

1 Exploring Identity: Tools & Approaches to Enhance Strengths & Resilience

Our identity is the essence of who we are, our values, strengths and resilience. Individuals receiving services from, and living in, our power-over-people culture have their identity spoiled. This workshop explores working with identity, personal strengths, values and resilience. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 50% DIDACTIC, 25% PARTICIPATORY, AND 25% EXPERIENTIAL.

Presenters: Annette M. Cañeda, EdD, Director of Organizational Learning, Telecare Corporation, Alameda, California; Jim Sechrist, MA, MFT, Administrator, Telecare Recovery Center at Woodburn, Woodburn, Oregon; Scott Madover, PhD, MINT Trainer, Administrator/Regional Administrator, Telecare Corporation, Oakland, California

2 MEDS 101

The treatment of persons with severe and persistent mental illness requires that clinicians must be knowledgeable and skilled in a wide variety of areas not the least of which is in the field of medication. Medication options and the development of new antipsychotic medications continue to expand. This workshop will provide an overview on basic brain chemistry found in the brain of those with a major mental illness, and of the chemical imbalance hypotheses, and will offer an assessment of target symptoms and drug types used to treat mental illnesses. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 80% DIDACTIC, 20% PARTICIPATORY.

Presenter: Theodore Mauger, MD, Chief of Psychiatry, Sojourner's Brain Injury Program, Grand Rapids, Michigan

3 Occupational Therapists' Role in ACT

One of the goals of occupational therapy is to assist people in identifying and engaging in meaningful activities as a means to recovery. This and its emphasis on person-centered services, community inclusion and in vivo experiences are shared by the ACT model. Despite varying roles with the ACT team, occupational therapists are able to teach team members simple strategies to assist in assessing and helping individuals achieve increased independence at home and in the community. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 75% DIDACTIC, AND 25% PARTICIPATORY.

Presenter: Devon Horton, BS, MOT, OTR/L, Occupational Therapist, NHS Human Services; Karen M. Schen, MS, OTR/L, CTT Occupational Therapist, Mercy Behavioral Health, both of Pittsburgh, Pennsylvania

*4 Moving ACT Teams from Crisis Operation to Recovery Planning

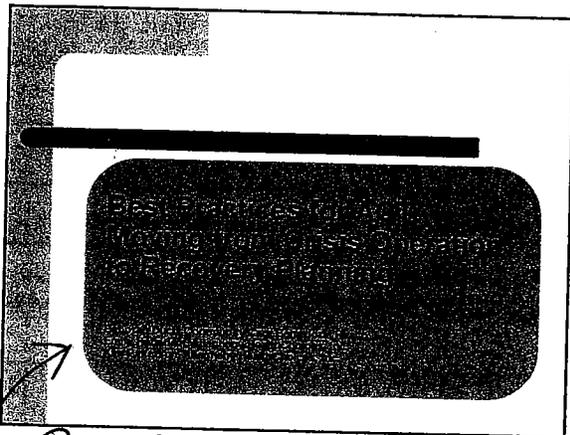
New and mature teams experience movement away from sustaining adherence to ACT. Teams experiencing 'drift' engage in crisis-focused practice and operations or look like case management. An effective staff communication system, the use of individual treatment teams, the establishment of recovery clinical processes, and continuous quality improvement form the building blocks for a sustainable and effective team. Discussion will focus on steps and tools to move teams toward ACT. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 65% DIDACTIC, 35% PARTICIPATORY.

Presenters: Deborah Duch, MPH, Program Manager, Community Care Behavioral Health; Emily Heberlein, MS, Manager of Evaluation and Outcomes; Kim Patterson, MSW, LSW, Director of Project Development and Management, both of Allegheny HealthChoices, Inc., all of Pittsburgh, Pennsylvania

5 Blending Integrated Dual Disorder Treatment within ACT

Outcomes associated with implementing Integrated Dual Disorder Treatment (IDDT) within ACT teams include decreased substance use and decreased criminal justice involvement. One ACT team in Washington State will describe their experience with IDDT implementation including providing stage-wise treatment to clients. Presenters will discuss utilizing the TMACT fidelity tool to further guide team training in IDDT as well as describe the challenges in implementing IDDT within a traditional parallel-treatment system of care. CONTENT IS BEST SUITED FOR PARTICIPANTS AT INTERMEDIATE LEVEL; 75% DIDACTIC, 25% PARTICIPATORY.

Presenters: Shannon Blajeski, MSW, Trainer & Consultant, Washington Institute for Mental Health Research & Training, University of Washington, Seattle, Washington; Dana Oatis, MSW, LICSW, Team Leader, Lourdes Counseling Center, Pasco, Washington



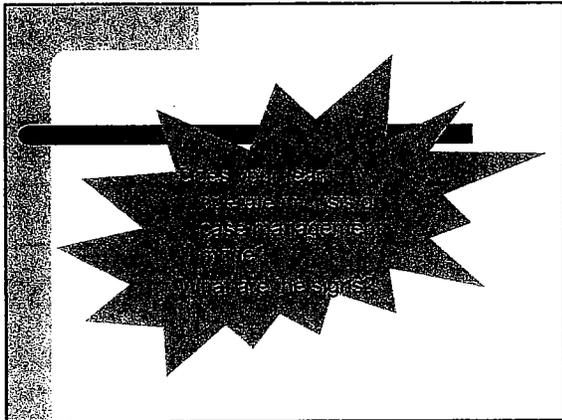
Best Practices for ACT:
Moving from Crisis Operation
to Recovery Planning

ACT in Allegheny County, PA

- 9 teams, 4 providers
 - 4 teams are considered mature (9.5 years)
 - 1 team works with transition age population
 - 2 teams were created to work with consumers involved in the regional state hospital closure
 - 3 teams were created to ensure capacity
- Approximately 800 consumers served (100/team capacity)
- Funded through Medicaid and County Funds for non-eligible individuals
- Expectations for high fidelity to ACT model

Objectives

- Review signs that team is moving away from ACT model and is operating in crisis or case management mode
- Develop strategies to (re)build three key components of the model:
 - Staff communication system
 - Individual(ized) Treatment Teams (ITTs)
 - Recovery treatment planning
- Identify tools and processes for continuous quality improvement



← Does your team operate in crisis or case management mode?
What are the signs?

Signs

- Treatment plans do not drive day to day work, schedule cards are not used ✓
- Contacts with consumers revolve around meds and basic case management tasks (not rehab, wellness, therapy or meaningful activity) ✓
- Goals focus on stability and compliance, do not cover other life domains like work and other meaningful activity ✓
- Frequent consumer crises, increased hospitalization rates ✓
- Most staff work as generalists, with little time (or expertise?) for specialty work of voc, D&A, peer and wellness/rehab ✓
- Staff burnout, dissatisfaction ✓

etc

Comparison of CM to ACT

<ul style="list-style-type: none">• Case Management<ul style="list-style-type: none">- Individual caseloads- Primary- Work as generalists- Team meetings weekly or two to three times weekly- Work and respond in weekly or bi-weekly intervals- Assessment at Intake- Engagement complete once consumer starts service- TX Planning domain focused- Broker all services	<ul style="list-style-type: none">• ACT<ul style="list-style-type: none">- Team caseload ✓- ITT- Work as generalists and specialists ✓- Team meetings 5xs week ✓- Work and respond in 24 hour intervals ✓- Assessment and engagement on-going ✓- TX planning driven by consumer- Provide all services ✓
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6/8

Focus Areas: Allegheny Co.

- **Staff Communication System:** built-in mechanisms for communication to ensure timely and highly effective interventions.
- **Recovery TX Planning Process:** the roadmap for services to support consumers' recovery journey.
- **Quality Improvement:** using fidelity reviews, outcomes data and consumer advisory boards to identify and address improvement areas to positively effect consumer outcomes.

Staff Communication: Daily Meeting and Shift Management

- **Daily meeting**
 - Status call
 - Consumer schedule card
 - Daily assignment sheet
- (Tips: rotate responsibilities, cover consumers' crisis, concerns as their names come up, use meeting to problem solve in real time)
- **Shift Manager/Management**
 - Gets daily meeting ready
 - Completes daily assignment sheet and announces assignments
 - Coordinates, problem solves, and triages clinical matters
 - Ensures evening and on-call assignments and alert
- (Tips: shift manager does not have to be office-bound, SM confers with ITT, program assistant can do most coordination)

Schedule Cards - Driven by Tip Dean.

Schedule revised when plan updated.

evening for most AT Hosp & Hosp.

Staff Communication: Program Assistant

- **Integral member of the team**
 - Handles all walk-ins and calls throughout the day
 - Distinguishes between clinical and routine needs
 - Team Leader's right hand
 - Enters team data
 - Makes and follows-up on appointments and referrals
- (Tips: program assistant is supervised by TL, physically located by TL, attends most team meetings, attends trainings, is designated to one team)

Balance: Generalist and Specialist

- Most teams are more comfortable with generalist work.
- Belief that because the team has and is responsible for a 'team caseload,' then decisions, planning and problem-solving are a team task.
- Daily interventions get assigned to the team member available because the team is responsible to work with each individual.

This results in a variety of problems:

- Too many opinions/directors = getting stuck.
- Inconsistent messages delivered to the individual and the individual's supports.
- Blaming the individual and each other.
- Working in a disorganized way and in crisis model!
- The loudest individuals get served the most.

ACT Staff Roles: Generalist and Specialist

- Each staff person has their own specialty area and cross-trains other staff in that specialty area, specific to each consumer
 - Dual Disorders
 - Vocational
 - Peer
 - Psychiatry and Nursing
 - Housing
- Each staff person is flexible enough to do whatever it takes to help as well, learns skills related to other specialty areas (generalist)
 - On-call coverage
 - Evening and weekend work
 - Eyes and ears for other staff
 - Seize the moment!

Staff Communication: Individual(ized) TX Team (ITT)

- An ITT includes the individual, three to five ACT staff who together have a range of clinical/rehabilitation skills and expertise (minimum: primary, psychiatrist, and at least one clinical or rehabilitation staff)
- ITT staff are assigned at the Initial Assessment and TX Plan by the Team Leader and MD. The assignments are based on need, best match and an individual's desires.
- Each member of the ITT completes a part of the Comprehensive Assessment.
- Each ITT member's role is spelled out in the Recovery TX Plan.

Staff Communication: ITT

- ITTs don't change much but might change in times of crisis, critical TX junctures, or when new plans are developed.
- ITT members share responsibilities by providing, directing and overseeing all interventions, and coordinating service procurement and provision.
- ITTs meet, at a minimum, prior to and during the assessment and planning process and as needed.

Staff Communication: ITT

- The primary, or the leader of the ITT, ensures that the ITT is working together and is assessing positive movement toward an individual's defined outcomes.
- The team looks to the ITT, on a daily basis, to problem solve, direct TX and cross-train on specific individual matters.
- The roles of each ITT member gets recorded in the TX Plan and on schedule cards.
- Each member of the ITT is responsible for writing progress notes reflecting back to the TX Plan.

Staff Communication: Supervision

Team Leader supervision is multi-dimensional and CRITICAL

- Basic supervision (HR, agency policy, etc.)
 - ACT: assure staff are trained in ACT and providing services consistent with ACT
 - EBPs: TLs must also be able to supervise and mentor specialists (voc, substance abuse, peer)
 - Clinical: assessment, summary and formulation, psychotherapies, goals and objectives, engagement
 - Case Management
- (Tip: Supervision happens individually, in group, and in the field)

Recovery TX Planning Process

TX Planning (Person-Centered Planning): 7 musts

1. The treatment planning process is *consumer-driven*.
 - Meeting prior to the planning meeting
 - Peer specialist helps
 - Coaching and support to promote self-direction and leadership within the meeting is provided to the consumer, as needed
2. The planning process is coordinated by the *individual treatment team (ITT)*.
 - The ITT includes the consumer
 - The ITT is present at every planning meeting unless the consumer says otherwise

Recovery TX Planning Process

3. *Engagement strategies* are used beginning with the initial visit through on-going monitoring of progress of the implementation of the plan.

- Consumers not engaged in TX nor with established rapport with team members are more likely to NOT participate or expand their vision.
- Using motivational interviewing as an engagement technique is useful to move individuals.
- Considering stages of change readiness will positively impact the change process.

Recovery TX Planning Process

4. *Assessment practices* are incorporated on an ongoing basis, and throughout the planning process.

- The initial assessment process begins to educate the consumer about the collaborative relationship between him/her and the team.
(Tip: completed within the first couple visits and also used as an engagement strategy)
- A comprehensive assessment is completed by multiple team members using multiple sources and includes historical and current information.
(Tip: completed within the first 6 weeks, reviewed with full team, reviewed in first full planning meeting to inform goals and objectives, updated annually and as new information arrives)

Recovery TX Planning Process

- Teams routinely complete assessments throughout the planning process.
 - Conduct assessments at critical treatment junctures and adjust the plan and interventions accordingly.
 - Timeframes are set to formally assess the progress of treatment interventions and treatment needs.
 - Prior to every treatment plan, an assessment is completed to inform goals and objectives.

(Tip: assessment is not summary and formulation)

- Teams assess on-going, in daily work.
 - Team reviews and adjusts scheduled interventions within their daily team meeting and when the consumer and ITT agree to revise.

Recovery TX Planning Process

5. Planning goals are supported by *consumer-identified strengths*.

- Where do you look for strengths?
 - ITT engages consumer to identify individual strengths/resources.
 - Review the initial and comprehensive assessments.
 - Look within the individual's family, natural support network, service system and community at large.
- How do strengths fit into a Recovery Plan?
 - The layout of a plan document is structured so that relevant strengths are naturally worked into and built upon when developing the action steps for each goal.

Recovery TX Planning Process

- What types of strengths can you look for?
 - Skills, talents, personal virtues and traits
 - Interpersonal skills, interpersonal and environmental resources, cultural knowledge and lore
 - Family stories and narratives, knowledge gained from struggling with adversity, knowledge gained from occupational and parental roles
 - Spirituality and faith, and hopes, dreams, goals and aspirations

Recovery TX Planning Process

6. Planning contains interventions that address a *wide range of treatment goals.*

- Identify goals that are related to a consumer's vision of what kind of life she or he wants to live.
- Look beyond medication and stability (rehabilitation, physical health, employment/education, housing, skill development, clinical intervention).
- Revisit the comprehensive assessment and other assessments and look for goals the consumer identified based on needs and past strengths.

Recovery TX Planning Process

7. The team demonstrates *ongoing adherence* to recovery treatment plans

- Consumer schedule cards are the primary method to ensure the recovery planning is being put into action on a daily basis.

(Tip: schedule cards should be the last task completed at the TX planning meeting and reviewed with the consumer and ITT)

Continuous Quality Improvement

- Fidelity reviews
- Data reports
- Consumer Advisory Board

ACT Fidelity Assessment (TMACT)

- Tool for Measurement of Assertive Community Treatment (TMACT) is the most current and comprehensive ACT fidelity tool
- Rates ACT teams on 47 items, organized into six areas:
 - Operations & Structure
 - Core Team
 - Specialist Team
 - Core Practices
 - Evidence-Based Practices
 - Person-Centered Planning Practices
- Process includes interviews with staff and consumers, observation (including accompanying staff in the community), and clinical record and program documents reviews

TMACT Reports and Quality Improvement

- Ratings and justification for each item
- For each subscale:
 - Strengths
 - Areas of concern
 - Expectations (recommendations)
- Provides team with clear direction for improving fidelity

TMACT Example: Person-Centered Planning

Definition	Score	Comments
<p>The team conducts person-centered planning according to the ACT model, including: (1) development of formalized treatment plan ideas based on initial inquiry and discussion with the consumer (prior to the meeting); (2) conducting regularly scheduled treatment planning meetings; (3) attendance by key staff, the consumer, and anyone else she prefers (e.g., family), including number of participants to fit with the consumer's preferences; (4) meeting driven by the consumer's goals and preferences; and (5) provision of coaching and support to promote self-direction and leadership within the meeting, as needed. For teams that use an Individual Treatment Team (ITT), treatment planning meetings should include members from this group.</p>	1	<p>The treatment plans in the reviewed sample were not representative of a person-centered approach to treatment planning. There was no evidence of consumer voice in the plans, and reviewers were unable to determine that the consumer was present and participated in the process. There was little evidence of team collaboration in these plans. Plans are not electronically signed by the consumers, and reviewers did not find progress notes indicating that consumer or other team members met to develop a treatment plan. Goals and interventions were written using generic, clinical jargon. The provision of coaching and support to promote self-direction and leadership during the treatment planning meeting is not occurring. Reviewers found that strengths, goals, and interventions were directly copied and pasted between consumer charts with no editing, leading to plans that completely lacked any evidence of individualized treatment.</p>

TMACT Example: Recovery Planning Expectations

- Appropriate team members (ITT) and natural supports should be present and involved during the actual *creation* of the plan, not its review.
- Fully implement the ITT structure.
- The team should create a schedule for when treatment-planning meetings will occur and then ensure that this scheduled time is protected for everyone on the team.
- During these treatment-planning meetings, the consumer, ITT, and natural supports are in attendance, and both the treatment plan and consumer schedule card are established. It is then recommended that staff meet as a full team to review and adjust these plans and consumer schedule cards.

TMACT Example: Recovery Planning Expectations

- Once a peer specialist is hired, the team will consider ways to maximize the use of the peer specialist role both before and during the treatment planning meeting to help the team maintain a more person-centered and recovery oriented approach.
- The benefits of weekly treatment planning include a space for shared consultation across the ITT/ACT, a time for the team leader to provide group supervision around engagement strategies, team brainstorming about stages of change as related to the person's treatment, and a fixed time to complete or adjust the consumer weekly schedule including planning staff appointments.
- Treatment planning is a useful area to work on during individual supervision sessions to ensure that all team members are skilled at creating person-centered treatment plans.

Between TMACT Reviews

- Follow-up site visits are scheduled with each team, generally three months after the assessment.
 - Teams report this follow-up process and continued face-to-face dialogue is very helpful.
 - It has helped keep issues on progress towards fidelity at the forefront of CTTs' attention.
- The reviewers include AHCI, Community Care, and Office of Behavioral Health.
- TMACT items with low scores are the focus.
- Progress reports and further recommendations are provided.

Reviewing fidelity has led to...

- Expert training and on-going consultation in other EBPs like SE, IDDT, CBT, person-centered planning for individual teams and across system
- Awareness for Leadership that teams are working with individuals who may not meet strict ACT criteria
- Preparation for licensure
- Consistency in expectations across teams
- Supported Employment incentive

Data Reports

- Program assistants use Web-based application to report:
 - Hospitalizations, jail, housing, crisis use
 - Employment, education, natural supports
 - Stage of treatment
- Service utilization data for ACT, other services (e.g. hospitalizations, D&A services)

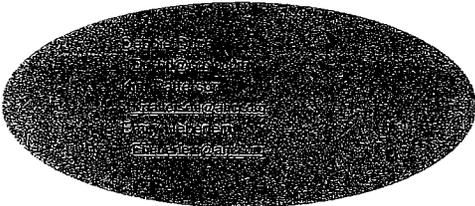
Different Reports for Different Purposes

Consumer-level reports	Team and system reports
Involvement in supported employment	• Monitor SE implementation • TL use in supervision with voc specialist
Hospitalizations and jail	• Identify people who may need change in treatment plan
Quarterly consumer summary	• Use in treatment planning • Identify successes and challenges
Quarterly summary of key domains	• Monitor team performance • Identify successes, outcomes to target
Annual and long-term analyses	• Compare teams and agencies • Identify trends, successes, progress

Resources for Quality Improvement

- TMACT: Maria Monroe-DeVita, Ph.D., University of Washington Department of Psychiatry & Behavioral Sciences Division of Public Behavioral Health & Justice Policy (mmdv@u.washington.edu)
- Dartmouth Psychiatric Research Center and Hazelden for multiple EBP manuals for TX for individuals with a severe and persistent mental illness (ACT, SE, IDDT, CBT, Trauma)
- Lia Hicks and ML Reuf, Adult and Child, Indianapolis, IN for Person-Centered Planning (lhicks@aduitandchild.org)

Presenter Contact Information



Consumer Schedule Card

Name:

Residence location:

ITT: Primary- Psychiatrist:

RN:

Voc:

Peer:

Therapist:

Other supports:

	Monday	Tuesday	Wed	Thurs	Friday	Sat	Sun
WEEK ONE	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON
WEEK TWO	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON	AM ----- NOON
EVE							
Special Instructions	● ● ● ● ●						
RISKS/OTHER:	● ● ● ●						

Consumer Schedule Card

Name: Consumer
Residence location: Gardenview Apts
ITT: Primary- Brian
Psychiatrist: Usman
RN: Sue
Voc: Paulette
Peer: Aaron
Therapist: Dana
Other supports: GV neighbor (Jim), payee is RCS (Melanie), Peer mentor-Paul (PSAN), employer (Judy), Pastor Sam

	Monday	Tuesday	Wed	Thurs	Friday	Sat	Sun
WEEK ONE	AM Before team meeting: Brian(or Dana)-PC: BT assessment re: overnight.	AM Before team meeting: Brian(or Dana)- PC: BT assessment re: overnight..	AM Before team meeting: Brian(or Dana)- PC: BT assessment re: overnight. 11am-Job site visit/mtg	AM Before team meeting: Brian(or Dana)- PC: BT assessment re: overnight. Cloz draw	AM Before team meeting: Brian(or Dana t)- PC: BT assessment re: overnight.	AM CTT- PC: BT assessment re: overnight.	AM CTT- PC: BT assessment re: overnight.
	NOON 1-2:Paulette-Voc profile and job development	NOON 12-3:CTT WRAP Group or individual visit	NOON	NOON	NOON 1-3-Brian/Paul- orient to com/asst w/building relatshps w/com (stores, church, etc).	NOON CTT visit- cooking/cleaning indep skills	NOON
WEEK TWO	AM SAME	AM SAME	AM SAME	AM SAME	AM SAME	AM SAME	AM SAME
	NOON	NOON SAME	NOON After work: (Mel)Cash chk and groceries (indep skills)	NOON	NOON	NOON SAME	NOON
EVE	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve	Brian or eve CTT- on Call eve 9 pm to check and problem-solve
	- AM calls daily, symptom assessment, med reminder -Review weekly activities every Sunday nite -Monitor and problem-solve all issues/behaviors etc from day every eve for 15 mins. -Remind/practice BOB to NOT shake hands with others-nod and smile						

Special Instructions

RISKS/OTHER:
 -poor health(see documents)
 -BT is large & people are intimidated therefore possible com. complaints.
 -Anxious before sleep
 -Bob gives away \$ and clothes-help him figure out other things to give people like gum or mints, special occasion cards

Prevention/Crisis Plan: GOAL-
 NO Inpatient admits
 -include/look to Bob re: all problem-solving, provide any opportunities for him to help others, -don't deviate from routine, offer him choices, do a pros/cons,
 - call ACT to intervene in home and in community NOT at ER. If at ER, use crisis bed

Daily Consumer Status Log			Month
NAME:		Statement (content, progress, syms, next step)	RISKS: Critical info indicating ACUTE status
	F/F,PC, CC,A,Initials		
1.			
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CTT CLIENT DATA LOG

MONTH/YEAR

NAME	MONTH/YEAR																															
CATEGORIES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
CRISIS (on-call only)																																
HOSPITAL																																
CRIMINAL JUSTICE																																
HOUSING																																
NATURAL SUPPORTS																																
EDUCATION																																
EMPLOYMENT																																

CODES **CODES** **CODES** **CODES** **CODES** **CODES**

CRISIS	F/E, P/C, ER, NON-CTT, DIVERSION
HOSPITAL	CPH, SMH, D AND ADX, D AND ARB, RCBD, MED/V/A, RTFA, TRU, OIS
CRIMINAL JUSTICE	JL, PO
HOUSING	IND,FAM,SPRV APT, PCH, EPCH, CRR, MR-CLA, DAR, HFVY HS, LTSR, NH, SRO, HSM, OCB, IS
NATURAL SUPPORTS	FF, REC, PA, SH, NN, OT
EDUCATION	SEC, PSEC, NN
EMPLOYMENT	VOL, PD-TRN or PSE or PTE, PSUPE/PCE (for PSUPE/PCE see voc specialist for further details)

SUMMARY AND FORMULATION - Sarah

Sarah is a spirited, 61 year old divorced woman who has a great desire to live her life freely by making decisions for herself. She identifies with her American Indian heritage and has great confidence in the sun's powerful ability to heal and nourish. This belief gives her great relief when faced with life's challenges. Sarah is a painter and owns a number of her own canvases and ones her mother has painted. Sarah has a Bachelor's degree in Education, however she has never taught. Sarah has some employment experience primarily working in libraries and through temporary agencies performing various office tasks. Sarah states she would like to work again sometime in the future however this is not a top priority for her at this time.

Sarah has lived most of her life with her mother, Pearl, who has "been my guardian since I was 17 years old." Pearl is currently in the end stage of colon cancer and is residing at Greenacres Care Center in a hospice room. Sarah visits her mother and reports that she both "loves" and "hates" her. She has a cousin, "Belinda, (who) has been like a second mother to me." Sarah has similar feelings towards Belinda and this ambivalence towards both of these family members is likely related to guardianship and other issues of control such as financial concerns. Pearl wants Sarah to sign a paper giving joint guardianship to Belinda and Josie Mae, another cousin. Sarah doesn't want to sign this even though she has told her mother that she would (only to appease her for the moment.) It is Sarah's wish to delay the signing until after her mother dies so that she will be legally free of the guardianship. Sarah is her own legal payee yet her social security check is automatically deposited into Pearl's account to which Belinda now has access. Sarah must ask Belinda for all of her financial needs and an allowance.

Sarah's greatest desire is "I want to take care of myself in my own apartment." By this she means that she wants to obtain her own lease and live healthily so that police no longer come to her door with an emergency detention or immediately detain her in a psychiatric hospital. Sarah feels she has been "blackballed" at her former residence and both that facility and her family reportedly do not support her return there. Pearl wants Sarah to move into a residence where she will be surrounded by other people. Sarah also wants "to live 2 more years," meaning that in her poor health she wants to avoid death - a primary concern given her mother's current condition. Sarah's current medical conditions consist of hypothyroidism, hypertension, obesity, and osteoarthritis, Bipolar I disorder, most recent episode manic with psychotic features and mixed personality features.

Sarah's experience with mental health problems can be summed up in her statement, "I've experienced 50 years of hell. When you have a life like this one you're crying, you're angry, your family has nothing to do with you, and you are less than dirt." Sarah has been ill since the age of 17 and was hospitalized at 2

state hospitals before she was 30. She has had a number of hospitalizations of varying lengths through the years with the last one being 5 years ago. Sarah has no known history of alcohol or other drug problems. She does report that both biological parents were alcoholics. Sarah remains hypomanic with rapid tangential and circumstantial speech. Her expansive mood is accompanied by broad gesturing at times and she has a wide-eyed, flat affect with little emotional expressiveness. She will talk non-stop and becomes irritable when someone tries to interrupt or redirect her. She is a poor historian; she has given several conflicting reports and remains guarded. Part of this presentation seems to be her general distrust of people and likely paranoia as she often makes statements like, "The doctors are trying to kill my mother. I fear for anyone's life if they try to help me." Sarah's Depakote level is within normal range and she is refusing to take any additional psychiatric drugs. Dr. Hamilton feels that she has great risk for her psychiatric condition to worsen given the great stress that she is under.

The most immediate issues to be addressed in treatment according to Sarah and her family are psychiatric stabilization, further physical assessment, and housing, as well as multiple grief and loss issues. Barriers include her increased psychiatric symptoms, having always lived with an overprotective and controlling mother, and that Sarah may not have the life management skills to succeed with independent living. It will be important for providers to continue to work on building a trusting relationship with Sarah as she is currently dependent and only partially aware of the possibilities and potential for her recovery. Sarah remains guarded and fearful about her future. Therefore an intensive level of care is recommended for at least 6 months given the severity of Sarah's symptoms and the major life change she is experiencing. Sarah will be ready for a transfer to a lower level of outpatient care once she demonstrates success and reports a comfort level with managing her symptoms and independent living.

Ima Therapist, LCSW

4/7/2010

Ima Therapist, LCSW

DATE

**MENTAL HEALTH
AND ADDICTION RECOVERY PLAN
FOR SARAH**

GOALS

Goals should be stated in the individual's or family's own words, and include statements of dreams, hopes, role functions and vision of life.

"I want to take care of myself in my own apartment"

**ANTICIPATED
DISCHARGE/TRANSITION
SETTING AND CRITERIA**

Describe the setting in terms of location, level of care, length of stay and service needs. Describe changes in the individual's and family's current needs and circumstances that will need to occur in order to succeed in discharge or transition.

Transition from high intensity level of service to outpatient community treatment once consistently and independently completing daily household tasks, self-administering medications with weekly intervention, disabling psychiatric symptoms are well managed as evidenced by no hospitalizations or police interventions for at least 6 months.

BARRIERS

Describe the **challenges as a result of the mental illness or addictive disorder** that stand in the way of the individual and family meeting their goals and/or achieving the discharge/transition criteria. Identifying these barriers is key to specifying the objectives as well as services and interventions in the following section of the plan.

Sarah has never lived on her own and has been dependent on her mother for meeting basic needs. Her mother has terminal cancer and Sarah has increasing grief and loss issues. Loss of primary support system. Her severe mania and paranoia has made it difficult for her to trust others, resulting in inconsistent follow through with treatment and limited illness management skills for both her physical and mental health.

Objective Work Sheet #1

This objective is related to which goal(s) or transition/discharge criteria (i.e. treatment goal) or barrier?

Is there more than one active objective that addresses this goal? Yes No

OBJECTIVE

Using action words, describe the **specific changes expected** in measurable and behavioral terms. Include the target date for completion.

A

Sarah will move into her own apartment within the next 60 days

TARGET DATE

4-24-10

INDIVIDUAL/FAMILY STRENGTHS

Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to help accomplish this objective.

Sarah has the finances to move; desires to manage her own finances; has the desire to live independently; intelligent; has some family support; has begun to engage with treatment team; is artistic and creative

INTERVENTIONS

Describe the specific activity, service or treatment, the provider or other responsible person (including the individual and family), and the **intended purpose or impact as it relates to this objective**. The intensity, frequency and duration should also be specified.

1. Team staff will assist Sarah with identifying her preferences and locating apartments that meet those preferences. 3 times per week for 60 minutes, for 30 days; Skills Development.

2. Team staff will assist Sarah with gathering necessary information/documentation, completing necessary apartment applications and related paperwork, 120 minutes per week, for 60 days; skills development.

3. Team staff will conduct ADL skills assessment to determine what assistance Sarah will need to maintain independent living. 2 times per week for 90 minutes, for 4 weeks. Case management

4. Team staff will assist consumer in taking inventory of and accessing needed household items for her new apartment. 4 times per month for 90 minutes, for 60 days. Skills Development/case management

Team staff will assist consumer with contacting her benefits providers (Medicaid, social security, etc.) to inform them of her move and help educate and prepare Sarah for the changes that will occur as a result of such. 4 times per month for 45 minutes, for 60 days. Case management

This objective is related to which goal(s) or transition/discharge criteria (i.e. treatment goal) or barrier?

Is there more than one active objective that addresses this goal? Yes No

OBJECTIVE

Using action words, describe the **specific changes expected** in measurable and behavioral terms. Include the target date for completion.

B Sarah will experience a stable mood 5 of 7 days per week, as evidenced by self report in her daily logs.

TARGET DATE 4-24-10

INDIVIDUAL/FAMILY STRENGTHS

Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to **help accomplish this objective**.

Sarah has the finances to move; desires to manage her own finances; has the desire to live independently; intelligent; has some family support; has begun to engage with treatment team; is artistic and creative

INTERVENTIONS

Describe the specific activity, service or treatment, the provider or other responsible person (including the individual and family), and the **intended purpose or impact as it relates to this objective**. The intensity, frequency and duration should also be specified.

1. Dr. H. will evaluate Sarah's symptoms, side effects, and functioning and prescribe appropriate medications. 2 times monthly for 30 minutes for 60 days.

2. Team staff will monitor Sarah's self-administration of medications, providing med education related to names, purposes, and dosages of medications, as well as ongoing assessment of symptoms and functioning. 1 time daily for 20 minutes for 60 days.
Skills Development/case management

3. Team therapist will help Sarah develop distress tolerance/coping skills to assist her in preparing for and dealing with her mother's death and how this may impact her physical and mental health. Sarah & therapist will review her daily mood logs to determine her progress. 1 time per week for 60 minutes for 60 days. Individual therapy

4. Sarah will begin painting again as a means to cope with her symptoms and to increase her feelings of self-worth and self-control. 2-3 times per week for 1-2 hours over the next 60 days.

5. Team staff will assist Sarah with the development and implementation of a crisis plan to aid in proactive management of her symptoms. 1 time weekly for 30 minutes for 60 days. Case management

This objective is related to which goal(s) or transition/discharge criteria (i.e. treatment goal) or barrier?

Is there more than one active objective that addresses this goal? Yes No

OBJECTIVE

Using action words, describe the **specific changes expected** in measurable and behavioral terms. Include the target date for completion.

C Sarah will experience improved physical health, specifically decreased blood pressure and blood sugar, as evidenced by primary care doctor's report, as well as Sarah's self report from weekly group check-in.

TARGET DATE 4-24-10

INDIVIDUAL/FAMILY STRENGTHS

Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to help accomplish this objective.

Sarah has the finances to move; desires to manage her own finances; has the desire to live independently; intelligent; has some family support; has begun to engage with treatment team; is artistic and creative; wants to feel better physically so she will live longer

INTERVENTIONS

Describe the specific activity, service or treatment, the provider or other responsible person (including the individual and family), and the **intended purpose or impact as it relates to this objective**. The intensity, frequency and duration should also be specified.

1. Team nurse will provide wellness education to address healthy lifestyle changes as related to the connection between physical and mental health. Wellness group 1 time per week for 90 minutes, Group skills development

2. Team staff will assist Sarah with the coordination of medical appointments with her PCP, and other specialists, as well as follow up related to physicians' orders. 2 times per month for 20 minutes for 60 days. Case management; 2 times per month for 90 minutes for 60 days. Medication Training & Support/skills development

3. Team staff will assist Sarah in researching, identifying, and creating a list of healthy activities she can become involved in. 2 times for 45 minutes for 2 weeks. Skills Development

4. Sarah would like to use the list created to engage in physical activity at least 4 times per week for at least 15 minutes.

5. Team staff will assist Sarah with weekly meal planning and grocery trips to aid in a diet with decreased fat, sugars, and calories to better support improved vitals. 1 time per week for 90 minutes for 60 days. Skills Development.