Comprehensive Community Services (CCS)

CCS Overview and Recovery

Please ensure your full first and last name are indicated on your Zoom square in addition to your agency for attendance purposes.

v.2024-7

Welcome to the CCS Overview

- Presenter:
  - Julie Meister, MSW, LCSW
    - CCS Administrator
- Training will last from 12:30-4:30
  - 10-15 minute break in middle of training
- Certificates will be emailed to participants within 5 business days

What we will cover today:

- CCS program and eligibility requirements.
- CCS Policy & Procedure highlights.
- Staff training and supervision requirements.
- CCS documentation and forms.
- Structure of CCS teams.
- CCS Service Array
- CCS Quality Assurance
- Psychosocial Rehabilitation, what is it?
- Recovery concepts and dialogue.

What is CCS?

Comprehensive Community Services

A Medical Assistance-funded flexible array of individualized, community-based, psychosocial rehabilitation services authorized by a Mental Health Professional for people with mental health and/or substance use needs across the lifespan.

Who is eligible for CCS services?

- Children and adults with a diagnosis of mental illness or substance use disorder who:
  - Have **any** form of full Medical Assistance insurance
    - Not FPOS, QMB, SLMB
  - Need more than outpatient services
  - Want to be a participant in the CCS Program (voluntary program)
  - Are interested in being active in directing their recovery and services.
  - Are determined eligible for CCS via a Functional Screen
  - Have a need for psychosocial rehabilitation in at least one area of their life

CCS: Important Documents

- DHS 36: Wisconsin Administrative Code
  - Required reading for all CCS staff
  - Outlines all of the requirements of CCS programs
    - Staff roles and qualifications (p. 18-19)
    - Staff training and supervision (p. 19-20)
    - Documentation requirements (p. 21-23)
    - Policies and procedures (p. 16-22)
    - Client discharge (p. 22-23)
    - Centralized records (p. 23)
- Service Array
  - Description of all services covered under the Medicaid CCS benefit.

CCS Policies & Procedures

- All CCS staff are expected to be familiar with and follow CCS-specific policies and procedures (in addition to agency P & P)
- All agencies and staff providing CCS services have access to the online CCS Policy and Procedure Manual for reference
  - https://providers.dcdhs.com/Partnering-With-Dane/Comprehensive-Community-Services/CCS-Plan-and-Policies

Policy and Procedure Highlights

Cultural Competence and Linguistic Services

- CCS services must acknowledge and take into account clients' beliefs, customs, and practices.
- Interpretation services must be provided by CCS agencies, free of charge to the client, to allow clients with limited English proficiency maximum participation in their recovery services

Policy and Procedure Highlights, ctd.

Client Records

- Electronic CCS Module
  - Used for completion of Assessment, Recovery Plan, progress notes, medications, general client info
- Central record at DCDHS must be complete
  - All CCS providers MUST forward all non-CCS Module chart information to DCDHS
    - Signed Recovery Plan
    - Signed Assessment Summary
    - Signed recovery team meeting rosters
    - Informed Consent for Medications and Treatment
    - Release of Information forms (ROIs)
    - Medication administration record (MAR)
    - Legal paperwork (Ch. 51, guardianship, POA, etc.)
    - Specialized assessment results (i.e. neuropsychological, etc.)
    - Discharge Summary

Policy and Procedure Highlights, ctd.
Timely Exchange of Information

- Critical due to larger, inter-agency teams working closely together
- Case notes must be completed within **2** business days in the CCS Module
- Phone calls must be returned within **2** business days
- Service providers must keep service facilitator informed about changes
- Inform MHP, service director and service facilitator of dangerousness when present
- Inform DCDHS of client death within 24-hours (email CCS@danecounty.gov)

Sharing of Information in CCS

- Information can be shared between the Service Facilitator and other CCS Service Providers without signed ROI as all are staff of CCS Program
  - This is covered in the Admission Agreement at the time of intake at DCDHS

"Information about your care and progress may be shared between the members of your team and your service providers even though the team members and service providers may be from different agencies."

--Admission Agreement

Policy and Procedure Highlights, ctd.
Orientation & Training of Staff

- Orientation
  - Must be completed within 3 months of becoming CCS Staff (or lose Module access)
  - 20 hours: If staff member has more than 6 months experience
  - 40 hours: If staff member has less than 6 months experience or is volunteer
- Ongoing training
  - Each staff member of CCS program must have 8 hours of ongoing training each year

CCS Service Provider Orientation Checklist
(revised 1.2023)

Staff Name: **Date of Enrollment:**

Check box that applies:
☐ Staff has at least 6 months experience providing psychosocial rehabilitation services to adults or children with mental health or substance abuse disorders. Requires 20 hours of orientation within 3 months of CCS enrollment.
☐ Staff has less than 6 months experience providing psychosocial rehabilitation services to adults or children with mental health or substance abuse disorders or is a Volunteer. Requires 40 hours of orientation within 3 months of CCS enrollment.

*Certificates of completion must be submitted for all training areas except for those indicated with an (*)

Orientation/Training	Date	Method (e.g. webcast, Workshop)	Duration
*Read and review DHS 36 – *Comprehensive Community Services*		Reading	2 hrs.
*Read and review CCS policies and procedures		Reading	2 hrs.
*Overview of job responsibilities for CCS staff members and volunteers within agency		Review CCS Provider Handbook	2 hrs.
Laws & Client Rights that affect CCS: *Chapter 48 – Children's Code; Chapter 51—Mental Health Act; Chapter 54—Guardianship; Chapter 55 Protective Services System; Americans with Disabilities Act; Civil Rights Act of 1964; Client Rights—DHS 94 and 51.61; Documentation and Confidentiality: *HIPAA, *51.30, *Chapter 92, *42 CFR Part 2*		**DCDHS Online Training** (https://www.danecountyhumanservices.org/ccs/prov/orient_trng.aspx)	3 hrs.
CCS Overview *Overview of DHS 36:* • *Supervision & training requirements* • *CCS staff roles/responsibilities* • *CCS Policies and Procedures* • *Centralized records* • *Service Array*; *Recovery Concepts and Principles:* • *SAMHSA Definition of Recovery* • *Consumer participation and choice* • *Recovery-oriented assessment/services* • *Psychosocial Rehabilitation principles* • *Culturally and linguistically appropriate services*		**DCDHS Training** (Please register via [illegible])	4 hrs.
CCS Module • CCS Documentation		**DCDHS Training** (Please register via [illegible])	3 hrs.
***Client Rights & Grievances** • Review of agency policy and procedure • Review of CCS policy and procedure		Reading	1 hr.
Techniques and procedures for non-violent crisis management and verbal de-escalation. • Including methods for obtaining backup, self-protection and protection of the consumer and others in emergency situations, suicide assessment, prevention and management in emergency situations.			
Trauma Informed Care • Relationship of trauma to mental health/AODA needs • Trauma assessment and treatment approaches			
Current knowledge about mental health disorders, substance-use disorders, and co-occurring disorders and treatment methods. • Must include age-appropriate assessment/services and relapse prevention.			
Cultural Competency • Topics may include practice with specific diverse populations, cultural humility, cultural differences, discrimination, behavioral health equity, self-awareness, and cross-cultural skills.			
Suicide Risk Assessment • Complete the Columbia- Suicide Severity Rating Scale (C-SSRS) training and submit verification of your passing quiz score and Certificate of Learning		**C-SSRS Online Training** https://cssrs.columbia.edu/training/training-options/	1 hr.
Service Facilitator/Mental Health Professional/Substance Abuse Professional Training (only required for SF agency staff)		**DCDHS Training** (Please register via [illegible])	(4 hours)
Additional:			
TOTAL ORIENTATION AND TRAINING HOURS			

This staff member has met the training requirements for CCS as outlined in DHS 36. Documentation of training is attached.

Employee Signature Date

Supervisor Signature Date

Send to Provider Network Coordinator (CCSProviderNetwork@danecounty.gov)
Access to CCS Module will be removed if Orientation Checklist is not received within 3 months of CCS employment

Dane County CCS
Ongoing Training Log

Year: ___________

Staff Name: ____________________ **Agency Name:** ____________________

Each staff member must receive at least 8 hours of training each year which is designed to increase their knowledge and skills related to providing psychosocial rehabilitation services.

*Documentation of each training must be submitted with the completed training log.

Training	Date	Method (e.g. reading, webcast, workshop)	Hours

Employee Date

I certify that this staff member has met the annual training requirements for CCS as outlined in DHS 36.

Supervisor Signature Date

Send to Provider Network Coordinator annually

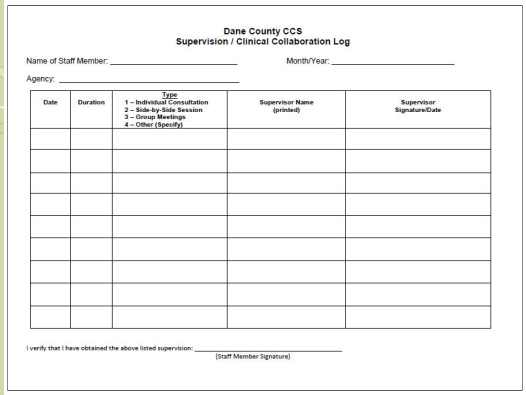
CCSProviderNetwork@danecounty.gov

Policy and Procedure Highlights, ctd.
Supervision and Clinical Collaboration

- All CCS staff that do not have full clinical licensure require one hour of supervision per week or 30 hours of face-to-face service
- Supervision must be provided by qualified, fully-licensed CCS staff
  - Allowable credentials of CCS Supervisors:
    - Psychiatrist, physician, psychiatric resident, psychologist, LCSW, LPC, LMFT, APNP, nurse practitioner

Policy and Procedure Highlights, ctd.
Supervision and Clinical Collaboration

- Supervision requirements are less for the following fully-licensed clinical staff:
  - Psychiatrist, physician, psychiatric resident, psychologist, LCSW, LPC, LMFT, APNP, nurse practitioner
- Requirement is for one hour of supervision (or clinical collaboration) per month or for every 120 hours of face-to-face service



Dane County CCS
Supervision / Clinical Collaboration Log

Name of Staff Member: _____ Month/Year: _____

Agency: _____

Date	Duration	Type 1 – Individual Consultation 2 – Side-by-Side Session 3 – Group Meetings 4 – Other (Specify)	Supervisor Name (printed)	Supervisor Signature/Date

I verify that I have obtained the above listed supervision: _____
(Staff Member Signature)

Send to Provider Network Coordinator each month
CCSProviderNetwork@danecounty.gov

Policy and Procedure Highlights, ctd.
Staff Functions

- **Service Facilitator** – Under clinical supervision of MH/SA professional, facilitates assessment process, serves as Recovery Team member, arranges services, assures services are coordinated, integrated and monitored, supports the person served.
  - Any staff, except clinical students.
- **Mental Health Professional** – Participates in assessment process, attests to need for psychosocial services, serves as Recovery Team member, reviews Recovery Plan, authorizes CCS services.
  - Psychiatrist, physician, psychiatric resident, psychologist, LCSW, LPC, LMFT, APNP
- **Substance Use Professional** – Involved for people who have *or may have* a substance use disorder, participates in assessment process, serves as Recovery Team member, co-authorizes SUD services.
  - CSAC, SAC, SAC-IT, physician, psychologist, SUD specialty, or MHP per above if within scope of practice

Policy and Procedure Highlights, ctd.
Staff Functions

- **Service Director(s)** – Multiple people serve in this role—both at DCDHS and at the program level in service facilitation agencies. Responsible for quality of services to clients and day to day consultation to CCS staff.
  - Psychiatrists, physicians, psychiatric residents, psychologists, LCSW, LPC, LMFT, APNP
  - Jessica Gilbert, LPC is DCDHS Service Director
- **CCS Administrator** – DCDHS position, responsible for overall CCS program operation, compliance with DHS Chapter 36 and all other regulations, policies and procedures, contracting, and quality of services.
  - Julie Meister, LCSW

From intake to services in CCS . . .

Perceived need

▼

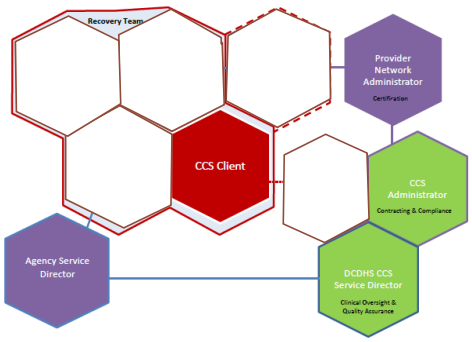
CCS Intake at DCDHS

▼

Connection to Service Facilitation agency

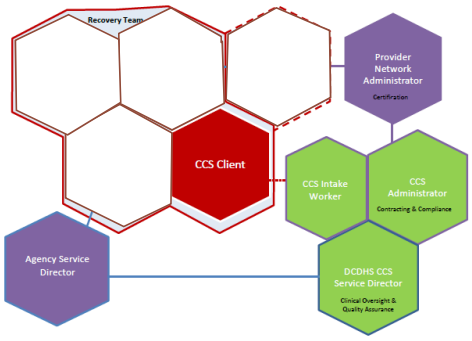
▼

Connection to other needed providers



Perceived Need & Intake

- Referral for CCS Services
  - CCS Intake process completed by DCDHS staff
    - Consumer/guardian initiates intake process
    - Physician's prescription and diagnosis verification for service eligibility obtained
    - Consumer chooses Service Facilitation Agency
    - Functional Screen completed by DCDHS Intake staff to determine need for psychosocial rehabilitation
    - Connect CCS participant to service facilitation agency
  - CCS Intake Worker will assist with any immediate needs and facilitate warm hand off to Service Facilitation agency

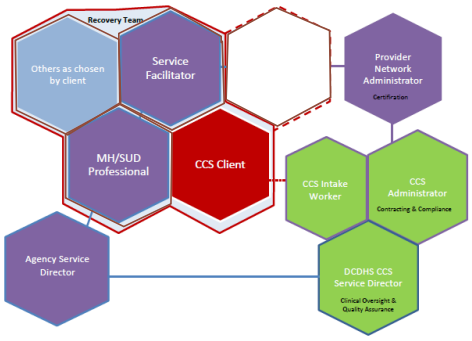


Service Facilitation Agency

- Complete comprehensive assessment and summary
  - Client's perspective/words shall be incorporated into assessment
- Assemble Recovery Team
  - Client (and parent/legal guardian as appropriate)
  - Service Facilitator
  - Mental Health Professional/Substance Abuse Professional
  - Others chosen by client: service providers, family, natural supports, advocates, etc.
- Develop Recovery Plan in CCS Module
- Authorization of Services

Service Facilitation Agency, ctd.

- Authorization of Services
  - Services written in the Recovery Plan must be authorized by a Mental Health Professional (and a Substance Abuse Professional for individuals with co-occurring disorders) ***prior to*** services being delivered.
  - MHP/SAP complete a clinical review of the appropriateness of services requested and may not approve all requested services.
  - Authorization is completed and verified via the CCS Module



Connection to Other Providers on Service Array

- Once services have been authorized by the MH/SA Professional, service provision may begin.
  - Verify in CCS Module
- Unused authorized services may not be carried over into future Recovery Plan period, new services must be authorized.
- Services may ***only*** be provided at the frequency and duration authorized in the Recovery Plan.
- Document service provision in the CCS Module via progress notes, which also serves as the billing mechanism. (2 business days)

CCS Progress Notes

- ALL billable progress notes must relate back to a need identified in the participant's assessment and a goal in the current, approved Recovery Plan
  - If goal/action steps in plan are not sufficiently descriptive, reach out to service facilitator to amend the plan.
- Telehealth is allowable in CCS for all service types and providers.
  - Telehealth does **NOT** include phone calls with CCS participants solely to cancel or schedule appointments.
    - EXCEPTION: *ONLY* Service Facilitator can bill for phone calls that involve scheduling or canceling appointments.

Telehealth in CCS

- CCS services can be provided via telehealth (including audio-only) to ensure CCS participants have maximum access to services.
  - Telehealth service **MUST** be functionally equivalent to face-to-face service.
  - Both provider and CCS participant must agree for service to be provided via telehealth.
- See document: *Dane County CCS Telehealth Guidance*

You generally can NOT bill for CCS services when the CCS participant is not present. There are some, very specific, exceptions based on the service descriptions in the Service Array.

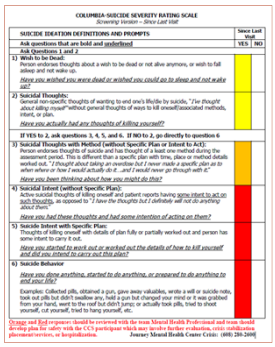
Exceptions:

- Screening and Assessment
- Service Planning
- Service Facilitation
- Diagnostic Evaluations time spent interpreting test results and generating report.
- Physical Health Monitoring time spent *with the CCS participant's family* members providing a covered Physical Health Monitoring service
- Individual Skill Development and Enhancement time spent *with the family of a minor* (under age 18) CCS participant providing a covered Individual Skill Development and Enhancement service
- Individual and/or Family Psychoeducation Services time spent providing a covered Individual and/or Family Psychoeducation service to the CCS participant's *family or natural supports*

CCS Progress Notes, ctd.

- DAP note format
  - **D = Data**
    - What actions are you taking with client to meet goals during this session?
    - What skills are you teaching client?
    - Use client quotes.
  - **A = Assessment**
    - How does client present today?
      - Assess for thoughts of self-harm/suicidal ideation.
    - What is client's response to today's interventions?
  - **P = Plan**
    - When will you see client next?
    - What actions need to be taken in the interim by provider and/or client?

Assessing Suicide Risk: C-SSRS



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening Version – Since Last Visit

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Visit YES	NO
Ask questions that are bold and underlined		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/be by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. *Have you actually had any thoughts of killing yourself?*		
IF YES to 2, ask questions 3, 4, 5, and 6. IF NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*" *Have you been thinking about how you might do this?*		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" *Have you had these thoughts and had some intention of acting on them?*		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. *Have you started to work out or worked out the details of how to kill yourself and did you intend to carry out this plan?*		
6) Suicide Behavior *Have you done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Orange and Red responses should be reviewed with the team Mental Health Professional and team should develop plan for safety with the CCS participant which may involve further evaluation, crisis stabilization placement/services, or hospitalization. **Journey Mental Health Crisis Crisis: (608) 280-2600**

- Simple tool for all staff to use; do not need to be a clinician, mental health professional, or therapist.
- If responses are in Orange or Red section, immediately inform SF and MHP on team of suicidal ideation and develop plan for safety.
- If needed, assist individual with implementing immediate safety measures (i.e. welfare check, ER, CRISIS unit, etc.).
- Include assessment of suicide risk in "Assessment" portion of progress note.

The CCS Service Array

- Outlines the psychosocial rehabilitation services that are covered under the Medical Assistance CCS benefit.
  - If it is not in service array, it is not a billable service.
- Described in detail in Attachment 1 of the June 2014 ForwardHealth Update, can be found on DCDHS website.
- Useful for development of goals and wording of progress notes in context of psychosocial rehabilitation.

CCS Service Array

- Assessment
  - Completion of initial comprehensive assessment (within 30 days of admission to CCS) and subsequent assessment updates
- Service planning
  - Development of a written plan of the psychosocial rehabilitation services in collaboration with the client
  - Must be based upon comprehensive assessment and client-stated goals
  - Must be reviewed and updated every 6 months.
- Service facilitation
  - Coordination and monitoring of service plan
  - Helping participant obtain necessary services
  - Agency must have a Mental Health Professional and Substance Use Professional

CCS Service Array, ctd.

- Diagnostic evaluations
  - Specialized evaluations needed
  - Provider must be licensed and acting within scope of practice
- Medication management
  - Prescriber services
  - Non-prescriber services: monitoring changes in symptoms and side effects, supporting individual in taking medications
  - NOT delivery alone
- Physical Health Monitoring
  - Development of health monitoring and management skills
  - Monitoring of physical health medications and treatments

CCS Service Array, ctd.

- Peer Support
  - Provided by Wisconsin Certified Peer Specialists
  - Wide range of supports to assist participant and family in recovery process
- Individual Skill Development and Enhancement
  - Individual or group
  - Training in activities of daily living
  - Various methods: modeling, mentoring, monitoring, supervision, cueing, etc.
- Wellness Management and Recovery Services
  - Includes development of recovery action plan
  - Empowering participants to manage their mental health and substance use issues

CCS Service Array, ctd.

- Employment-Related Skill Training
  - Does not include time working in clubhouse or job development
- Individual and/or Family Psychoeducation
  - Providing education and information about mental health/substance use issues
  - Skills training and problem solving
  - Ongoing guidance about coping with mental health/substance use issues
- Psychotherapy
- Substance Use Treatment
  - Day treatment and outpatient substance abuse counseling

Non-Covered Services

Examples:

- Cannot be dually enrolled in CCS and CSP or TCM
- Services to a resident of NH, ICF, IMD or hospital except to prepare for discharge to community
- Services provided when participant is in RCC or jail (never)
- Detoxification services, residential intoxication monitoring, Narcotic Treatment Benefit (methadone); OWI assessment
- Time participant spends working in clubhouse
- Time spent solely to transport CCS participant
- Services that are not rehabilitative and are primarily recreation-oriented.
- Sheltered Workshop or Job Development
- Autism, DD or Learning Disability services
  - List is not exhaustive

Quality Assurance

- CCS documentation is regularly reviewed for compliance with DHS 36 and Medicaid standards
- For a service to be billable in CCS it MUST:
  - Be related to a need identified in the assessment
  - Be related to a goal on approved Recovery Plan
  - Be provided at frequency/duration listed in Plan
  - Be psychosocial rehabilitation as defined in CCS Service Array (skill building/treatment)
  - Be provided in the most efficient manner
  - Be medically necessary
  - Be related to needs resulting from MH/SUD challenge(s)

CCS: Psychosocial Rehabilitation and Recovery

Karen Milstein
Wisconsin Certified Peer Specialist

Julie Meister
CCS Administrator

*With special contributions from **Ankita Bharadwaj***

Key Components of CCS

- Psychosocial Rehabilitation
- Recovery

What is Psychosocial Rehabilitation?

" . . . a process that facilitates the opportunity for individuals—who are impaired, disabled, or handicapped by a mental disorder—to reach their optimal level of independent functioning in the community."

-1996, World Health Organization

What is Psychiatric Rehabilitation?

" … promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives … (The) services are collaborative, person-directed, and individualized. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice."

-2023, Psychiatric Rehabilitation Association

What is Psychosocial Rehabilitation?

Psychosocial rehabilitation helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: learning coping skills so that they are more successful handling a stressful environment and developing resources that reduce future stressors.

- 2023, National Alliance on Mental Illness (NAMI)

History of Psychosocial Rehabilitation
Treatment of Marginalized Populations

- Drapetomania
  - Term coined in1851 by Samuel Cartwright, surgeon, psychologist, and professor of psychiatry at University of Louisiana
  - Mental illness that caused enslaved Black people to flee captivity
- Homosexuality
  - Included in first DSM in 1952
  - Individuals were criminalized (jail) or subjected to harsh medical treatments in psychiatric hospitals (electroshock therapy, lobotomy, aversion therapy)
  - Removed from DSM in 1973
- Hysteria
  - Considered almost exclusively female condition until1900s
  - Popularly diagnosed in women in the 1700s-1800s
  - Common symptoms: anxiety, fainting, nervousness, insomnia, irritability
  - Removed from DSM in1980

Acknowledging Systemic Harm

June 2019: APsaA issues apology
- Psychoanalytic association issues apology for past views that pathologized homosexuality and transgender identities leading to discrimination and trauma.
- https://apsa.org/wp-content/uploads/2022/10/StonewallApology.pdf

January 2021: APA apology
- Psychiatric association issues apology to BIPOC for support of structural racism in psychiatry
- https://www.psychiatry.org/newsroom/apa-apology-for-its-support-of-structural-racism-in-psychiatry

June 2021: NASW apology
- Social Work association apologizes for racist practices in American social work
- https://www.socialworkers.org/News/News-Releases/ID/2331/NASW-apologizes-for-racist-practices-in-American-social-work

October 2021: APA issues apology
- Psychological association issues apology to BIPOC for the APA's Role in promoting, perpetuating, and failing to challenge racism, racial discrimination, and human hierarchy in U.S.
- https://www.apa.org/about/policy/racism-apology

History of Psychosocial Rehabilitation

- 1750: Sobriety Circles
  - First known self-help groups in North America
- Pre-1800s: Very poor conditions and treatment
- 1800s: Moral Treatment Era
  - Primarily custodial, compassionate treatment, recreation, space, fresh air
    - 1864: New York State Inebriate Asylum
    - 1880: Dane County Asylum (Badger Prairie) opened
- 1918: Soldiers Rehabilitation Act of 1918
  - 1920: Eligibility expanded to non-veterans with disabilities
  - 1943: Vocational Rehabilitation Act amendments
    - Expanded eligibility to individuals with psychiatric disabilities
- 1935: Alcoholics Anonymous formed
- 1935: Narcotics Farm opens
  - US Public Health Prison Hospital in Kentucky
  - Beginning of federal involvement in SUD research

- 1944: Formation of first Clubhouse
  - Fountain House, NYC: Work & Peer Support valued
- 1963: Community Mental Health Act
  - Deinstitutionalization, community-based treatment
- 1990: Americans with Disabilities Act
  - Civil rights law that prohibits discrimination based on disability
    - Included both physical and mental disabilities
- 1997: Blue Ribbon Commission on Mental Health
  - Recommended recovery-focused treatment
  - 2004: Directly led to development of DHS 36/CCS
- 2008: Mental Health Parity and Addiction Equity Act
  - Prevents insurers that provide mental health/SUD benefits from having less favorable limits for MH/SUD than for medical services
- 2010: First Wisconsin Certified Peer Specialist exam
- 2015: Dane County CCS receives certification
- 2019: First Wisconsin Certified Parent Peer Specialist Exam

Key Components of Psychosocial Rehabilitation

- Staff convey hope and respect
- Culture is central to recovery
- Informed and shared decision-making
- Builds on strengths and capabilities
- Person-centered, self-determination
- Community interaction and participation
- Facilitates development of support networks
- Promotes health and wellness

Psychosocial Rehabilitation is Holistic

Helps people improve quality of all aspects of their lives:

- Health
- Social
- Occupational
- Educational
- Residential
- Intellectual
- Spiritual
- Financial

Focus on Recovery

- Recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." -SAMHSA

Four dimensions that support recovery:

- Health: making informed, healthy choices that support physical and emotional well being
- Home: a safe, stable place to live
- Purpose: meaningful daily activities
- Community: relationships that provide support, friendship, and hope.

SAMHSA's Guiding Principles of Recovery

Recovery:

- Emerges from hope.
- Is person driven.
- Occurs via many pathways.
- Is holistic.
- Is supported by peers and allies.
- Is supported through relationships and social networks.
- Is culturally-based and influenced.
- Is supported by addressing trauma.
- Involves individual, family, and community strengths and responsibility.
- Is based on respect.

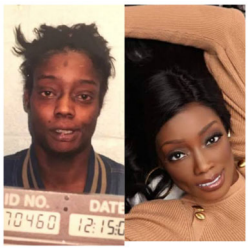
Practices of Recovery-Oriented Mental Health Workers*

- Reflective about practice and always learning
- Recognize own personal values & assumptions
- Demonstrate humility
- Demonstrate knowledge and understanding of recovery concepts and keep at forefront of practice—always!

*From Practices of Recovery-Oriented Mental Health Workers by Laurie Curtis

In CCS, embracing and practicing recovery is EVERYONE'S job EVERY DAY!

Listening to Lived Experience
Tonier Cain



"They helped me to deal with what happened to me . . . not what's wrong with me."

"Where there's breath, there's hope."

Key Recovery Concepts
Connection

- Communicate in way that shows respect
  - Share information directly, honestly
  - Admit mistakes openly and apologize sincerely
  - Presume that individuals have knowledge, skills, etc.
  - Take the time to listen
  - Build a common language and construct shared meaning
  - Validate what person experiences is real to them
  - Work to earn and keep trust (timeliness, responsiveness, etc.)
  - Establish parameters for safety in each relationship

Connection—Examples

- Recovery-oriented:
  - F-I-N-E or Mrs. F you
- Could do better:
  - Doctor did not validate experiences. Assumed many things "were in my head."
  - Provider defensiveness when client upset about provider being late to appointment in community

Key Recovery Concepts
Empowerment

- Support individual autonomy and personal decision-making responsibility
  - Seek client input in treatment and organizational issues
  - Create range of choices available
  - Provide information to allow for informed decision-making
  - Allow people to take risks and make mistakes in their lives
  - Respect that person is "expert" of their life
  - Choosing words/Consumer participation
  - Honor preferences for meeting (time, place, frequency)

Empowerment—Examples

- Recovery
  - Psychiatrist that "gave me choices and allowed me to help make the choices as we decreased medications."
- Could do better
  - Treatment providers not allowing for risk that client wants to take, i.e. moving to apartment, getting a pet, etc.

Small Group
Connection & Empowerment

- In your small group each person discuss:

1. A situation where you or someone else demonstrated recovery-oriented skills in working with a client.
2. A situation where you or someone else could have done better with regard to your recovery-orientation in practice.

Key Recovery Concepts
Hope

- Uses hope-inspiring practices and strategies
  - Genuine concern about person's well-being
  - Trust authenticity of person's experience
  - Expectation of recovery and success
- Focuses on building people's strengths and personal resources
  - Notice and celebrate successes
  - Emphasize what is working (not just problems)
  - Help people recognize own strengths

Hope—examples

- Recovery-oriented:
  - Amazingly supportive therapist
  - Eyes rolling or bugs
- Could do better:
  - Discouraged when psychology tests stated would "never be in a position" that was in a busy atmosphere

Key Recovery Concepts
Healing

- Help people define themselves as apart from the illness or challenge
  - Relate to whole person, not just illness
- Honor the diverse ways people view their life situations and illness
  - Try to find out what is important to each person and how to best connect
  - Respect individual's worldview based on their history
- Help people build on existing abilities and strengths and develop new coping skills

Healing—Examples

- Recovery-oriented:
  - New friend took chance to visit me on psychiatric unit in 1989. We're still close friends.
  - Circles 
- Could do better:
  - "Do you hear voices, do you see things?"

Small Group—Hope & Healing

- In your small group each person discuss:

1. A situation where you or someone else demonstrated recovery-oriented skills in working with a client.
2. A situation where you or someone else could have done better with regard to your recovery-orientation in practice.

Key Recovery Concepts
Community

- Help people find personal purpose and meaning in their lives
  - Reclaiming roles: worker, tenant, artist, student, parent, etc.
  - Support ability of people to live successfully in lifestyles of their own choosing
  - Help people get on with life beyond mental illness
    - Develop natural support networks
    - Willingness to disengage when services are no longer needed

Community—Examples

- Recovery-oriented
  - Successfully engaged in the community
- Could do better
  - Client wanted to be discharged but management kept putting roadblocks up for her. "She has credit card debt."

Key Recovery Concepts
External Conditions

- Knowledge of client rights (legal, civil)
  - Help people exercise their rights (Ch. 51, WATTS review, grievances)
- Respect right of client to exert control over information about them
  - Assist with access to records
  - Acknowledge right to "a private life" (i.e. don't have to answer all questions all the time or have workers in home)

External—Examples

- Recovery-oriented
  - Client wanted to review clinical record at regular intervals and was readily granted this opportunity. She also wrote notes based on her differences of opinion that were included as part of her clinical record.
- Could do better
  - Trying to talk client out of contesting their Chapter 51 or placement.

How to reach Dane CCS:

New CCS Enrollments and Transfers:

- CCS Intake: (608) 242-6415

Sending Documents to CCS:

- CCS Fax: (608) 283-2994
- CCS Email: CCS@danecounty.gov

Contact Information

- Julie Meister, CCS Administrator
  - Contracts, Compliance, Policies
  - meister.julie@danecounty.gov
  - (608) 504-8931
- Jessica Gilbert, CCS Service Director
  - Programmatic Technical Assistance, Quality Assurance
  - gilbert.jessica@danecounty.gov
  - (608) 334-8030
- Brianna Vejvoda, CCS Provider Network Coordinator
  - Orientation & Training, Supervision, Staff Listing Forms
  - vejvoda.brianna@danecounty.gov
  - (608) 358-0083
- Nick Nelson, IT Specialist
  - CCS Module Challenges
  - nelson.nick@danecounty.gov

Resources

- Dane County Human Services
  - Access to forms, policies, etc.
  - https://danecountyhumanservices.org/
- State CCS website
  - https://www.dhs.wisconsin.gov/ccs/index.htm
- SAMHSA
  - FREE resources
  - http://www.samhsa.gov
- WPPNT (Free MH/SUD Teleconference Series)
  - 1.0 CEU per training
  - Join the email list for notification of virtual trainings
  - https://www.dhs.wisconsin.gov/wppnt/index.htm

In CCS, embracing and practicing recovery is EVERYONE'S job EVERY DAY!