additional services will be authorized or sanctioned (as uncovered through the audit process) on these occasions.
- On all treatment plans, it's mandatory that each task list the amount and duration of the services to be provided.
- It's incorrect to list a range of time and duration in "cookie-cutter fashion" across tasks on any treatment plan (e.g., listing the amount as "1-5 hours" or "up to 5 hours", including a statement such as, "None of the above hours in any combination will exceed 5 hours without prior authorization).
- All treatment plans must be constructed with the participant's (and/or participant's guardian) involvement and agreement.
- All treatment plans must be written in language the participant understands.
- All treatment plans should reflect the participant's ability to succeed at completing the plan
  (e.g., plans with numerous objectives and tasks are inappropriate). Of course, there can't be a
  requirement for the participant to succeed; the requirement is that the plan be reasonable and
  practical to promote the possibility of success.
- All treatment plans must be sensitive to the symptoms of the participant's mental disorder and distinctly address the steps, however small, needed for the participant to move toward no longer needing the service. One way to approach writing a sensitive plan is to answer the following question for each objective and task: Is this practical and achievable by this participant given the severity of the disorder, the community resources available, the participant's living arrangements, cognitive ability, and motivation for participation?

Please direct questions regarding this document to Pat Guidry at 208-364-1813 or email her at guidryp@dhw.idaho.gov.