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INDIVIDUALIZED RECOVERY PLANNING

MANUAL

A Guide for Recovery Planning Teams

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

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1 INTRODUCTION

1.1 Individualized Recovery Plan

An Individualized Recovery Plan (IRP) is the blueprint or roadmap for recovery that is initiated during an individual's admission to our hospital and is continued when discharged to the next level of care. The development of an IRP proceeds from a synthesis of (a) the reason for admission, (b) anticipated placement, (c) discharge criteria, (d) the individual's life goals and choices, (e) treatment and recovery needs as identified by risk and multidisciplinary assessments, and (f) discharge plan. The discharge process begins at admission, and the reason for admission determines the pathway to discharge. A person-centered planning assumes that the individual will take increasing responsibility for his or her recovery as treatment, rehabilitation and enrichment progresses, resolve the reasons for admission, overcome discharge barriers with the assistance of hospital and community agency staff to the greatest extent possible, and be discharged to the next level of care. The individual's legal status may determine the next level of care but, in its absence, discharge should be to the most integrated setting available in the community (e.g., permanent housing with wraparound supports).

The IRP is designed to offer the individual in recovery, family members and significant others, conservators and guardians, and other authorized representatives an opportunity to participate meaningfully in the recovery and discharge process. The IRP is individualized, person-centered, strength-based, and demonstrates respect for personal choices, hopes, aspirations, and cultural and spiritual values, beliefs and practices. As a general rule, staff should encourage the individual to engage in recovery planning, fully understand the IRP process, and collaborate with his or her Recovery Planning Team (RPT) to develop the goals, objectives, and interventions. The individual's signature on the signature page of the IRP is necessary, but not sufficient, to show that these conditions have been met. As the individual's recovery proceeds, his or her RPT should engage, encourage, and facilitate the individual to gradually assume increasing responsibility for reviewing and revising his IRP.

The IRP should **not** be a long document. Although there may be exceptions, a fully developed IRP is typically between **8 to 12 pages**, and written at the reading and comprehension level of the individual.

1.2 Recovery Planning Team

The membership of a Recovery Planning Team (RPT) is dictated by the particular needs and strengths of the individual in recovery. In addition to the individual, at a ***minimum***, the core team members include a

1. Psychiatrist
2. Clinical Psychologist
3. Registered Nurse
4. Social Worker
5. Rehabilitation Therapist, and
6. Direct Care Staff (e.g., Health Service Technician, Forensic Service Technician)

The core RPT members should be consistent and enduring, as staffing permits. Other staff (e.g., dietitian, primary care physician, physical therapist, occupational therapist, speech and

language pathologist, activity therapist), and family members, significant others, conservators, guardians, advocates, and friends (as authorized by the individual), may be invited to attend depending on the specific needs of the individual. The core RPT members must be verifiably competent in the development and implementation of IRPs.

1.3 Role of the Recovery Planning Team

A key role of the RPT is to develop and implement an IRP that optimizes the individual's recovery and ability to sustain himself or herself in the most integrated, appropriate setting based on the individual's legal status, life goals, strengths, and functional abilities, and promotes the individual's self determination and independence. The RPT should ensure that individuals have substantive input into the IRP process including, but not limited to, input with regard to mall groups and individual therapies appropriate to their assessed needs. In addition, the RPT should educate the individuals regarding their roles, rights, and responsibilities with regard to the development of their IRP, the need to engage in treatment and rehabilitation, to work on their discharge goals, and to engage in revision of their IRPs, as clinically indicated.

1.4 Role of the Recovery Planning Team Facilitator

A clinical professional who is involved in the care of the individual facilitates the RPT. The team facilitator ensures either directly or by delegation:

1. The team functions in an interdisciplinary manner
2. Appropriate parameters are established for participation by the individual in his or her treatment, rehabilitation, and enrichment
3. Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring and, as necessary, revising the IRP
4. Assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy, and rehabilitation by no later than the next scheduled IRP review
5. The Present Status section of the case formulation is updated during the Recovery Planning Team meetings and other sections in the case formulation are consequently updated as clinically indicated, and
6. The scheduling and coordination of assessments and team meetings, the drafting of the IRP, and the scheduling and coordination of necessary progress reviews are undertaken in a timely manner.

1.5 Definitions

Initial Recovery Plan

The Initial Recovery Plan is the individual's first "treatment plan" and the admitting physician and the registered nurse develop it at the time of admission (i.e., within 24 hours of admission). It is based on the Physician's Intake Assessment, History and Physical, and Initial Nursing Assessment, and includes a small *prioritized* list of care plans that is focused on stabilizing the individual's psychiatric, medical and behavioral concerns. The individual's RPT meets on the second business day of admission and begins the process of updating the Initial Recovery Plan

as new information and assessment data become available. The Initial Recovery Plan is updated by the RPT at 72 hrs (+3 days) of admission. The 72-hr Initial Recovery Plan provides the basis for treatment services for the individual until the first Individualized Recovery Plan (IRP) is developed on the 15th (±3) day. Changes in the individual's status and updates can be made to the 72-hr plan until the first IRP is developed.

Individualized Recovery Plan (IRP)
The Individualized Recovery Plan (IRP) is the first "recovery plan" that is developed by the individual's Recovery Planning Team in collaboration with the individual on the 15th (±3) day of admission. Subsequently, the IRP is reviewed and revised on a predetermined schedule (see Chapter 3).

Recovery Planning Team Conference (RPTC)
The Recovery Planning Team Conference (RPTC) is convened to develop or review the individual's IRP.

Recovery Planning Team (RPT)
The Recovery Planning Team (RPT) is the individual's recovery team at the hospital. It has consistent and enduring core members (including a psychiatrist, clinical psychologist, registered nurse, social worker, rehabilitation therapist, and direct care staff). The individual is a member of this team, as well as a recipient of its services.

Recovery Planning Schedule
This is the schedule that defines when an individual will meet with his or her RPT to collaborate on the development, review, and revision of his or her IRP. The recovery planning schedule is anchored to the individual's date of current admission.

Recovery Planning Team Leader
By hospital policy, the RPT Leader is the team psychiatrist.

Recovery Planning Team Facilitator
The RPT Facilitator is the clinical professional who facilitates a RPTC. This person need not necessarily be the RPT leader. It is typically the person who can best facilitate the individual's recovery and discharge. In some cases, the individual can be the RPT Facilitator.

2 ASSESSMENTS

2.1 Admission Assessments

The admitting physician/psychiatrist and nurse complete the admission assessments. These are completed within the first 24 hours of admission. Parts of the nursing assessment can be completed within the first 8 hours of admission.

2.2 Integrated Assessments

The individual's Recovery Planning Team (RPT) psychiatrist, clinical psychologist, registered nurse, social worker, rehabilitation therapist, and dietitian complete discipline-specific integrated assessments. These assessments are completed prior to the individual's 15-day RPTC. The RPT facilitator synthesizes the assessments before the next team meeting and provides a holistic picture of the individual's assessments at the RPTC on the 15th (±3) day. This synthesis incorporates other assessments, including admitting assessments (initial psychiatric assessment, history and physical, nursing assessment), suicide risk assessment, clinical risk assessments, input from the individual (as much as possible depending on his/her mental health), his/her family (as appropriate) and community sources, as necessary and appropriate.

2.3 Focused Assessments

Periodically, the RPT may request additional assessments, as clinically indicated. Examples include neuropsychological assessments, personality tests, speech, dysphagia, and other assessments that may assist differential diagnosis, assessments related to specific psychiatric disorders and psychological distress, and outcome measures.

2.4 Cognitive Assessments

These are a specific example of focused assessments. Individuals with cognitive impairments (e.g., developmental disabilities, dementia, traumatic brain injury (TBI), and other conditions that may lead to cognitive decline) should be assessed at admission and periodically thereafter, as clinically indicated. The purpose of the cognitive assessment is to provide the individual's RPT information and recovery recommendations that will enable the RPT to assist the individual in making appropriate choices with regard to treatment, psychosocial rehabilitation, and enrichment activities. These assessments should be in the form of cognitive screening or a full neuropsychological battery, and should specify particular types of cognitive remediation programs that will best enhance the individual's recovery.

2.5 Strengths

Knowledge of an individual's strengths can enable the RPT and care staff to provide specific social and instrumental supports, and enable group facilitators in the psychosocial malls to motivate the individual to fully participate in recovery activities. In this context, whatever the individual presents (including personal attributes, characteristics, skills, diseases, disability or disorders) can be used as strengths to achieve symptom and functional recovery and to enhance quality of life.

The ***Strengths-Based Conversation*** is a 45-item protocol that clinicians can use as the basis for holding a conversation with the individual (see Appendix 1). The aim of this conversation is to facilitate the mutual exploration of the individual's general strengths and highlight specific strengths that the individual wishes to enhance or use in recovering from mental illness. The *Strengths-Based Conversation* is not used as a tool for a structured interview. In addition, an individual's strengths may emerge from discussions of his or her Life Goals, but remember that an individual's Life Goals should be discussed prior to, but not during a RPTC.

The individual's strengths should be updated as the individual recovers and is increasingly able to use them in the IRP process.

2.6 Stages of Change

In a recovery model of mental health service delivery system, it is important to consider the concept of stages of change. An individual's psychotic behavior may be so serious in terms of severity, frequency, intensity, and duration that it interferes with his or her quality of life. The clinician may think that the person needs to be in treatment. Whether the individual agrees with the clinician's assessment will depend on the individual's understanding of the disorder, the need for treatment, and agreement to engage in the treatment. To determine at what approximate level the treatment should begin, clinicians often assess the individual's stage of change. There are five nonlinear stages in the transtheoretical model—precontemplation, contemplation, preparation, action and maintenance. Stage of change does not assess the individual's capacity to change because that quality is a given in all individuals.

The University of Rhode Island Change Assessment (URICA) is a widely used tool that can be used to assess an individual's stage of change. Traditionally, the URICA is completed by a clinician who has the greatest rapport with the individual, or by the individual. The URICA is used with specific issues and is not a general or global measure of a person's stage of change. It measures the person's stage of change for a specific area of life functioning (e.g., substance use), and may change over time or with treatment. A skilled clinician may determine an individual's stage of change clinically without using a rating scale. Other instruments include Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), Readiness to Change Questionnaire (RCQ), and the Readiness Ruler. In recovery planning, we will focus on stage of change assessments specifically for substance use disorders.

In our hospitals, we will use the URICA as a statewide tool. The RPT clinical psychologist should complete the URICA by the 30-day RPTC for all individuals with a diagnosis of substance-related disorders.

3 RECOVERY PLANNING SCHEDULE

3.1 Initial Recovery Plan

The admitting physician and nurse following intake assessments develop the Initial Recovery Plan within the first 24 hours of admission. This plan focuses on the immediate care of the individual, especially with regard to providing psychiatric, medical, and behavioral stability. The individual's RPT meets on the second business day of admission and begins the process of updating the Initial Recovery Plan as new information and assessment data become available. When updated at the 72-hr RPTC, the Initial Recovery Plan provides critical information that can be used by the individual's RPT to develop the Individualized Recovery Plan (IRP) on the 15th day (±3 days) following admission. It remains current until the IRP is finalized. The time between the two plans is used for discipline-specific assessments, careful observation of the individual in the hospital, integration of formal and informal findings, and assessment of discharge needs, as appropriate. The 72-hr plan can be revised during this interval, as clinically indicated.

3.2 The Individualized Recovery Plan

The 15-day IRP, sometimes referred to by some agencies as the Master Treatment Plan, is the first individualized recovery plan that provides a roadmap for the beginnings of an individual's recovery while in the hospital, development of discharge criteria, and initiation of the discharge process. It is developed by the 15th day (± 3 days) of admission, reviewed for progress on a preset schedule, incrementally completed as new information, assessment, consultation, and treatment data become available, and fully developed by the 60th day of admission.

3.3 Recovery Planning Schedule

The following Table summarizes the Recovery Planning Schedule, as well as the Recovery Planning Team's (RPT) tasks for each type of Recovery Planning Team Conference (RPTC). The RPT is required to incrementally develop the individual's IRP and have a fully developed plan by the 60th day. Available information can be inserted in the IRP prior to the scheduled RPTC. Typically, the 15-day and 30-day reviews should take between 20 to 30 mins, and quarterly and annual reviews should take a little longer because of the interval length. This table lists the minimum requirements, but teams may complete as much of the IRP as they wish at each meeting depending on time constraints, availability of information, and populating of the sections in a draft format prior to the scheduled RPTC.

Type of Recovery Planning Conference	Days from Admission	IRP Requirements
24-hr Recovery Plan (Initial Recovery Plan)	1	24-hr Initial Recovery Plan based on psychiatry, medical, and nursing assessments. • Plan developed by admitting physician and RN • Plan updated on the 2nd business day, as clinically

		indicated
72-hr Recovery Plan (Initial Recovery Plan)	3	72-hr Initial Recovery Plan based on all available assessments and observational information. • Include in the goals, objectives and intervention, as well as discharge plan update, and consider recommendations from the Repeat Admissions Review (RAR) assessment • Plan should be developed on the 3rd day but no earlier • Plan can be developed on the first working day after the 3rd day, if the 3rd day since admission falls on the weekend or a holiday
Individualized Recovery Plan	15	First Individualized Recovery Plan (IRP) based on all available assessments and observational information • Complete demographic information and legal status (from SW or admission face sheet) • Begin inserting Pertinent History (from SW assessment) • Insert all Precipitating Factors, if risk factors (e.g., aggression of any type, suicidal ideation/attempts, choking, falls) have been identified (from the individual's Clinical Risk Profile) • Begin developing a skeleton Present Status section from discipline-specific assessments and observations • Insert Preferred Method of De-escalation (from the Personal Safety Interview, as part of the Initial Nursing Assessment, or as new information is subsequently obtained) • Insert Diagnosis (from Psychiatric evaluation or the most recent Weekly Psychiatric Progress Note) • Insert Individual's Life Goals, if available • Insert Reason for Admission • Insert Discharge Criteria for Anticipated Placement (from SW) • Insert Discharge Plan (from SW) • Develop goals/objectives/interventions based either on Precipitating Factor identified above, RAR assessment or clinical priority • Develop goals, objectives and interventions for medical conditions, as clinically indicated • Assign mall group(s) only for the interventions that have been developed • Insert Deferred Issues, if identified • Insert Social Support (from SW)

First 15-day IRP review	30	First IRP review and update • Update Pertinent History, if new information has become available • Update Precipitating Factors, if new information has become available since admission • Begin inserting Previous Treatments and Response • Update the Present Status section based on new information • Update Diagnosis, as clinically indicated (Psychiatrist) • Update Individual's Life Goals, as indicated • Update Discharge Criteria for Anticipated Placement, if indicated (SW) • Update Discharge Plan, if indicated (SW) • Insert Discharge Barriers, if a barrier has been identified by SW • Begin Discharge Process Review (SW) • Develop an additional goal/objectives/interventions based on Discharge Criteria and/or Precipitating Factors, and RAR assessments • Update goals, objectives and interventions for medical conditions, as clinically indicated • Assign mall group(s) only for the interventions that have been developed • Update Deferred Issues, if identified
Second 15-day IRP review	45	Second IRP review and update • Update Pertinent History, if new information has become available (SW) • Update Precipitating Factors, if new information has become available since admission • Insert Predisposing Factors, based on the individual's Clinical Risk Profile • Insert Perpetuating Factors, based on the individual's Clinical Risk Profile • Update the Present Status section, including a review of status of all objectives • Update Diagnosis, as clinically indicated (Psychiatrist) • Update Individual's Life Goals, as indicated • Update Discharge Barriers, if additional barriers have been identified by SW • Update Discharge Process Review (SW) • Develop an additional goal/objectives/interventions based on Discharge Criteria and/or Precipitating

		Factors • Update goals, objectives and interventions for medical conditions, as clinically indicated • Assign mall group(s) only for the interventions that have been developed • Update Deferred Issues, if identified
Third 15-day IRP review	60	Third IRP review and update • Update and finalize all sections, as the IRP should be complete by the 60th day • Review status of all objectives, and document this review in the Present Status section • Update Discharge Plan Review • Assign 20-hrs of mall groups and individual therapy, as clinically appropriate • Fewer hours of mall groups may be assigned, but clinical justification must be documented in the Present Status section (e.g., psychiatric instability, cognitive impairment)
First Quarterly	90	First Quarterly review and update • Complete as for the 60-day IRP, but with 3-month interval history
Monthly	120	As above with 1-month interval history
Monthly	150	As above with 1-month interval history
Second Quarterly	180	As above with 3-month interval history
Monthly	210	As above with 1-month interval history
Monthly	240	As above with 1-month interval history
Third Quarterly	270	As above with 3-month interval history
Monthly	300	As above with 1-month interval history
Monthly	330	As above with 1-month interval history
Annual	360	As above with 12-month interval history

3.4 IRP for Internal Transfers

When an individual is transferred between units and/or programs, the Recovery Planning Team Conference (RPTC) is scheduled on the 1st day (+3 days) following transfer, and then placed on the regular RPTC cycle from the original admission date. If the transfer is made within five business days of a scheduled 15-day, 30-day, Quarterly or Annual RPTC, the RPT may complete the 15-day, 30-day, Quarterly, or Annual IRP in lieu of the 1-day IRP post-transfer review.

3.5 IRP for Readmissions

Some individuals may be discharged and readmitted to the hospital for a number of reasons (e.g., court returns, outside medical care, failure to integrate fully in the community). When an individual is readmitted in less than 90 days, the Initial Recovery Plan is completed within the first 24 hours, the individual's original IRP (from previous admission) is updated on the second business day of the new admission, and the first RPTC is scheduled on the 15th day following readmission. The Repeat Admissions Review (RAR) recommendations should be considered at the 15-day IRP. If the integrated assessments indicate no major changes in the individual's condition, the individual should be placed on a 30-day IRP review cycle from the date of admission. If the assessments indicate major changes in the individual's condition, follow the new admission sequence of RPTCs, and take into account the RAR recommendations at the 72-hr update of the Initial Recovery Plan. In either case, the assessment findings should be documented in the Present Status section of the individual's IRP.

For readmissions longer than 90 days, treat the individual as a completely new admission.

3.6 IRP for External Transfers

When an individual is transferred between state hospitals, the admission should be treated as a new admission.

4 IRP TEMPLATE

The IRP template used in our hospitals is presented in Appendix 2. Currently this template is in MS Word, but will eventually be in the Avatar statewide electronic medical records (EMR) system. Although the electronic IRP will closely follow the MS Word version, there will be a few modifications to the template. These will be highlighted in a subsequent revision of the manual.

5 HOW TO COMPLETE THE IRP TEMPLATE

5.1 Individual's Name

Fill in the individual's full (legal) name, with first name followed by last name.

5.2 ID Number

Fill in the individual's hospital identification number.

5.3 Admission Date

Fill in the date of the individual's most recent admission to the hospital.

5.4 Date of Continuous Admission

Fill in the date the individual was admitted to the DBHDD system (i.e., at any of our state hospitals) on this current episode. This is the original date of admission if we take out transfers and temporary leaves. If the individual was fully discharged into the community and then returns to one of our hospitals on a different charge, the new charge requires a new admission date.

5.5 Date

Fill in the date the Recovery Planning Team (RPT) met for a scheduled RPT conference. Fill in one check box to identify the type of recovery planning meeting.

5.6 Legal Status

Specify the individual's legal status. It may be one of the following:

a. Voluntary status
b. Involuntary status
c. Voluntary by guardian
d. Pre-trial evaluation
e. NGRI
f. IST
g. Civilly committed
h. Return from conditional release
i. Hold order
j. Mandated Outpatient Treatment
k. Transfer from another regional facility

5.7 Case Formulation

A case formulation assists an individual in recovery to understand where his or her problems are likely to have originated from, what triggers them, and what maintains them. It assists the individual's Recovery Planning Team (RPT) to collaborate with the individual in developing optimal treatment and support options that will put the individual on a trajectory to recovery. The case formulation is developed by the RPT and not just by a single member of the team.

Using a team process to develop, review, and revise the case formulation ensures the team is focusing on the individual as opposed to just on specific diseases, disorders, or deficits of the individual.

In the IRP, the case formulation can be structured as follows:

Pertinent History

Describe pertinent history in the following sequence:

a. *Personal:* Begin with a brief sketch of the individual's social history (i.e., age, education, employment, family of origin, course of life, current support system).
b. *Psychiatric, Behavioral, and Medical:* Follow with a brief description of the individual's history of mental illness (i.e., brief psychiatric history, course of illness), maladaptive behaviors, and a brief medical history.
c. *Legal:* Provide a brief description of the individual's forensic history (i.e., brief history of the individual's interaction with the legal system and a description of the instant offense, if applicable).

The Pertinent History need not be long, and can be as short as three succinct paragraphs. Do not repeat Pertinent History in other sections of the case formulation.

Predisposing Factors

A predisposing factor is any condition that predisposes the individual to possible adverse outcomes in the long term (e.g., genetic factors, personal characteristics, psychiatric disorders), but it may not express itself unless the right biological, psychosocial or physical environmental conditions are present.

If the individual's clinical risk profile has identified risks, identify those that could be predisposing factors for conditions that may occur in the absence of preventative interventions.

EXAMPLE #1 Diabetes Jonathan has a family history of type 2 diabetes, BMI of 37, and is on two new generation antipsychotics; thus, he is at risk for developing diabetes.
EXAMPLE #2 Fractures Larry has low bone mineral density and he has had four falls in the last 30 days; thus, he is at risk for fractures.
EXAMPLE #3 Metabolic Syndrome Francis has diagnoses of dyslipidemia and hypertension, and BMI of 35; thus, he is at risk for developing metabolic syndrome.

[Note that the individual's clinical risk profile can be a separate document, but is also included in the Present Status section (see below). The clinical risk profile is linked to Attachment B of the DBHDD Risk Management Policy—03-601.]

Precipitating Factors

A precipitating factor is any condition that has been found through assessment or observation (or evidence-based research) to precipitate the occurrence or exacerbation of an adverse outcome (e.g., maladaptive behavior, medical condition, psychological distress, psychiatric disorder). The bases for these are the individual's clinical risk profile and the discipline-specific assessments, as well as observations of clinical and support staff.

If the individual is a forensic admission, consider the precipitating factor(s) that led to the most recent hospitalization.

For all admissions, consider the recent history of maladaptive behaviors, including those that are listed in Attachment A of the DBHDD Risk Management Policy—03-601, and other behaviors that may precipitate medical and psychiatric conditions. If an individual has a recent history of one or more of the behaviors, assess the risk factors for the behaviors recurring during hospitalization. Thus, identification of the antecedents of the behaviors would be critical because the antecedents may well be the precipitating factors for future occurrence of the trigger behaviors during hospitalization.

EXAMPLE #1 Assault and Robbery Tim's instant offence was assault and robbery. Although his substance abuse was well controlled upon discharge, he relapsed after three months in the community because he could not find employment, and was under the influence of substances when he assaulted and robbed a grocery store. His lack of employment precipitated his relapse, which in turn precipitated his instant offence.
EXAMPLE #2 Aggression towards staff Jane does not want to get out of bed in the mornings because of drowsiness due to the effects of clozapine. When a staff member repeatedly asks her to get out of bed, she gets angry and upset, and occasionally will hit the staff member. Repeated requests by staff occasionally precipitate her aggression.
EXAMPLE #3 Aggression due to a medical condition Judy is very irritable when she is hypoglycemic. If a staff member makes a demand when she is irritable, she is likely to be verbally and, occasionally, physically aggressive. With Judy, low blood sugar level precipitates irritation, which may lead to verbal and physical aggression under demand conditions.

Perpetuating Factors

Identifying possible perpetuating factors enables us to monitor and/or treat maintenance factors that may continue to perpetuate adverse conditions or outcomes for the individual. In some cases, identifying a perpetuating factor (e.g., treatment non-adherence) may enable us to develop and implement an effective treatment. In other cases (e.g., cancer), while we may not be able to fully treat the disease itself we may be able to treat the condition that the disease perpetuates (e.g., depression). In either case, it is important to identify perpetuating factors so that we can develop interventions that may enhance an individual's quality of life. Certain

psychosocial factors (e.g., crowded rooms, unsupervised transition times, fear of discharge for long-term inpatients) are also perpetuating factors for some behaviors.

EXAMPLE #1 Medication Nonadherence David has high LDL cholesterol, but he refuses to take his statin medication. His refusal to take his medication will perpetuate his high LDL cholesterol, which is a risk factor for heart disease and stroke.
EXAMPLE #2 Self-injury Janice occasionally engages in self-injury to express her anger and to relieve negative emotions. Although she is in a DBT group, her diagnosed borderline personality disorder is a perpetuating factor for her self-injury.
EXAMPLE 3 Depression Bruce is depressed because of his pain and suffering due to cancer. His cancer is a perpetuating factor for his depression.

In some cases, there may be an overlap between precipitating and perpetuating factors, and occasionally among predisposing, precipitating and perpetuating factors. It is important to remember that these factors are individualized, with the overlap applying in some cases and not in others, depending on current conditions pertaining to each individual.

Previous Treatment

Consider the following factors, if clinically appropriate, in your narrative:

a. Include treatments previously utilized during the course of the individual‘s psychiatric and medical illnesses, treatments for maladaptive behavior, response to previous treatments, adverse effects of psychotropic and other medications, culture-based treatments, and psychosocial interventions
b. Update using information from the Present Status section in the last review period, as appropriate.
c. For long-stay individuals, it is acceptable to consider previous treatments and responses only during the previous 12 to 24 months.

The narrative is a synthesis and not a chronological listing of previous treatments. The Previous Treatment section need not be long, and could be as short as one or two succinct paragraphs. We are interested in what has worked or not worked for this individual, and the narrative is presented in a manner that informs decisions regarding current treatments.

Present Status

This section provides a clear description of the individual’s current overall status. It should provide a clinical picture across relevant multiple domains, current efforts to provide treatment, and discharge readiness.

Describe the individual's present status succinctly in the following sequence:

a. Begin with symptom status. Include current signs and symptoms of psychiatric disorder(s), including a reference to specific DSM-IV-TR diagnoses, maladaptive behavior(s), and psychological distress. For each of the disorders, include current interventions and response (include medications, psychosocial interventions, and behavioral interventions, as appropriate).

Example
Mr. Smith's auditory hallucinations have decreased with 10mg of Zyprexa, but his visual hallucinations still occur. He is learning coping strategies for visual hallucinations in his mall group. His aggression decreased with the implementation of a PBS plan, from 3 a month in June to 1 in August.

b. Describe all medical conditions, with an update on their current status and treatment. Update medication side effects.
c. Include status of any ***psychiatric, medical, or behavioral risk profile*** (e.g., violence, suicide, assault) or other vulnerabilities covered under predisposing, precipitating, and perpetuating factors. Examples of risks include: bowel dysmotility, choking, diabetes, falls, fractures, infectious diseases, metabolic syndrome, osteoporosis, seizure disorder, refractory seizures, status epilepticus, electrolyte imbalance, impaired skin integrity, aggression (self and others), elopement, illicit substance use, property destruction, suicide, violence, and victimization. For each ***high***-risk condition, develop a separate goal, objective, and interventions. (See the State Risk Management Policy [#03-601], Attachment B for risk categories). Here are examples of the format you can use to present the Clinical Risk Profile of an individual, as well as an example of how to update the risk profile at each subsequent RPTC.

Risk Profile
Example #1: Ms. Falconer has the following risk profile: a. Metabolic syndrome b. Aggressive acts to self c. Aggressive acts to others d. Property destruction, and e. Suicide
Example #2: Mr. Smith does not currently have an assessed high-risk condition.
Updating Risk Factors
Example #1: The current status of Ms. Falconer's clinical risk profile is as follows: a. *Metabolic syndrome:* She is attending the Medical Risk Factors Group to reduce her risk for Metabolic Syndrome. b. *Aggressive acts to self:* Her risk for aggressive acts to self has decreased since she has

been enrolled in DBT. She had no incidents of swallowing in the last month.

c. *Aggressive acts to others:* Her risk for aggressive acts to others has remained the same despite being on a PBS plan. She had three incidents of aggression in the last month.
d. *Property destruction:* She is on a motivation plan, and has not had any acts of property destruction in the last two months.
e. *Suicide:* Since she started attending ACT Suicide group in May, she has not threatened or attempted suicide.

d. All incidents and triggered events, with specific thresholds, should be covered as well. Examples include: aggressive act to self, aggressive act to others, alleged abuse/neglect/exploitation, choking, elopement, falls, specified observations, pneumonia, restraints, seclusion, and suicide. Reviews and recommendations by the PRC and FRC should be mentioned. (See the State Risk Management Policy [#03-601], Attachment A for triggers, thresholds, and trigger definitions).

Incidents and Triggered Events

Example #1: Monthly (30-day) IRP

In July, James had 4 incidents of aggressive acts to others, and 2 incidents of property destruction. The PRC recommended (a) a psychopharmacology consultation because of inadequate clinical justification for using five new generation antipsychotics, and (b) a structural and functional assessment by the PBS team prior to developing a behavioral intervention because his current behavioral intervention is out of date and was not based on adequate assessment.

Example #2: Quarterly IRP

During the last quarter, James engaged in aggressive acts to others and property destruction and he was on 1:1 observations, and PRN and Stat medications. He was followed by the PRC and his case was also presented to the FRC. During this quarter, his diagnosis and medications were reviewed and revised, as recommended by a psychopharmacology consult. He is now on a formal PBS plan that was developed and implemented following a new structural and functional assessment. He has shown an improvement in both behaviors, with aggression being reduced from 10 in the last quarter to 3 in the present quarter, and property destruction from 3 to 0.

Example #3: Annual IRP

The note for the annual should be similar to the Quarterly IRP above, but with a 12-month interval history.

e. Describe functional status in terms of what the individual is able to do at present (e.g., self-care, adherence to the recovery plan, skills, and strengths). Focus on skills that may be considered essential at the next level of care (e.g., ADL skills, job skills, independent living skills). Include a description of the individual‘s attendance and participation in the PSR Mall and enrichment activities in the therapeutic milieu. Describe the individual’s level of achievement of current objectives and interventions.

f. Describe any cultural issues that may impact the individual‘s interventions and wellness, general wellness concerns, and areas in need of further intervention. If a cultural issue is identified, it should be included in the individual’s IRP, and clinical and support staff should be aware of and value this issue.
g. Describe current legal status as related to discharge status.
h. Briefly state discharge readiness status (e.g., James has achieved three of his four discharge criteria).

5.8 Preferred Method of De-escalation

Occasionally individuals in our care get irritated, agitated, or aggressive. Often we can de-escalate the situation by engaging in methods that the individual has found to be particularly effective with him or her in the past. In this section, include de-escalation method(s) the individual would prefer staff to use when he or she becomes upset. Key information from the Personal Safety Interview (see Appendix 3), or if new information is subsequently made available, should be included here. This should be written in a manner that staff reading this section of the IRP can understand and use the information to preempt maladaptive or challenging behavior.

5.9 Diagnosis

Write the most current diagnostic information. Typically, this information would be aligned with the most recent psychiatric evaluation or psychiatric progress note. However, the team psychiatrist may wish to update the individual’s diagnosis at the recovery planning meeting based on his or her clinical observations, together with input from the team members. Data on all five Axes should be included. If there is disagreement amongst the RPT members regarding the diagnosis of an individual, the matter should be referred to the Clinical Director for resolution before the individual’s IRP is developed or revised.

5.10 Individual’s Life Goals

Provide a statement of the individual’s vision of recovery, including dreams, hopes, and aspirations. It may include what the individual would like to do while at the hospital, but it is much better to help the individual envision life following discharge. It is best stated as quotations in the individual’s own words. If the individual declines to state life goals, document it as such. The individual’s life goals should be elicited in conversations (see Appendix 1) prior to RPTC, but never during it.

If the RPT feels that the individual’s life goals represent delusional thinking, record what the individual has stated anyway. However, revisit and revise the life goals periodically as the individual’s psychiatric condition improves. The main thing to remember is that we want to know what the individual envisions his or her life could be if given hope, and tools for recovery.

5.11 Discharge Process

5.11a Reason for Admission

Write a brief statement of the reason the individual was admitted to the hospital. The statement should include the precursor behavior that resulted in the admission. For example, if an individual was admitted for assault, assault or aggression would be the reason listed, but what is more important for informed intervention is what lead to the aggression (e.g., medication non-adherence worsened the individual's underlying psychosis, and the assault occurred during a psychotic episode). At admission, it would be important to assess why the individual was medication non-adherent, and the treatment or training should focus on this reason.

If this is a forensic admission, it should explain the individual's legal status and what alleged behavior led to that legal status. It should also reference any evaluations that bear on that legal status (e.g., if newly admitted Incompetent to Stand Trial (IST), what information in pretrial report is relevant to the finding of incompetency). It is critical that for forensic admissions, we use only the official account (i.e., law enforcement or court documentation) so that potentially discoverable, legally prejudicial information revealed by the individual is not recorded in his or her chart.

If it is a civil commitment, explain the clinical condition and behavior that warranted hospitalization. It is best to describe the specific context of the individual's behavior that led to the hospitalization. If it is a readmission, clearly state the reason why the individual was not able to maintain community placement. Be specific in describing the reason, because it will help you and the individual to collaboratively develop goals, objectives and interventions to overcome the barrier(s) to maintaining community placement upon next discharge.

5.11b Discharge Criteria for Anticipated Placement

Anticipated Placement:

State where this person will be discharged to at the next level of care. If known, provide the name of the placement; if unknown at present, state the generic class of placement (e.g., independent living, supported apartment, group home).

Discharge Criteria:

List the admission criteria to the anticipated placement that are specified by the receiving agency. The hospital's discharge criteria are the admission criteria at the next level of care, or determined by the legal system (i. e., the penal code specifies competency requirements). Individualize and, as much as possible, state the discharge criteria in behavioral and measurable terms. Write them in simple and clear language in terms of what the individual must do in order to be discharged to a specific place. If a specific placement is not available, work on the basis of what the individual must do to be discharged to the most integrated setting available in the community.

The discharge criteria should be written in language that the individual understands. A good way of doing this is by (a) discussing each discharge criterion with the individual, (b) asking the individual to restate each criterion in his/her own words, and (c), if stated correctly,

record the individual's version as the discharge criterion. This will ensure the individual has understood what he/she needs to do and, when the discharge criteria are read to him/her again, he/she will understand them correctly without further discussion or training.

Remember that the discharge criteria are written in terms of what the **individual** needs to do to be discharged.

EXAMPLE #1

Mr. Jones will

1. Manage his anger and aggression without harming himself or others, as evidenced by the use of a positive coping skill, such as mindful breathing, to preempt any instances of aggression for a period of six consecutive months,
2. Be medication adherent as evidenced by taking his prescribed medications for a period of six months immediately prior to being discharged, and
3. Have completed a substance abuse group at the preparation stage.

EXAMPLE #2

Mr. McCain will demonstrate factual knowledge of information regarding the court process relevant to his case, as evidenced by being able to state

1. His charges of possessing a controlled substance (cocaine) and potential sentence,
2. The nature of evidence that may be pertinent and a rational appraisal of potential outcomes,
3. The basics of the trial process, including the four pleas [i.e., guilty, not guilty, not guilty by reason of insanity, and no contest],
4. The concept of a plea bargain, and
5. The roles of the courtroom participants.

EXAMPLE #3

To be assessed as being competent to stand trial, Mr. (individual) will demonstrate that he:

1. Is able to understand the nature and object of the court proceedings,
2. Is able to understand his role as the defendant in the court proceedings, and,
3. Is able to assist his attorney in his own defense.

Example #4

Ms. Roberts will

1. Complete a drug rehabilitation course (state mall program), and
2. Be able to develop, and discuss with her substance abuse counselor, a relapse prevention plan that can be implemented in the community.

5.11c Discharge Plan

List in chronological sequence all tasks that hospital staff (i.e., SW, Case Manager, RPT) and/or community agencies will initiate and complete that will enable the individual to be discharged when the last item on the plan is completed. Write the actual names of hospital and community agency staff responsible for each step, as well as realistic time lines. The time lines should be specified for only the initial step(s), with further timelines provided at successive reviews of the discharge plan.

Ensure the discharge plan includes specific, individualized action steps for each individual that were traditionally included in the Transition Action Plan, as opposed to generic plans that may vaguely apply to all hospitalized individuals.

Remember that the discharge plan is written in terms of what the **staff** needs to do to enable the individual to be discharged expeditiously.

EXAMPLE #1: LICENSED RESIDENTIAL PROVIDER: STATE (COMMUNITY INTEGRATION HOME, SUPERVISED MENTAL HEALTH RESIDENCE, INTENSIVE TRANSITION RESIDENCE)

- ***Forensic individual that is NGRI (Not Guilty By Reason of Insanity)***

1. Dr. Freud, Psychologist, will complete annual risk assessment by May 10, 2011.
2. Mr. Smith, MSW, will arrange for the Case Expediter, Loran Williams, and Ms. Jones (mother) to attend Mr. Jones' RPT conference on May 11, 2011 to identify appropriate community resources.
3. Mr. Smith, MSW, and Mr. Jones will complete Authorization for Release of Information for: Mr. Ben Achord, Certified Peer Specialist; Ms. Sarah Hogan, Oconee Center Community Service Board Mental Health Liaison; Central Care (Mr. Jack Taylor and Ms. Elizabeth Walters) for service referral by May 15, 2011.
4. Mr. Smith, MSW, will send Ms. Loran Williams, Region 2 Forensic Case Expediter, request for start-up funds/bridge funding for first month's rent, medication, and clothing will be submitted to Ms. Williams by Mr. Smith, MSW, by May 25, 2011.
5. Mr. Smith, MSW, will complete Application for Community Integration Home for Mr. Jones' application to Central Care CIH on North Avenue in Macon, GA by May 25, 2011.
6. Ms. Strawberry, HIM program assistant, will work with Mr. Smith, MSW, to supply Mr. Jack Taylor, Central Care, with needed documents for application (see CIH Checklist) by May 25, 2011.
7. Mr. Jones wants to be linked to Certified Peer Specialist (CPS) Supports in the community and Mr. Smith, MSW, will complete a CPS referral by May 25, 2011.
8. Ms. Elizabeth Walters, Central Care Team Leader, and Ms. Hogan, Oconee CSB MH Liaison, will meet and greet with Mr. Smith and Mr. Jones for placement interview and interview to identify needed community resources on May 31, 2011 at 11:00 AM.
9. Dr. Freud will coordinate with the RPT and Mr. Jones to formulate a Conditional Release Plan to Central Care by June 13, 2011. Mr. Jones' proposed plan and a letter to Bibb County Superior Court will be submitted to Dr. Mikita, Clinical Director, for review at Forensic Review- Internal Committee meeting on June 20, 2011.
10. If approved, Dr. Mikita will notify Mr. Mize, Team Facilitator. Dr. Freud will work with Ms. Debbie Sanders, Associate Program Assistant, to provide written correspondence to the court officials (Bibb County Superior Court Judge Martha Christian, District Attorney, Mr. Jon Regan, and Public Defender, Ms. Elizabeth Lane.) Dr. Freud will initiate a request for court hearing or a Consent Order by June 27, 2011.
11. If Mr. Jones is granted Conditional Release, Mr. Smith, MSW, will notify Ms. Walters, Ms. Williams and Ms. Hogan as well as Mr. Achord and Mrs. Jones, Mr. Jones' mother. Target date to be determined.
12. Ms. Cynthia Poole, Medicaid Economic Specialist, will assist Mr. Jones to apply for Social

Security benefits. Dr. Spock, Team Psychiatrist, will assist Ms. Poole in completing required documentation for application. Target date to be determined.

13. Mr. Smith, MSW, will coordinate with Ms. Walters, Ms. Hogan, Ms. Williams, Mr. Achord and Mr. Jones' mother, Mrs. Jones, trial visits, site visits and date for discharge. Target date to be determined.
14. Dr. Freud will coordinate with Dr. Mikita and Ms. Johnson a discharge date for Mr. Jones. Target date to be determined.
15. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate and Georgia photo identification card, and will arrange for any remaining funds in Mr. Jones' hospital account to be provided to Mr. Jones at the time of his discharge. Target date to be determined.
16. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at Central Care when it is deposited into his hospital account. Target date to be determined.
17. Mr. Smith, MSW, will schedule an intake appointment with Ms. Hogan at Oconee Center Community Service Board. Target date to be determined.
18. Ms. Betty Green, RN, will schedule Mr. Jones' physical examination no earlier than three days before date of discharge. Target date to be determined.
19. When his Medicaid is activated (at least 30 days after Conditional Release) Ms. Walters will set an initial appointment. Ms. Walters will also initiate an initial appointment for Mr. Jones to see Dr. Drill, community dentist, for continued dental hygiene needs. Mr. Jones will utilize Dr. Zhivago, community primary care physician, for management of his hyperlipidemia and diabetes. Target date to be determined.
20. Mr. Smith, MSW, will arrange for Mr. Jones to meet with Ms. Johnson, Conditional Release Coordinator, to discuss follow-up procedures for Conditionally Released individuals from state hospitals, and Ms. Johnson will check in monthly with Mr. Jones, Oconee Center CSB and Central Care regarding his progress. Target date to be determined.
21. Mr. Smith, MSW, will contact Mr. Jones' mother to confirm discharge plans and arrange for transportation. Target date to be determined.

EXAMPLE #2: LICENSED RESIDENTIAL PROVIDER: PRIVATE (PERSONAL CARE HOME, BOARDING HOUSE, GROUP HOME)

- *Non-forensic individual with no identified placement and no longer meets inpatient civil commitment status in Adult Mental Health*

1. Mr. Smith, MSW, will notify Mr. Jim Cricket, Region 1 Case Expediter, to participate in Mr. Jones' team conference on May 27, 2011 and assist in identifying supports and services needed by Mr. Jones as his desire is to return to a group home setting. Target date: May 1, 2011.
2. Mr. Smith, MSW, and Mr. Jones will complete Authorization for Release of Information to Mr. John Summers, Certified Peer Specialist. Mr. Jones wanted to be linked to Certified Peer Specialist (CPS) Supports in the community and Mr. Smith will complete a CPS referral by May 25, 2011.
3. Mr. Smith, MSW, and Ms. Strawberry, HIM program assistant, will supply any needed

medical record information to Mr. Cricket so that can make appropriate personal care home referrals by May 30, 2011.

4. Ms. Cynthia Poole, Medicaid Economic Specialist, will assist Mr. Jones to apply for Social Security benefits. Dr. Spock, Team Psychiatrist, will assist Ms. Poole in completing required documentation for application, by May 30, 2011.
5. Mr. Smith, MSW, will coordinate the attendance of Mr. Cricket, Mr. Summers, Certified Peer Specialist and Mrs. Jones at Mr. Jones' treatment review meeting on June 13, 2011 to finalize recommendations for services and supports. Target date to be determined.
6. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate, Georgia photo identification card, and arrange for any remaining funds in Mr. Jones' hospital account to be provided to Mr. Jones at the time of discharge. Target date to be determined.
7. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at his community residence when it is deposited into his hospital account. Target date to be determined.
8. Mr. Smith, MSW, will arrange initial appointment with Oconee CSB for Mr. Jones one week before discharge. Target date to be determined.
9. Mr. Smith, MSW will contact Mr. Jones' mother to confirm discharge plans and arrange for transportation. Target date to be determined.

EXAMPLE #3: HOME: WITH SUPPORTS

- *Adult Mental Health discharge, non-forensic*

1. Mr. Smith, MSW, will notify Mr. Jim Cricket, Region 1 Case Expediter, to participate at Mr. Jones' team conference on May 27, 2011 to assist in identifying supports and services needed by Mr. Jones as his desire is to return to his home. Target date: May 1, 2011.
2. Mr. Jones wanted to be linked to Certified Peer Specialist (CPS) Supports in the community and Mr. Smith will complete a CPS referral by May 25, 2011.
3. Mr. Smith, MSW, and Mr. Jones will complete Authorization for Release of Information to Mr. John Summers, Certified Peer Specialist as well as Mr. Bob Barker, Mental Health Liaison at Anka Behavioral Health Center by May 25, 2011.
4. Mr. Smith, MSW, and Ms. Strawberry, HIM program assistant, will supply any needed medical record information to Anka Behavioral Health Center for continuity of care. Target date to be determined.
5. Mr. Smith, MSW, will refer Mr. Jones to ACT services through Anka Behavioral Health Center and Mr. Barker will schedule Mr. Jones an initial appointment for intake on June 20, 2011.
6. Ms. Cynthia Poole, Medicaid Economic Specialist, will assist Mr. Jones to apply for Social Security benefits. Dr. Spock, Team Psychiatrist, will assist Ms. Poole in completing required documentation for application by May 27, 2011.
7. Mr. Smith, MSW, will coordinate attendance by Mr. Cricket, Mrs. Jones, Mr. Summers and Mr. Barker at Mr. Jones' treatment review meeting on May 31, 2011 to discuss transfer of care and discharge to the community. Target date to be determined.
8. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate and Georgia photo identification card, and will arrange for any remaining funds in Mr. Jones' hospital

account to be provided to Mr. Jones at the time of his discharge.

9. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at his community residence when it is deposited into his hospital account. Target date to be determined.
10. Mr. Smith, MSW, will notify Mr. Jim Cricket, Region 1 Case Expediter, of Mr. Jones' discharge date to his mother's residence in Rome, GA, as soon as a date is determined by the RPT. Target date to be determined.
11. Mr. Smith, MSW, will confirm services and appointment dates with Anka Behavioral health Center for Mr. Jones one week before discharge. Target date to be determined.
12. Mr. Smith, MSW, will contact Mr. Jones' mother to confirm discharge plans and arrange for transportation. Target date to be determined.

EXAMPLE #4: HOME: WITH FAMILY

- *Forensic, Condition of Bond (Incompetent to Proceed, Likely Non-Restorable)*

1. Mr. Smith, MSW, will notify Ms. Loran Williams, Region 2 Forensic Case Expediter, that Mr. Jones is seeking Condition of Bond release to his mother's residence in Macon, GA. Mr. Smith, MSW, will submit a request for start-up funds/bridge funding for two month's supply of medication and personal clothing to Ms. Williams by May 25, 2011.
2. Mr. Jones wanted to be linked to Certified Peer Specialist (CPS) Supports in the community and Mr. Smith, MSW, will complete a CPS referral by May 25, 2011.
3. Mr. Smith, MSW, and Mr. Jones will complete Authorization for Release of Information to Mr. Ben Achord, Certified Peer Specialist and Ms. Greta O'Dell, River Edge Behavioral Health Center Community Service Board Mental Health Liaison for service referral. Target date to be determined.
4. Mr. Smith, MSW, will invite Ms. O'Dell and Mrs. Jones to attend Mr. Jones' next RPT Conference for placement interview and to review Mr. Jones' Condition of Bond order on May 31, 2011 at 11:00 AM. Target date to be determined.
5. Ms. Strawberry, HIM program assistant, will work with Mr. Smith to supply Ms. O'Dell with needed documents for continuity of care. Target date to be determined.
6. Dr. Freud, psychologist, will coordinate with the RPT and Mr. Jones to formulate a Condition of Bond order and corresponding letter to Bibb County Superior Court by June 13, 2011.
7. Mr. Jones' proposed plan and a letter to Bibb County Superior Court will be submitted to Dr. Mikita, Clinical Director, for review at Forensic Review—Internal Committee meeting on June 20, 2011. Target date to be determined.
8. If approved, Dr. Mikita, Clinical Director, will notify Mr. Mize, Team Facilitator. Dr. Freud will work with Ms. Debbie Sanders, Associate Program Assistant, to provide written correspondence to the court officials (Bibb County Superior Court Judge Martha Christian, District Attorney, Mr. Jon Regan, and Public Defender, Ms. Elizabeth Lane.) Dr. Freud will initiate a request for court hearing or a Consent Order by June 27, 2011.
9. If Mr. Jones is granted release with conditions, Mr. Smith, MSW, will notify Mrs. Jones, Ms. O'Dell and Mr. Achord, and a date of discharge will be determined with the Red 1 RPT. Target date to be determined.
10. Ms. Cynthia Poole, Medicaid Economic Specialist, will assist Mr. Jones to apply for Social

Security benefits. Dr. Spock, Team Psychiatrist, will assist Ms. Poole in completing required documentation for application. Target date to be determined.

11. Mr. Smith, MSW, will coordinate the Red 1 RPT with Mrs. Jones, Ms. O'Dell, Ms. Williams and Mr. Achord to schedule trial visits to his home and to set a date for discharge. Target date to be determined.
12. Dr. Freud will coordinate with Dr. Mikita and Ms. Johnson a discharge date for Mr. Jones. Target date to be determined.
13. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate and Georgia photo identification card, and will arrange for any remaining funds in Mr. Jones' hospital account to be provided to Mr. Jones at the time of his discharge. Target date to be determined.
14. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at his mother's house located at 123 Sesame Street, Macon, GA 31213 when it is deposited into his hospital account. Target date to be determined.
15. Mr. Smith, MSW, will schedule an intake appointment with Ms. O'Dell at River Edge Behavioral Health Center Community Service Board for the date of Mr. Jones' discharge. Target date to be determined.
16. Ms. Betty Green, RN, will schedule Mr. Jones' physical examination no earlier than three days before date of discharge. Target date to be determined.
17. Mrs. Meredith Taylor, Activity Therapist, will refer Mr. Jones to Supported Employment services at River Edge Behavioral Health Center in Macon, GA so he can continue to work. Target date to be determined.
18. Mr. Jones will utilize Dr. Bates, his family's primary care physician, for management of his hypothyroidism and Hepatitis C management. When his Medicaid is activated (at least 30 days after Conditional Release) Ms. Jones will be assisted by his CSB Case Manager, Ms. Candler Trawick, to set an initial appointment. Ms. Trawick will link Mr. Jones to Dr. Drill, community dentist, for continued dental hygiene needs. Target date to be determined.
19. Mr. Smith, MSW, will contact Mr. Jones' mother to confirm discharge plans and arrange for transportation. Target date to be determined.

EXAMPLE #5: TRANSFER TO A PSYCHIATRIC HOSPITAL

1. Mr. Smith, MSW, will notify Mr. Painting, Region 3 Case Expediter, to participate in Mr. Jones' RPT conference on May 25, 2011 and assist in identifying supports and services needed by Mr. Jones, and discuss the need for transfer to another psychiatric hospital near his family. Target date: May 1, 2011.
2. Mr. Mize, Team Facilitator, will formally request that Dr. Mikita, Clinical Director, consider Mr. Jones for transfer to Georgia Regional Hospital-Atlanta to be closer to his family. Target date to be determined.
3. Dr. Mikita, Clinical Director, will coordinate transfer criteria with Dr. Peach, Clinical Director of Georgia Regional Hospital-Atlanta. Target date to be determined.
4. When Mr. Jones has 80 consecutive days tracked, Dr. Mikita will initiate with Dr. Peach transfer to Atlanta. Target date to be determined.
5. If approved for transfer, Mr. Smith, MSW, will contact Fred Coleman, LCSW, Social

Service Chief at GRH/Atlanta to arrange for transfer. Target date to be determined.
6. Mr. Smith, MSW, will contact Mr. Jones' mother as well as Ms. Susie McQue, Case Expediter for Region 3, of approval and plans for transfer. Target date to be determined.
7. Mr. Smith, MSW, will contact Mr. Coleman, to confirm transfer plans and arrange for transportation. Target date to be determined.
8. Mr. Smith will notify Mrs. Jones of Mr. Jones' transfer. Target date to be determined.

EXAMPLE #6: SUPERVISED APARTMENT PROGRAM

- Adult Mental Health, non-forensic

1. Mr. Smith, MSW, will notify Mr. Painting, Region 3 Case Expediter, to participate at Mr. Jones' RPT conference on May 25, 2011 to assist in identifying supports and services needed by Mr. Jones. Target date: May 1, 2011.
2. Mr. Smith, MSW, and Mr. Painting, Region 3 Case Expediter, will work with Mr. Jones to apply for placement with AmericanWork, Inc. supervised apartment program in Savannah, GA. Target date to be determined.
3. Mr. Smith, MSW, will make a referral to ACT team with AmericanWork, Inc. Target date to be determined.
4. Mr. Smith, MSW, will coordinate attendance by Mr. Painting, Mrs. Jones, and AmericaWork, Inc. ACT representatives at Mr. Jones' RPT conference meeting on June 5, 2011 to discuss transfer of care and discharge to the community. Target date to be determined.
5. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate and Georgia photo identification card, and will arrange for any remaining funds in Mr. Jones' hospital account to be provided to Mr. Jones at the time of his discharge. Target date to be determined.
6. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at AmericanWork, Inc. located at 456 River Street, Savannah, GA 31987 when it is deposited into his hospital account. Target date to be determined.
7. Mr. Smith MSW, will invite ACT, Mrs. Jones (mother,) and AmericanWork, Inc. director, Ms. Amy Redd to attend Mr. Jones' RPT Conference meeting on June 25, 2011 at 3:30 pm to discuss Mr. Jones' anticipated discharge. Target date to be determined.
8. Mr. Smith will schedule an initial intake appointment for Mr. Jones three days prior to his discharge date. Target date to be determined.
9. Mr. Smith, MSW, will confirm services and appointment dates with AmericanWork, Inc. for Mr. Jones one week before discharge. Target date to be determined.
10. Mr. Smith, MSW, will coordinate with AmericanWork, Inc. to confirm discharge plans and arrange for transportation. Target date to be determined.
11. Mr. Smith will notify Mrs. Jones of Mr. Jones' discharge. Target date to be determined.

EXAMPLE #7: PRE-TRIAL AND COMPETENCY

1. Pending Competency Restoration.

EXAMPLE #8: PRE-TRIAL FOR A FIRST REVIEW IRP (COMPETENCY IS UNKNOWN AND INDIVIDUAL WAS HOMELESS PRIOR TO ADMISSION)

1. Mr. Smith, MSW, will assist Mr. Jones to complete Authorization for Release of

Information for River Edge Behavioral Health Center. Target Date: May 1, 2011.
2. Mr. Smith, MSW, will schedule an intake appointment at River Edge Behavioral Health Center on the date of his discharge. Target date to be determined.
3. Mr. Smith, MSW, will work with Ms. Greta O'Dell, River Edge Behavioral Health Center Mental Health Liaison, and Mr. Jones to plan an effective discharge plan of care including discussion of housing options and steps needed to obtain housing of Mr. Jones' choice. Target date to be determined.

EXAMPLE #9: PRE-TRIAL FOR A FIRST REVIEW IRP (TEAM BELIEVES INDIVIDUAL WILL NOT REACH COMPETENCY)

1. Mr. Smith, MSW, will notify Ms. Williams, Region 2 Case Expediter, to participate at Mr. Jones' RPT conference on May 25, 2011 to assist in identifying supports and services needed by Mr. Jones. Target date: May 1, 2011.
2. Mr. Smith, MSW, will coordinate with Region 2 Forensic Case Expediter, Ms. Loran Williams, and Mr. Jones for assistance in identifying appropriate housing and mental health provider in Bibb County near his mother. Target date to be determined.
3. Mr. Smith, MSW, will invite Ms. Greta O'Dell, River Edge Behavioral Health Center Mental Health Liaison and Ms. Williams to attend Mr. Jones' scheduled RPT Conference on June 25, 2011 at 3:30 PM. Target date to be determined.
4. Medicaid Economic Specialist, Ms. Cynthia Poole, will assist Mr. Jones to apply for Social Security benefits. Dr. Zhivago, Team Psychiatrist, will assist Ms. Poole in completing required documentation for application. Target date to be determined.
5. Dr. Freud, Psychologist, and the Green 1 RPT members will work to formulate a packet for submission to Hospital Administrative Team/Clinical Director (CSH-FRIC) for review of inpatient civil commitment status as Dr. Freud has opined Mr. Jones IST, Likely Non-Restorable and recommended outpatient civil commitment. Target date to be determined.
6. If approved for outpatient civil commitment, Mr. Smith. MSW, with work with Ms. Williams, Ms. O'Dell, Mr. Jones and Mrs. Jones (mother) to identify appropriate community placement. Target date to be determined.
7. When Mr. Jones is granted off-campus supervised privileges (Forensic STEP level C-O) Mr. Smith, MSW, will notify Ms. O'Dell and Ms. Williams to initiate meetings with potential providers and site visits to prospective placements in Bibb County. Target to be determined.
8. Mr. Smith, MSW, and Mr. Jones will complete Authorization for Release of Information to Mr. Ben Achord, Certified Peer Specialist. Mr. Jones wanted to be linked to Certified Peer Specialist (CPS) Supports in the community and Mr. Smith will complete a CPS referral by May 25, 2011.
9. Mr. Smith, MSW, will assist Mr. Jones to obtain a Georgia state photo identification card and Social Security card on an off-campus outing when he obtains level C-O. Target to be determined.
10. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate by June 13, 2011. Target date to be determined.
11. When appropriate community placement has been identified based on the recommendation of the Risk Assessment completed by Dr. Freud, a Condition of Bond

order will be prepared by Dr. Freud with a letter requesting a hearing for release or consent order. Dr. Freud will work with Ms. Sanders in communicating the documentation to the Bibb County Superior Court officials involved with Mr. Jones' case. Target date to be determined.

12. Pending administrative review and approval, and corresponding court order supporting the COB discharge plan, the Team Facilitator will schedule a transition meeting with RPT. Target date to be determined. members and Case Expediter, CSB Liaison, family and potential home provider.

EXAMPLE #10: NURSING HOME

1. Mr. Bob Smith, Social Worker, will notify Ms. Julie Johnson, Social Service Coordinator, and Mrs. Evelyn Harris, Social Service Chief, that the team is recommending Mr. Jones for nursing home placement by May 10, 2011.
2. Mr. Smith, MSW, will provide Mrs. Harris a copy of Mr. Jones' current MAR, HMP, Psychosocial Assessment, Physician Psychiatric Evaluation, Psychological Evaluation, Nursing Assessment and any other needed information as requested by May 10, 2011.
3. Mrs. Harris will present Mr. Jones' information to Dr. Risby, State Medical Director, for evaluation for nursing home placement. Dr. Risby will consider Mr. Jones' information and schedule a date with Mr. Mize, Team Leader, to evaluate Mr. Jones face-to-face. Target date to be determined.
4. If approved by Dr. Risby, Mr. Smith, MSW, will work with Dr. Alexander and Ms. Betty, RN, to complete Level 1 online screening and DMA-6. Target date to be determined.
5. Mr. Smith, MSW, will notify Ms. Loran Williams, Region 2 Forensic Case Expediter, the RPT has recommended that Mr. Jones be transferred to a NH and request for her to attend the RPT conference meeting with Mr. Jones on May 25, 2011. Target date to be determined.
6. Mr. Smith, MSW, will print a copy of the completed online forms and obtain signature from Dr. Alexander and file in Mr. Jones' active medical chart. Target date to be determined.
7. A Level II screening will need to be completed due to Mr. Jones' diagnosis of Schizophrenia. Mr. Smith, MSW, and Ms. Strawberry, HIM Program Assistant, will provide APS Healthcare PASRR Evaluator with current MAR, HMP, Psychosocial Assessment, Physician Psychiatric Evaluation, Psychological Evaluation, Nursing Assessment and any other needed information as requested by APS Healthcare for completion of PASRR Level II screening at the time of the evaluation. Target date to be determined.
8. Ms. Cynthia Poole, Medicaid Economic Specialist, will assist Mr. Jones to apply for Social Security/Medicaid benefits after referral by Mr. Smith by May 31, 2011.
9. Mr. Smith, MSW, will obtain a record of Mr. Jones' current financial assets and benefits by May 20, 2011.
10. Mr. Smith, MSW, will identify a nursing home that allows smoking and has services for individuals with Schizophrenia by May 31, 2011.
11. Mr. Smith, MSW, will assist Mr. Jones to complete Authorization for Release of Information forms for each facility referral. Target date to be determined.
12. Mr. Mize, Team Facilitator, will coordinate a transition meeting with selected Nursing

Home, Mr. Jones, Ms. Williams (Case Expediter) and all RPT members and Mr. Jones' family for transfer. Target date to be determined.
13. Mr. Smith, MSW, will contact Mr. Jones' mother to confirm discharge plans and arrange for transportation. Target date to be determined.

5.11d Discharge Barriers

List all systems barriers that arise from implementing the action steps in the Discharge Plan, such as legal issues, shortage of a specific type of housing, financial resources, citizenship status, and so on. List only those barriers that are actually encountered when implementing the action steps, as opposed to anticipated barriers. Until an actual barrier is identified write, "None identified at this time". When a barrier is identified, ensure follow-up in terms of steps that will be taken to overcome it.

Typically, discharge barriers do not include the clinical status of the individual (e.g., psychiatric unstable, major medical problems, psychiatric or behavioral decompensation) because this is covered in the individual's IRP. An exception is that it may include any behavior(s) that the individual engages in to thwart placement (e.g., aggressive behavior when discharge is imminent). When such a barrier is identified, it should be followed up with an assessment and appropriate treatment, with documentation in the goals, objectives and interventions.

If discharge barriers have been identified by the 15-day RPTC, list them and update at successive RPTCs. If a barrier has not been identified before the 15-day RPTC write, "None identified at this time," and update at successive RPTCs.

5.12 Discharge Process Reviews

Discharge process reviews provide an opportunity for the RPT and the individual to assess progress made during the review period with regard to the discharge criteria and discharge plan. First, take each action step in the individual's Discharge Criteria, add two dashes following each step, and update current status at each RPTC. Second, take each action step in the Discharge Plan, add two dashes following each step, and update current status at each RPTC. If a step in the Discharge Plan has been achieved, update time line for the next step.

EXAMPLE: DISCHARGE CRITERIA

Mr. Jones will

1. Manage his anger and aggression without harming himself or others, as evidenced by the use of a positive coping skill, such as mindful breathing, to preempt any instances of aggression for a period of six consecutive months—in process, 4 months of no aggression
2. Be medication adherent as evidenced by taking his prescribed medications for a period of six months immediately prior to being discharged—in process, 3 months of continuous medication adherence, and
3. Have completed a substance abuse group at the preparation stage—in process, has completed 4 weeks of a 12-week course.

EXAMPLE: DISCHARGE PLAN

1. Mr. Smith, MSW, will notify Mr. Painting, Region 3 Case Expediter, to participate at Mr. Jones' RPT conference on May 25, 2011 and assist in identifying supports and services needed by Mr. Jones—completed.
2. Mr. Smith, MSW, and Mr. Painting, Region 3 Case Expediter, will work with Mr. Jones to apply for placement with AmericanWork, Inc. supervised apartment program in Savannah, GA—the application is in process.
3. Mr. Smith, MSW, will make a referral to ACT team with AmericanWork, Inc—pending.
4. Mr. Smith, MSW, will coordinate attendance by Mr. Painting, Mrs. Jones, and AmericaWork, Inc. ACT representatives at Mr. Jones' RPT conference meeting on June 5, 2011 to discuss transfer of care and discharge to the community—pending.
5. Mr. Smith, MSW, will assist Mr. Jones to obtain a birth certificate and Georgia photo identification card, and will arrange for any remaining funds in Mr. Jones' hospital account to be provided to Mr. Jones at time of discharge—pending.
6. Mr. Smith, MSW, will provide Ms. Angie Brown, Financial Services, the discharge summary for Mr. Jones so his final paycheck from working at NDI can be mailed to him at AmericanWork, Inc. located at 456 River Street, Savannah, GA 31987 when it is deposited into his hospital account—pending.
7. Mr. Smith, MSW, will invite ACT, Mrs. Jones (mother) and AmericanWork, Inc. director, Ms. Amy Redd to attend Mr. Jones' RPT Conference meeting on June 25, 2011 at 3:30 PM to discuss Mr. Jones' anticipated discharge—pending.
8. Mr. Smith will schedule an initial intake appointment for Mr. Jones three days prior to his discharge date—pending.
9. Mr. Smith, MSW, will confirm services and appointment dates with AmericanWork, Inc. for Mr. Jones one week before discharge—pending.
10. Mr. Smith, MSW, will coordinate with AmericanWork, Inc. to confirm discharge plans and arrange for transportation—pending.
11. Mr. Smith will notify Mrs. Jones of Mr. Jones' discharge—pending.

5.13 Goals

A goal statement documents an assessed treatment, rehabilitation, or enrichment need of the individual. In non-recovery terminology, it is the "problem statement" described in behavioral terms. As much as possible, collaborate with the individual in determining his or her goals before you develop goal statements. Keep the statement simple by defining the goal as clearly as possible. See Chapter 6 for examples.

5.14 Objectives

Once a goal is clearly defined, we can develop the steps the individual can take to accomplish the goal. A goal can be broken down into small steps the individual can incrementally engage in to achieve it. These small steps form the Objectives for the individual. So write an objective in terms of what the individual will do to achieve the goal. Remember, an objective is always an action statement, e.g., John will learn (or use) a mindfulness strategy to self-manage his rising

anger when he cannot get what he wants. Write the objective in behavioral, observable, and/or measurable terms, and in language free of jargon that the individual will understand easily. To make it measurable, include a performance and a termination criterion.

The majority of the objectives will be learning-based, but a few may be service-based. Learning-based objectives are those where the objectives specify what the individual will learn. Service-based objectives are those where the staff, usually nursing staff, will provide a service to the individual (e.g., provide a certain medical treatment). See Chapter 6 for guidance on writing objectives.

5.15 Interventions

When an individual's objective has been clearly defined, we need to find ways how staff will help the individual attain his or her objective. So write the interventions in terms of what the staff will do to assist the individual, i.e., in terms of what staff can teach him or her in Mall groups, individual therapy, or in the therapeutic milieu. See Chapter 6 for details on how to develop interventions.

5.16 Deferred Issues

Occasionally there will be issues that we know about and wish to include in an individual's IRP, but cannot do so because the individual either does not have the prerequisite skills or the needed supports have not been developed. In addition, when an individual has too many goals and objectives, we may prioritize them in terms of what the individual can focus on now, while leaving the rest as substitutes when these are achieved. In this section, list all issues that have been deferred, including the reason for deferral. If there are absolutely no deferred issues, state, "No deferred issues at this time".

Deferred issues include only those that the team eventually plans to address during the current hospital admission, but not all possible issues. Deferred issues cannot be risk factors (from the clinical risk profile) that are precipitating factors, or medical conditions for which the individual receives or should receive treatment (even if in a health maintenance state). RPTs should review and update the deferred issues at each scheduled RPTC.

5.17 Social Support

List all individuals that the individual has approved as members of his or her social support group that can be contacted on behalf of the individual.

5.18 Individualized Recovery Plan Review

The IRP Review is for documenting the individual's progress during the review period. The IRP Review form is to be used for all monthly RPTCs. The actual IRP is to be completely updated during the Quarterly and Annual RPTCs. This form will not be used in the Avatar system.

5.19 Team Members Present

Following each RPTC, the RPT Facilitator should ensure that (1) the IRP is printed, (2) each team member present during the RPTC has signed the individual's IRP, (3) the individual and others present during the RPTC have signed the IRP, (4) a copy of the signed IRP is offered to the

individual, and (5) a signed copy of the IRP is placed in the individual's medical record. Treat the IRP Review form in exactly the same manner as the IRP. All participants should sign it, and a signed copy should be offered to the individual, and another signed copy attached to the IRP in the individual's medical record.

6 HOW TO WRITE GOALS, OBJECTIVES, AND INTERVENTIONS

6.1 Goals

A goal statement documents an assessed treatment, rehabilitation, or enrichment need of the individual. In the old terminology, it is the "problem statement" described in behavioral terms. It presents what the individual wants to achieve while in the hospital.

EXAMPLE #1 Gary who has schizophrenia occasionally hits his peers with his fists when he is in a psychotic state and, at other times, when he wants to avoid a task or escape from a mall group that he does not want to participate in. The goal is for Gary to learn how to control his psychotic behavior, and meet his needs in a socially acceptable manner without resorting to aggression.
EXAMPLE #2 Nate reports he is hearing voices that are telling him he is worthless and he wants to make them go away. Staff members have observed him covering his ears and screaming, "go away". The goal is for Nate to learn positive methods of responding to the voices.

6.2 Objectives

Here are a few basic principles to remember when you are developing or revising learning-based objectives. Each objective is:

1. linked to a goal of hospitalization,
2. written in terms of what the individual in recovery is going to learn or do,
3. written in behavioral, observable and/or measurable terms to provide the individual and staff with specific thresholds for measuring outcomes of interventions,
4. focused on what the individual can do within a specific timeframe,
5. attainable given the individual's current level of cognitive functioning and engagement level, and
6. functional and meaningful to the individual, and taught within the context in which the individual will use the skill (e.g., instead of "ambulate 100 feet," write, "ambulate 100 feet to the dining room").

In addition, each objective should pass the "dead man's" test, which means that it should focus not only on what the individual should not do (e.g., not engage in aggressive acts for 6 months) but also alternative positive behaviors (e.g., by learning anger management skills),

What to cover in an Objective

Each objective should include the following four components:

1. what the individual will accomplish (e.g., learn, identify, state, demonstrate, discuss, read, draw, play, make, . . .) in measurable terms,
2. performance criterion,
3. termination criterion, and
4. where the individual's performance will be documented.

How to Write an Objective

You can use the following examples as a guide to writing an objective that meets generally accepted professional standards. The Question Sequence provides "thinking prompts", the Step-by-Step Development lists instructions, and the Statement Format gives a template for the whole Objective.

EXAMPLE #1 Ann will learn two signs or symptoms that indicate an impending seizure as evidenced by correctly stating them to her Case Manager or RN weekly for four weeks. Progress will be documented in the Nursing Progress Note.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ann will learn two signs or symptoms that indicate an impending seizure
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to her Case Manager or RN weekly
Termination criterion	State termination criterion	. . . for 4 consecutive weeks.
Where will you find the documentation?	State documentation requirements	Progress will be documented in the Nursing Progress Note.
EXAMPLE #2 Ann will utilize relaxation techniques to help with her poor sleep as evidenced by self- and staff-report of sleeping for at least 8 hours, 3 nights a week, for 2 consecutive months. Nightly data will be documented in the Change of Shift Report.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ann will utilize relaxation techniques to help with her poor sleep
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . self- and staff-report of sleeping for at least 8 hours, 3 nights a week
Termination criterion	State termination criterion	. . . for 2 consecutive months.
Where will you find the documentation?	State documentation requirements	Nightly data will be documented in the Change of Shift Report.
EXAMPLE #3 Ann will learn to correctly shoot a basketball as evidenced by scoring at least 5 of 10 baskets during each of 10 free-throw practice sessions with Coach Pierce, once a week, for four consecutive weeks. Her progress will be reported in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say,	Ann will learn to correctly shoot a basketball

	demonstrate, use, etc.	
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . scoring at least 5 of 10 baskets
Termination criterion	State termination criterion	. . . during each of 10 free-throw practice sessions with Coach Pierce, once a week, for four consecutive weeks.
Where will you find the documentation?	State documentation requirements	Her progress will be reported in the PSR Mall Facilitator Progress Notes.

6.3 Interventions

We write interventions in terms of what our staff will do to assist the individual achieve the relevant objective. Interventions may consist of an active treatment component (e.g., a mall group or individual therapy), or a service component (e.g., services provided by a nurse). Remember that interventions should **not** be job descriptions (i.e., avoid "The physician will prescribe medication", or "The nurse will administer medication").

How to Write an Intervention

You can use the following examples as a guide to writing an intervention that meets generally accepted professional standards. The Question Sequence provides "thinking prompts", the Step-by-Step Development lists instructions, and the Statement Format gives a template for the whole Objective.

Example 1:
Dr. Joe Johnson will facilitate the Medication and Wellness group from 16:25 to 17:15 on Mondays, Wednesdays, and Fridays in Room 50 in the PSR Mall. Dr. Johnson will teach Ann about factors that may trigger seizure activity including hyperventilation, fever, infection, stress, excitement, video games, excessive caffeine, medication changes, and sleep deprivation.

Question Sequence	Step-by-Step Development	Statement Format
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Dr. Joe Johnson will facilitate the
What is the title of the intervention?	Write the title of the intervention.	. . . Medication and Wellness group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . from 16:25 to 17:15 on Mondays, Wednesdays, and Fridays
Where will the intervention take place?	State the location of the group.	. . . in Room 50 in the PSR Mall.
What will the provider	State what the provider will	Dr. Johnson will teach Ann

teach?	teach.	about factors that may trigger seizure activity including hyperventilation, fever, infection, stress, excitement, video games, excessive caffeine, medication changes, and sleep deprivation.
Example 2: Ms. Maryann Dawson, Unit R.N., will facilitate the Health & Wellness: Sleeping Better group from 10:40 to 11:30 am on Tuesdays & Thursdays in Room 32 in the PSR Mall. Ms. Dawson will teach Ann the Jacobson relaxation techniques and how using these consistently will reduce the physical and mental health effects of poor sleep.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Ms. Maryann Dawson, Unit R.N., will facilitate the
What is the title of the intervention?	Write the title of the intervention.	. . . Health & Wellness: Sleeping Better group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . from 10:40 to 11:30 am on Tuesdays & Thursdays
Where will the intervention take place?	State the location of the group.	. . . in Room 32 in the PSR Mall.
What will the provider teach?	State what the provider will teach.	Ms. Dawson will teach Ann the Jacobson relaxation techniques and how using these consistently will reduce the physical and mental health effects of poor sleep.
Example 3: Mr. Tom Izzo will facilitate the Leisure Education: Introduction to Basketball group from 9:40 to 10:30 am on Tuesdays & Thursdays in the courtyard. Mr. Izzo will assist Ann to improve her basketball shooting technique so that she can improve on the number of baskets she makes on free throws.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Mr. Tom Izzo will facilitate the
What is the title of the intervention?	Write the title of the intervention.	. . . Leisure Education: Introduction to Basketball group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . from 9:40 to 10:30 am on Tuesdays & Thursdays

Where will the intervention take place?	State the location of the group.	. . . in the courtyard.
What will the provider teach?	State what the provider will teach.	Mr. Izzo will assist Ann to improve her basketball shooting technique so that she can improve on the number of baskets she makes on free throws.

6.4 How to Revise an Objective and linked Intervention

Sometimes we find that an objective does not cover the four critical components listed above, or the linked intervention could be more specific. You can follow the examples below in order to modify existing Objectives and Interventions so that they meet generally accepted professional standards. In the examples below, we give an example of an Objective and a linked Intervention, followed by what's missing and what to include for each one separately, and a revised version of the same Objective and Intervention.

Original OBJECTIVE from an IRP		
Mr. James will demonstrate stability of emotions by having no aggressive behaviors for six consecutive months.		
Question Sequence	**Step-by-step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. James will demonstrate stability of emotions
How will you know?	Write "as evidenced by"	
Performance criterion	State what he must do	. . . by having no aggressive behaviors
How will you know that he/she has achieved the Objective?	State termination criterion	. . . for six consecutive months.
Where will you find the documentation?	State documentation requirements	

What's Missing and What to Include	
What's Missing	**What to Include**
"Stability of emotions" maybe difficult to attain	Restate in attainable terms
Does not include "as evidenced by"	Include "as evidenced by"
Does not pass the Dead Man's Test	Include information about what Mr. James will do, and not only what he won't do
Does not say where you will find the documentation	Include where the individual's progress will be documented

Revised OBJECTIVE		
Mr. James will be able to control his anger as evidenced by consistently using a preferred coping skill to avoid aggressive behaviors for six consecutive months. Documentation will be in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. James will be able to control his anger
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . consistently using a preferred coping skill to avoid aggressive behaviors
How will you know that he/she has achieved the Objective?	State termination criterion	. . . for six consecutive months.
Where will you find the documentation?	State documentation requirements	Documentation will be in the PSR Mall Facilitator Progress Notes.

Original linked INTERVENTION from the IRP		
Dr. Michael Rogers, psychologist, will facilitate the Coping with Anger group to support Mr. James in maintaining his stability.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention	Dr. Michael Rogers, psychologist, will facilitate the
What is the title of the intervention?	Write the title of the intervention	. . . Coping with Anger group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention	
Where will the intervention take place?	State the location of the group	
What will the provider teach?	State what the provider will teach	. . . to support Mr. James in maintaining his stability.

What's Missing and What to Include	
What's Missing	**What to Include**
Does not include the time and day(s) of the intervention	Include the time and day(s) of the intervention
Does not state where the intervention will take place	Include the location of the intervention
Does not clearly state what the facilitator will	Be specific about what the facilitator will

teach	teach to the individual

Revised INTERVENTION		
Dr. Michael Rogers, psychologist, will facilitate Coping with Anger group on Tue & Th from 9:30-10:20 am in Room 17 in the PSR Mall. Dr. Rogers will teach Mr. James how to use *Meditation on the Soles of the Feet* for coping with the triggers to his aggressive behaviors.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention	Dr. Michael Rogers, psychologist, will facilitate
What is the title of the intervention?	Write the title of the intervention	. . . Coping with Anger group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention	. . . on Tue & Th from 9:30-10:20 am
Where will the intervention take place?	State the location of the group	. . . in Room 17 in the IRP Mall.
What will the provider teach?	State what the provider will teach	Dr. Rogers will teach Mr. James how to use *Meditation on the Soles of the Feet* for coping with the triggers to his aggressive behaviors.

6.5 Writing Objectives for Substance Abuse

In a recovery model of mental health service delivery system, it is important for us to consider the concept of stages of change. An individual's substance abuse may be serious enough to interfere with his or her quality of life. As clinicians, we may think that the person needs to be in treatment. Whether the individual agrees with our assessment will depend on the individual's understanding of the disorder, the need for treatment, and agreement to engage in appropriate treatment. To determine at what approximate level the treatment should begin, we assess the individual's stage of change.

We can use a number of tools to assess an individual's stage of change. For example, the *University of Rhode Island Change Assessment* (URICA; McConnaughy, Prochaska, & Velicer, 1983, McConnaughy, DiClemente, Prochaska, & Velicer, 1989) is the most commonly used scale for this purpose. It has 32 items that resolve into four factors (precontemplation, contemplation, action, and maintenance) and can be completed by the clinician who has the best rapport with the individual. The *Stages of Change Readiness and Treatment Eagerness Scale* (SOCRATES; Miller &Tonigan, 1996) consists of 40 items that resolve into five factors (precontemplation, contemplation, preparation, action and maintenance), and the *Readiness to Change Questionnaire* (Rollnick, Heather, Gold, & Hall, 1992) consists of 12 items that resolve into three factors (precontemplation, contemplation, and action). The *Readiness Ruler* (Hesse, 2006) is sometimes used with those who are reading challenged. In our hospitals, we will use the URICA as a statewide tool.

The following are the five stages of change:

1. **Pre-contemplation** is the stage in which individuals have no intention of changing their behavior in the foreseeable future. Many individuals in this stage are unaware of or not fully aware that they are addicted to one or more substances.
2. **Contemplation** is the stage in which individuals are aware that a problem exists and are seriously thinking about overcoming it, but have not yet made a commitment to take action.
3. **Preparation** is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action or have just started to take action. These individuals may have unsuccessfully taken action in the past.
4. **Action** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their addiction. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
5. **Maintenance** is the stage in which individuals work to prevent relapse and consolidate the gains attained during action.

An assessment of an individual's stage of change, as well as readiness to engage in treatment or rehabilitation, provides the therapist a starting point in developing interventions and in affording the individual a choice in selecting one or more Mall groups or individual therapy that is appropriate for that individual. In general, individuals at the precontemplation level will benefit most from therapies that aim to change the cognition of the individuals, i.e., their thinking about their condition or functional status. Those at the other end of the continuum will benefit most from behavioral or action-oriented therapies (see Appendix 4 for suggested treatments at each stage of change).

The following are examples of objectives at each stage of change. The RPTC should ensure alignment between the staged objective and an intervention appropriate for that stage.

EXAMPLE #1: PRECONTEMPLATION John will identify at least two harmful outcomes that someone may experience by using illicit substances as evidenced by correctly stating them to the mall facilitator weekly, for four consecutive weeks. His progress will be documented in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	John will identify at least two harmful outcomes that someone may experience by using illicit substances
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to the mall facilitator weekly,
Termination criterion	State termination criterion	. . . for four consecutive weeks.
Where will you find the	State documentation	His progress will be

documentation?	requirements	documented in the PSR Mall Facilitator Progress Notes.
EXAMPLE #2: CONTEMPLATION John will identify at least two harmful outcomes that using illicit substances has had on his life as evidenced by correctly stating them to the mall facilitator weekly, for four consecutive weeks. His progress will be documented in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	John will identify at least two harmful outcomes that using illicit substances has had on his life
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to the mall facilitator weekly,
Termination criterion	State termination criterion	. . . for four consecutive weeks.
Where will you find the documentation?	State documentation requirements	His progress will be documented in the PSR Mall Facilitator Progress Notes.
EXAMPLE #3: PREPARATION John will identify at least two triggers that made it difficult for him to engage in or maintain a sober life style in the past as evidenced by stating them to the mall facilitator weekly, for 4 consecutive weeks. His progress will be documented in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	John will identify at least two triggers that made it difficult for him to engage in or maintain a sober life style in the past
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to the mall facilitator weekly,
Termination criterion	State termination criterion	. . . for four consecutive weeks.
Where will you find the documentation?	State documentation requirements	His progress will be documented in the monthly PSR Mall Facilitator Progress Notes.
EXAMPLE #4: ACTION John will learn and practice using a coping strategy to manage each identified trigger as evidenced by discussing each strategy with the mall facilitator weekly, for four consecutive weeks. His progress will be documented in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	John will learn and practice using a coping strategy to manage each identified trigger

How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to the mall facilitator weekly,
Termination criterion	State termination criterion	. . . for four consecutive weeks.
Where will you find the documentation?	State documentation requirements	His progress will be documented in the PSR Mall Facilitator Progress Notes.
EXAMPLE #5: MAINTENANCE John will identify at least two hypothetical situations that may challenge his abstinence in the community and strategies to cope with them as evidenced by discussing each hypothetical situation and strategy with the mall facilitator weekly, for four consecutive weeks. His progress will be documented in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	John will identify at least two hypothetical situations that may challenge his abstinence in the community and strategies to cope with them
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to the mall facilitator weekly,
Termination criterion	State termination criterion	. . . for four consecutive weeks.
Where will you find the documentation?	State documentation requirements	His progress will be documented in the PSR Mall Facilitator Progress Notes.

6.6 Writing Interventions for Substance Abuse

You can write the interventions for substance abuse in exactly the same manner as for other objectives, but be sure to align the mall group or individual therapy to the same stage of change as stated in the objective.

6.7 Writing the Goal, Objective and Interventions for Medical Conditions and Medical Risk factors

All medical conditions for which the individual receives treatment (not just those listed as an Axis III diagnosis) need either to have a separate goal, objective(s), and intervention(s) or be included in a health maintenance goal, objective(s), and intervention(s). Specifically,

- There needs to be a separate goal, objective(s), and intervention(s) for any medical condition that is not well-controlled and for any medical condition (regardless of "control") the RPT identifies as a priority for active treatment; and
- All medical conditions in which the individual receives treatment that the RPT determines to be both well-controlled and not requiring a learning-based objective with active treatment interventions can be combined into a health maintenance goal, objective(s), and intervention(s). (See below for an example).

In addition, there should a separate goal, objective(s) and intervention(s) for each medical risk factor identified in the individual's Clinical Risk Profile (as required in Attachment B of the DBHDD Risk Management policy – 03-601). Multiple medical risks should not be combined into a single goal, objective(s) and intervention(s).

Some medical risk factors may require a service-based rather than a learning-based objective. For example, all that may be required for an intervention in some cases is that a nurse attends to a medical condition (i.e., a "service" intervention—e.g., the nurse takes blood pressure every week). In other cases, both a mall group (or individual therapy) and a service intervention may be prescribed. In the example below, the individual can attend a mall group to learn more about diabetes, and the nurse monitors his blood sugar level and provides appropriate follow up nursing services.

GOAL Mr. Bernstein was diagnosed with diabetes, Type II, a year ago. He does not believe that he has it, but wants to learn more about it. His goal is to learn about the signs and symptoms of diabetes and how they can be managed.		
OBJECTIVE Mr. Bernstein will learn the normal range for blood sugar and two symptoms of low blood sugar as evidenced by correctly stating them to his group facilitator twice a week, for three consecutive weeks. Documentation will be in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Bernstein will learn the normal range for blood sugar and two symptoms of low blood sugar
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to his group facilitator twice a week,
How will you know that he/she has achieved the Objective?	State termination criterion	. . . , for three consecutive weeks.
Where will you find the documentation?	State documentation requirements	Documentation will be in the PSR Mall Facilitator Progress Notes.
ACTIVE TREATENT INTERVENTION Dr. Gouse will facilitate the Medical Health and Wellness mall group on Tuesdays and Thursdays from 10:40 to 11:30 am in Room 21 in the PSR Mall. Dr. Gouse will teach Mr. Bernstein normal blood sugar levels, signs and symptoms of low blood sugar level, how people feel when their blood sugar level falls below the normal range such as being sweaty, shaky and irritable, and what they can do about it.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible	State the name of the staff that	Dr. Gouse will facilitate . . .

for providing the intervention?	will be facilitating the intervention.	
What is the title of the intervention?	Write the title of the intervention.	. . . the Medical Health and Wellness mall group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . on Tuesdays and Thursdays from 10:40 to 11:30 am
Where will the intervention take place?	State the location of the group.	. . . in Room 21 in the PSR Mall.
What will the provider teach?	State what the provider will teach.	Dr. Gouse will teach Mr. Bernstein about normal blood sugar levels, signs and symptoms of low blood sugar level, how people feel when their blood sugar level falls below the normal range such as being sweaty, shaky and irritable, and what they can do about it.
NURSING INTERVENTION Unit Nursing staff will monitor blood sugar, as ordered by the physician and whenever Mr. Bernstein shows symptoms that could be hypoglycemia. If his blood sugar level is below 70 mg/dL, nursing staff will administer instant glucose gel into the side of his mouth, call the physician for further instructions, and monitor him until his blood sugar level is at an acceptable level.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff*
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor blood sugar
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . . as ordered by the physician and whenever Mr. Bernstein shows symptoms that could be hypoglycemia.
What will the nurse do with the test results?	State the care plan	If his blood sugar level is below 70 mg/dL, nursing staff will administer instant glucose gel into the side of his mouth, call the physician for further instructions, and monitor him until his blood sugar level is at an acceptable level.

*** If required by other agencies, specify the name of the person who will ensure that this will be done (e.g., Supervisor).**

Below are further examples of goals, objectives and interventions for medical conditions and medical risk factors.

A. <u>New medical condition</u>—Learning-based objective with both active treatment *and* nursing service interventions.

GOAL Mr. Harris is newly diagnosed as positive for the Hepatitis C virus, and his goal is to learn more about his condition.		
OBJECTIVE Mr. Harris will name two symptoms of acute Hepatitis C as evidenced by correctly stating them to his group facilitator twice a week, for three consecutive weeks. Documentation will be in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Harris will name two symptoms of acute Hepatitis C
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to his group facilitator twice a week,
How will you know that he/she has achieved the Objective?	State termination criterion	. . . for three consecutive weeks.
Where will you find the documentation?	State documentation requirements	Documentation will be in the PSR Mall Facilitator Progress Notes.
(ACTIVE TREATMENT) INTERVENTION Dr. Myers, RN, will facilitate the Managing Infectious Diseases mall group on Tuesdays and Thursdays from 10:40 to 11:30 am in Room 22 in the PSR Mall. Dr. Myers will teach Mr. Harris the signs of acute Hepatitis C, such as fever, malaise, right upper quadrant pain, and jaundice, and what he can do about it.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Dr. Myers, RN, will facilitate
What is the title of the intervention?	Write the title of the intervention.	. . . the Managing Infectious Diseases mall group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . on Tuesdays and Thursdays from 10:40 to 11:30 am
Where will the intervention take place?	State the location of the group.	. . . in Room 22 in the PSR Mall.

What will the provider teach?	State what the provider will teach.	Dr. Myers will teach Mr. Harris the signs of acute Hepatitis C, such as fever, malaise, right upper quadrant pain, and jaundice, and what he can do about it.
NURSING INTERVENTION Unit Nursing staff will monitor the signs and symptoms of acute Hepatitis C on a weekly basis. If symptoms are present, staff will notify RN/MD for further evaluation.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor the signs and symptoms of acute Hepatitis C
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . . on a weekly basis.
What will the nurse do with the test results?	State the care plan	If symptoms are present, staff will notify RN/MD for further evaluation.

B. <u>Medical condition *not* well controlled</u>—Learning-based objective with both active treatment *and* nursing service interventions.

GOAL Ms. Mistry has elevated lipids, and her goal is to lower her lipids in order to decrease risks of cardiovascular disease.		
OBJECTIVE Ms. Mistry will state two ways of decreasing her lipid level as evidenced by correctly stating them to her group facilitator twice a week, for three consecutive weeks. Documentation will be in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ms. Mistry will state two ways of decreasing her lipid level
How will you know?	Write “as evidenced by”	. . . as evidenced by
Performance criterion	State what he must do	. . . correctly stating them to her group facilitator twice a week,
How will you know that he/she has achieved the Objective?	State termination criterion	. . . for three consecutive weeks.
Where will you find the documentation?	State documentation requirements	Documentation will be in the PSR Mall Facilitator Progress Notes.

(ACTIVE TREATMENT) INTERVENTION Dr. Jones will facilitate the Medical Health and Wellness mall group on Tuesdays and Thursdays from 9:30 to 10:20 am in Room 32 in the PSR Mall. Dr. Jones will teach Ms. Mistry ways to decrease her lipid levels by decreasing consumption of fried foods, increasing dietary intake of vegetables and fruits, and by increasing exercise daily.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Dr. Jones will facilitate . . .
What is the title of the intervention?	Write the title of the intervention.	. . . the Medical Health and Wellness mall group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . on Tuesdays and Thursdays from 9:30 to 10:20 am
Where will the intervention take place?	State the location of the group.	. . . in Room 32 in the PSR Mall.
What will the provider teach?	State what the provider will teach.	Dr. Jones will teach Ms. Mistry ways to decrease her lipid levels by decreasing consumption of fried foods, increasing dietary intake of vegetables and fruits, and by increasing exercise daily.
NURSING INTERVENTION Unit Nursing staff will monitor signs or symptoms of increasing lipids such as quarterly lipid level, reports of not following diet, not exercising, weight gain, or reports of shortness of breath, dizziness or chest pains during exercise, on a monthly basis. If worsening signs or symptoms are present, the unit RN will perform a focused assessment, reinforce teaching as needed, and notify MD when clinically indicated.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor signs or symptoms of increasing lipids such as quarterly lipid level, reports of not following diet, not exercising, weight gain, or reports of shortness of breath, dizziness or chest pains during exercise
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . . on a monthly basis.
What will the nurse do with the test results?	State the care plan	If worsening signs or symptoms are present, the unit RN will

		perform a focused assessment, reinforce teaching as needed, and notify MD when clinically indicated.

C. <u>Medical conditions that are well controlled *and* in which a learning-based objective with active treatment interventions is *not* indicated</u>—Health maintenance goal and objective with nursing service interventions for an individual <u>able</u> to report signs and symptoms.

GOAL		
Mr. Cole has osteoporosis, hypothyroidism, and bilateral cataracts that are in a fairly stable condition with current treatment, and his goal is to keep these medical conditions well controlled.		
OBJECTIVE		
Mr. Cole will inform a unit nurse when he experiences any change in the signs and symptoms of his osteoporosis, hypothyroidism, or bilateral cataracts. Documentation will be in the nursing progress notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Cole will inform a unit nurse when he experiences any change in the signs and symptoms of his osteoporosis, hypothyroidism, or bilateral cataracts
Where will you find the documentation?	State documentation requirements	Documentation will be in the nursing progress notes.
NURSING INTERVENTIONS		
Unit nursing staff will administer medications and treatments as prescribed for Mr. Cole's osteoporosis, hypothyroidism, and bilateral cataracts.		
Unit nursing staff will ensure labs, diagnostic tests, consultation and clinic services related to Mr. Cole's osteoporosis, hypothyroidism, and bilateral cataracts are scheduled as ordered.		
If the individual reports recurrence of any health maintenance condition, nursing staff will undertake appropriate assessment, notify the medical physician for further evaluation, and provide treatment, if needed, as prescribed.		
Unit nursing staff will monitor Mr. Cole for signs and symptoms of acute complications related to his osteoporosis, hypothyroidism, and bilateral cataracts monthly, and will conduct focused physical assessments as clinically indicated. Nursing staff will notify the physician of any complications or abnormal findings and will provide treatment as prescribed.		

D. <u>Medical conditions that are well controlled *and* in which a learning-based objective with active treatment interventions is *not* indicated</u>—Health maintenance goal and objective with nursing service interventions for an individual <u>unable</u> to report signs and symptoms.

GOAL Mr. Martin has osteoporosis, hypothyroidism, and bilateral cataracts that are in a fairly stable condition with current treatment, and his goal is to keep these medical conditions well controlled.		
OBJECTIVE Mr. Martin will be able to participate in his daily routine and preferred activities without experiencing any complications related to his osteoporosis, hypothyroidism, or bilateral cataracts. Documentation will be in the nursing progress notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, experience, use, etc.	Mr. Martin will be able to participate in his daily routine and preferred activities without experiencing any complications related to his osteoporosis, hypothyroidism, or bilateral cataracts.
Where will you find the documentation?	State documentation requirements	Documentation will be in the nursing progress notes.
NURSING INTERVENTIONS		
Unit nursing staff will administer medications and treatments as prescribed for Mr. Martin's osteoporosis, hypothyroidism, and bilateral cataracts.		
Unit nursing staff will ensure labs, diagnostic tests, consultation and clinic services related to Mr. Martin's osteoporosis, hypothyroidism, and bilateral cataracts are scheduled as ordered.		
If there are signs of recurrence of any health maintenance condition, nursing staff will undertake appropriate assessment of Mr. Martin's condition, notify the medical physician for further evaluation, and provide treatment, if needed, as prescribed.		
Unit nursing staff will monitor Mr. Martin for signs and symptoms of acute complications related to his osteoporosis, hypothyroidism, and bilateral cataracts monthly, and will conduct focused physical assessments as clinically indicated. Nursing staff will notify the physician of any complications or abnormal findings and will provide treatment as prescribed.		

NOTE: Even objectives for health maintenance goals in which no active treatment is provided and the individual is unable to report signs or symptoms of changes should pass the dead man's test. For example, if the above objective read, "Mr. Martin will not experience any complications related to his osteoporosis, hypothyroidism, and bilateral cataracts", this would not pass the dead man's test, because Mr. Martin could meet this objective whether he was alive or not. However, the way the objective is worded above requires Mr. Martin to actively do something (i.e., participate in his daily routine and preferred activities. . .).

E. High risk for medical conditions (per Attachment B of the Risk Management policy)— Learning-based objective with both active treatment *and* nursing service interventions.

1. High risk for choking and aspiration

GOAL Mr. Lee is at high risk for choking and aspiration related to oropharyngeal dysphagia, fast eating pace, and GERD. The goal is for Mr. Lee to eat at a safe pace in order to maximize enjoyment during eating, aid in digestion, and reduce his risk of choking and aspiration episodes.		
OBJECTIVE Mr. Lee will set down his utensil after each bite with verbal prompts as evidenced by demonstration to his provider during Mindful Eating Group for three consecutive group sessions. Documentation will be in the PSR Mall Facilitator Progress Notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Lee will set down his utensil after each bite with verbal prompts
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . demonstration to his provider during Mindful Eating Group,
How will you know that he/she has achieved the Objective?	State termination criterion	. . . for three consecutive group sessions.
Where will you find the documentation?	State documentation requirements	Documentation will be in the PSR Mall Facilitator Progress Notes.
(ACTIVE TREATMENT) INTERVENTION Dr. Raisin, RN, will facilitate the Mindful Eating mall group on Tuesdays and Thursdays from 10:40 to 11:30 am in Room 22 in the PSR Mall. Dr. Raisin will teach Mr. Lee strategies for eating mindfully, such as eating slowly and appreciatively, paying attention to and enjoying the sensory experiences associated with eating and drinking, and the impact of mindful eating practice on his GERD symptoms and choking and aspiration risk.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Dr. Raisin, RN, will facilitate
What is the title of the intervention?	Write the title of the intervention.	. . . the Mindful Eating mall group
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . on Tuesdays and Thursdays from 10:40 to 11:30 am
Where will the intervention take place?	State the location of the group.	. . . in Room 22 in the PSR Mall.
What will the provider teach?	State what the provider will teach.	Dr. Raisin will teach Mr. Lee strategies for eating mindfully, such as eating slowly and

		appreciatively, paying attention to and enjoying the sensory experiences associated with eating and drinking, and the impact of mindful eating practice on his GERD symptoms and choking and aspiration risk.
NURSING INTERVENTION Unit Nursing staff will monitor for any documented or reported signs and symptoms of choking and/or aspiration or increased symptoms of GERD on a daily basis. If symptoms are present, staff will notify RN/MD for further evaluation.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor for any documented or reported signs and symptoms of choking and/or aspiration or increased symptoms of GERD
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . . on a daily basis.
What will the nurse do with the test results?	State the care plan	If symptoms are present, staff will notify RN/MD for further evaluation.

2. <u>High risk for falls</u>

GOAL Mr. Lee is at high risk for falls related to osteoporosis, vertigo, unsteady gait, and over 10 falls within the past 6 months, but he enjoys leading an active lifestyle and playing sports. The goal is for Mr. Lee to have a decrease in the probability of falling.		
OBJECTIVE Mr. Lee will demonstrate improved gait as evidenced by transitioning from the sidewalk to an uneven grass surface without stumbling with contact guard assistance x 1 when walking to soccer group for five consecutive trials. Documentation will be in the monthly physical therapy progress notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Lee will demonstrate improved gait
How will you know?	Write “as evidenced by”	. . . as evidenced by
Performance criterion	State what he must do	. . . transitioning from the sidewalk to an uneven grass

		surface without stumbling with contact guard assistance x 1 when walking to soccer group
How will you know that he/she has achieved the Objective?	State termination criterion	. . .for five consecutive trials.
Where will you find the documentation?	State documentation requirements	Documentation will be in the monthly physical therapy progress notes.
(ACTIVE TREATMENT) INTERVENTION Ms. Walker, physical therapist will provide 1:1 direct physical therapy treatment on Tuesdays and Thursdays from 9:30 to 10:20 am in the therapy clinic and at the soccer field. Ms. Walker will provide activities to improve strength, coordination and timing of gait, endurance, and dynamic balance, followed by practice in a natural setting.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Ms. Walker, physical therapist will provide. . .
What is the title of the intervention?	Write the title of the intervention.	. . . 1:1 direct physical therapy treatment
At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . on Tuesdays and Thursdays from 9:30 to 10:20 am
Where will the intervention take place?	State the location of the group.	. . . in the therapy clinic and at the soccer field.
What will the provider teach?	State what the provider will teach.	Ms. Walker will provide activities to improve strength, coordination and timing of gait, endurance, and dynamic balance, followed by practice in a natural setting.
NURSING INTERVENTION Unit Nursing staff will monitor Mr. Lee for signs of increased ataxia on a daily basis. If worsening signs or symptoms are present, the unit RN will perform an assessment, and notify physical therapist and MD when clinically indicated.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor Mr. Lee for signs of increased ataxia
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . . on a daily basis.

What will the nurse do with the test results?	State the care plan	If worsening signs or symptoms are present, the unit RN will perform an assessment, and notify physical therapist and/or MD when clinically indicated.

3. High risk for impaired skin integrity

GOAL Mr. Lee is at high risk for impaired skin integrity related to limited mobility and history of decubitus ulcer within the past 6 months. The goal is for Mr. Lee to increase his ability to self-monitor his skin, and be free of impaired skin integrity.		
OBJECTIVE Mr. Lee will demonstrate improved independence with awareness of his skin integrity as evidenced by using a hand-held mirror to assess his sacral area for redness with verbal cues and stand by assistance during his morning self care routine, for seven consecutive days. Documentation will be in the monthly occupational therapy progress note.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Mr. Lee will demonstrate improved independence with awareness of his skin integrity
How will you know?	Write "as evidenced by"	. . . as evidenced by
Performance criterion	State what he must do	. . . using a hand-held mirror to assess his sacral area for redness with verbal cues with stand by assistance during his morning self care routine
How will you know that he/she has achieved the Objective?	State termination criterion	. . .for seven consecutive days.
Where will you find the documentation?	State documentation requirements	Documentation will be in the monthly occupational therapy progress note.
(ACTIVE TREATMENT) INTERVENTION Ms. Fiddler, occupational therapist will provide 1:1 direct occupational therapy treatment daily from 7:00 to 7:30 am in Mr. Lee's room. Ms. Fiddler will provide activities to improve strength, range of motion, energy conservation, accurate mirror placement, self-efficacy, and strategies for integrating skin checks into his daily self care routine.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
Who will be responsible for providing the intervention?	State the name of the staff that will be facilitating the intervention.	Ms. Fiddler, occupational therapist will provide. . .
What is the title of the intervention?	Write the title of the intervention.	. . . 1:1 direct occupational therapy treatment

At what time and on which day(s) will the intervention take place?	State the time and day(s) of the intervention.	. . . daily from 7:00 to 7:30 am
Where will the intervention take place?	State the location of the group.	. . . in Mr. Lee's room.
What will the provider teach?	State what the provider will teach.	Ms. Fiddler will provide activities to improve strength, range of motion, energy conservation, accurate mirror placement, self-efficacy, and strategies for integrating skin checks into his daily self care routine.
NURSING INTERVENTION Unit Nursing staff will monitor Mr. Lee for signs or symptoms of redness or impaired skin integrity on a daily basis. If signs or symptoms are present, the unit RN will notify MD when clinically indicated.		
Who will be responsible for the monitoring?	State the name of the Unit staff responsible for the monitoring.	Unit Nursing staff
What symptoms will be monitored?	State the symptoms that will be monitored.	. . . will monitor Mr. Lee for signs or symptoms of redness or impaired skin integrity
How frequently will staff monitor these symptoms?	Specify the frequency of monitoring.	. . .on a daily basis.
What will the nurse do with the test results?	State the care plan	If signs or symptoms are present, the unit RN will notify MD when clinically indicated.

F. <u>High risk for medical conditions (per Attachment B of the Risk Management policy) in which a learning-based objective with active treatment interventions is *not* indicated</u>— Objective with interdisciplinary service interventions.

1. <u>High risk for choking and aspiration</u>

GOAL Ms. Moore is at high risk for choking and aspiration related to oropharyngeal dysphagia, fast eating pace, and GERD. The goal is for Ms. Moore to be free of choking and aspiration episodes.
OBJECTIVE Ms. Moore will eat and drink preferred foods and beverages within her prescribed least restrictive diet without experiencing any episodes of choking or aspiration. Documentation will be in the nursing and SLP progress notes.

Question Sequence	Step-by-Step Development	Statement Format
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ms. Moore will eat and drink preferred foods and beverages within her prescribed least restrictive diet without experiencing any episodes of choking or aspiration.
Where will you find the documentation?	State documentation requirements	Documentation will be in the nursing and SLP progress notes.
SERVICE INTERVENTIONS		
Unit nursing staff will administer Reglan and Nexium as prescribed for GERD.		
Direct care and nursing staff will implement the 24-hour Support Plan (Nutritional Physical Support Plan) related to mealtime, oral hygiene and medication administration. In addition, all staff will observe Nutritional Support general guidelines.		
Ms. Johnson, SLP will observe Ms. Moore during mealtime to monitor 24 Hour support plan implementation, and to reassess Ms. Moore for functional improvement or regression and determine if plan requires modification to best meet her needs.		
If Ms. Moore experiences a choking or aspiration episode, nursing staff will undertake appropriate assessment, notify the medical physician and SLP for further evaluation, and provide treatment, if needed, as prescribed.		

NOTE: Even objectives for medical risk factors in which no active treatment is provided should pass the dead man's test. For example, if the above objective just read, "Ms. Moore will not experience any episodes of choking or aspiration," this would not pass the dead man's test, because Ms. Moore could meet this objective whether she was alive or not. However, the way the objective is worded above requires Ms. Moore to actively do something (i.e., eat and drink).

2. High risk for falls

GOAL Ms. Moore is at high risk for falls related to osteoporosis, vertigo, unsteady gait, and over 10 falls within the past 6 months, but she enjoys leading an active lifestyle and playing sports. The goal is for Ms. Moore to have a decrease in the probability of falling.		
OBJECTIVE Ms. Moore will be able to participate in her daily routine and identified activities of interest and experience a decrease in the number of falls per month. Documentation will be in the nursing and PT progress notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ms. Moore will be able to participate in her daily routine and identified activities of interest and experience a decrease in the number of falls

		per month.
Where will you find the documentation?	State documentation requirements	Documentation will be in the nursing and PT progress notes.
SERVICE INTERVENTIONS		
Unit nursing staff will administer Calciferol and Fosamax as prescribed for osteoporosis.		
Unit nursing staff will ensure labs, diagnostic tests, and clinic services related to Ms. Moore's osteoporosis are scheduled as ordered.		
Direct care staff will reinforce with Ms. Moore the importance of calling staff for assistance during ambulation anytime she feels dizzy or unsteady on her feet.		
Direct care and nursing staff will implement the 24-hour Support Plan (Nutritional Physical Support Plan) related to mobility, transfers, and work and environmental modifications.		
Mr. Barber, PT, will perform quarterly monitoring and reassessment of Ms. Moore's physical supports to ensure that they are implemented across environmental contexts and settings, are appropriate for reducing falls or fall severity, and support safe engagement in preferred activities.		

3. <u>High risk for impaired skin integrity</u>

GOAL Ms. Moore is at high risk for impaired skin integrity related to limited mobility and history of decubitus ulcer within the past 6 months. The goal is for Ms. Moore to be free of impaired skin integrity.		
OBJECTIVE Ms. Moore will be able to engage in her daily routine and preferred activities without development of a decubitus ulcer. Documentation will be in the nursing and OT progress notes.		
Question Sequence	**Step-by-Step Development**	**Statement Format**
What will the individual do?	State what you want the individual to learn, do, say, demonstrate, use, etc.	Ms. Moore will be able to engage in her daily routine and preferred activities without development of a decubitus ulcer.
Where will you find the documentation?	State documentation requirements	Documentation will be in the nursing and OT progress notes.
SERVICE INTERVENTIONS		
Unit nursing staff will apply Triple Paste Barrier Cream to Ms. Moore's skin as prescribed.		
Direct care and nursing staff will implement the 24-hour Support Plan (Nutritional Physical Support Plan) related to custom seating system, alternate positioning, selection of alternate positions, positioning equipment, and functional participation in repositioning.		
Ms. Fiddler, OT, will perform quarterly monitoring and reassessment of Ms. Moore's physical supports to ensure that they are appropriate for preventing decubitus ulcers as well as supporting enhanced function and participation.		
If Ms. Moore develops a decubitus ulcer, nursing staff will undertake appropriate assessment,		

notify the medical physician and occupational therapist for further evaluation, and provide treatment, if needed, as prescribed.

7 DEVELOPING INTERVENTIONS FROM THE CASE FORMULATION

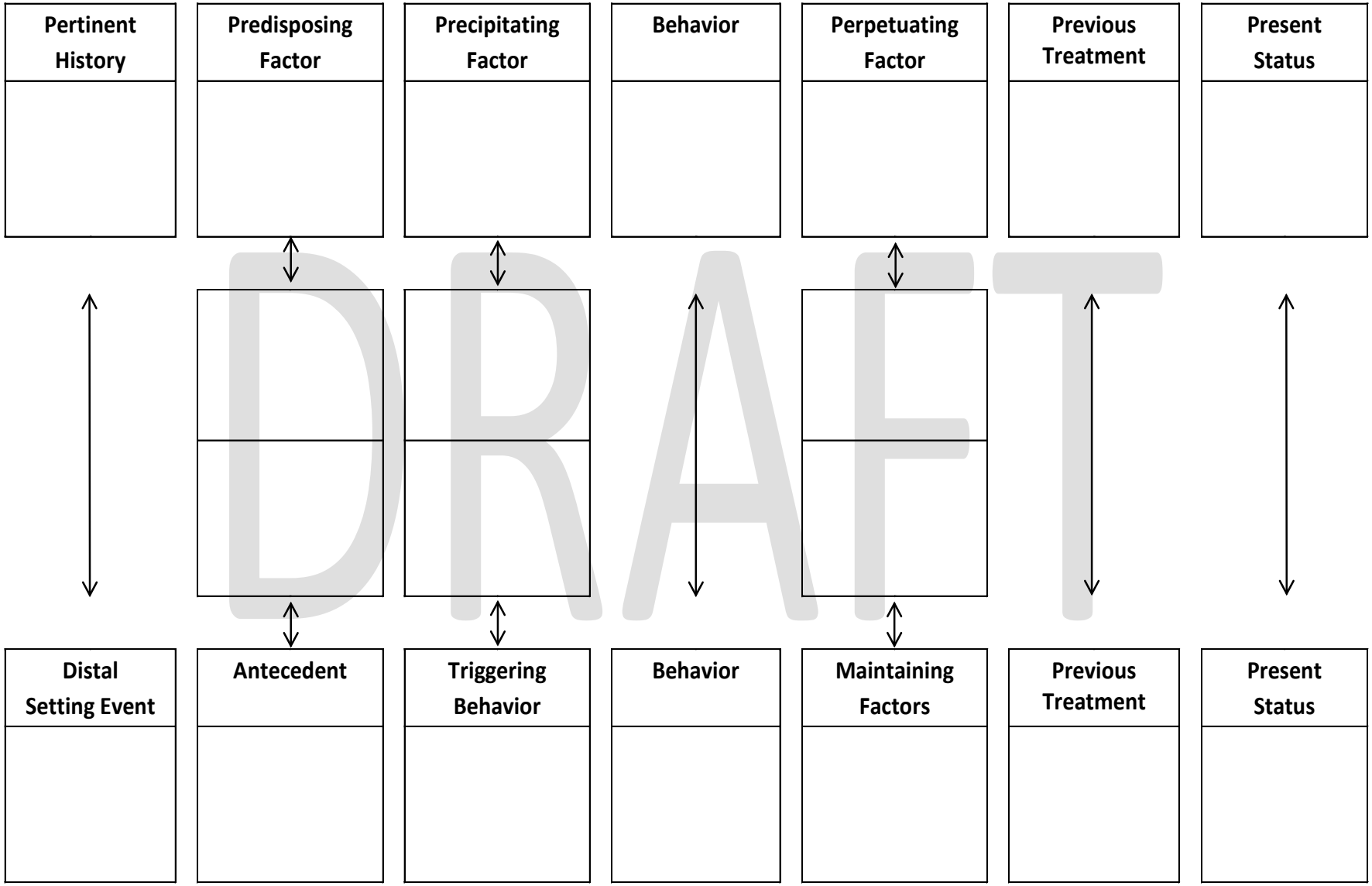
A good case formulation informs the clinician and the individual about the nature, possible causes, and trajectory of the individual's psychiatric, behavioral, and medical concerns. In addition, a well-constructed case formulation provides the basis for developing hypotheses for possible interventions. In the 6P formulation, the three critical Ps involve the Predisposing, Precipitating, and Perpetuating factors. Treatments can be derived for each of these, depending on the disease, disorder, or deficit. Which interventions would be feasible and possibly effective in the context of the individual's current hospitalization is an issue the RPT needs to discusses and resolve.

The *6Ps and PBS Worksheet* provides a simple pathway for developing interventions, especially for the individual's high-risk conditions. The first step is to determine the target issue—a specific disease, disorder, or deficit—as the focus for treatment, and write this information in the cell immediately below Behavior. The second step is to complete the cells immediately below each P—Pertinent History, Predisposing Factor, Precipitating Factor, Perpetuating Factor, Previous Treatment, and Present Status as it relates to the target issue only. The third step is to develop possible interventions for the predisposing, precipitating and perpetuating factors, and complete the top half of the cells in the middle row. Not every target issue will lend itself to a treatment aligned with each P, so there is no need to force a treatment option for each P for every disease, disorder, or deficit.

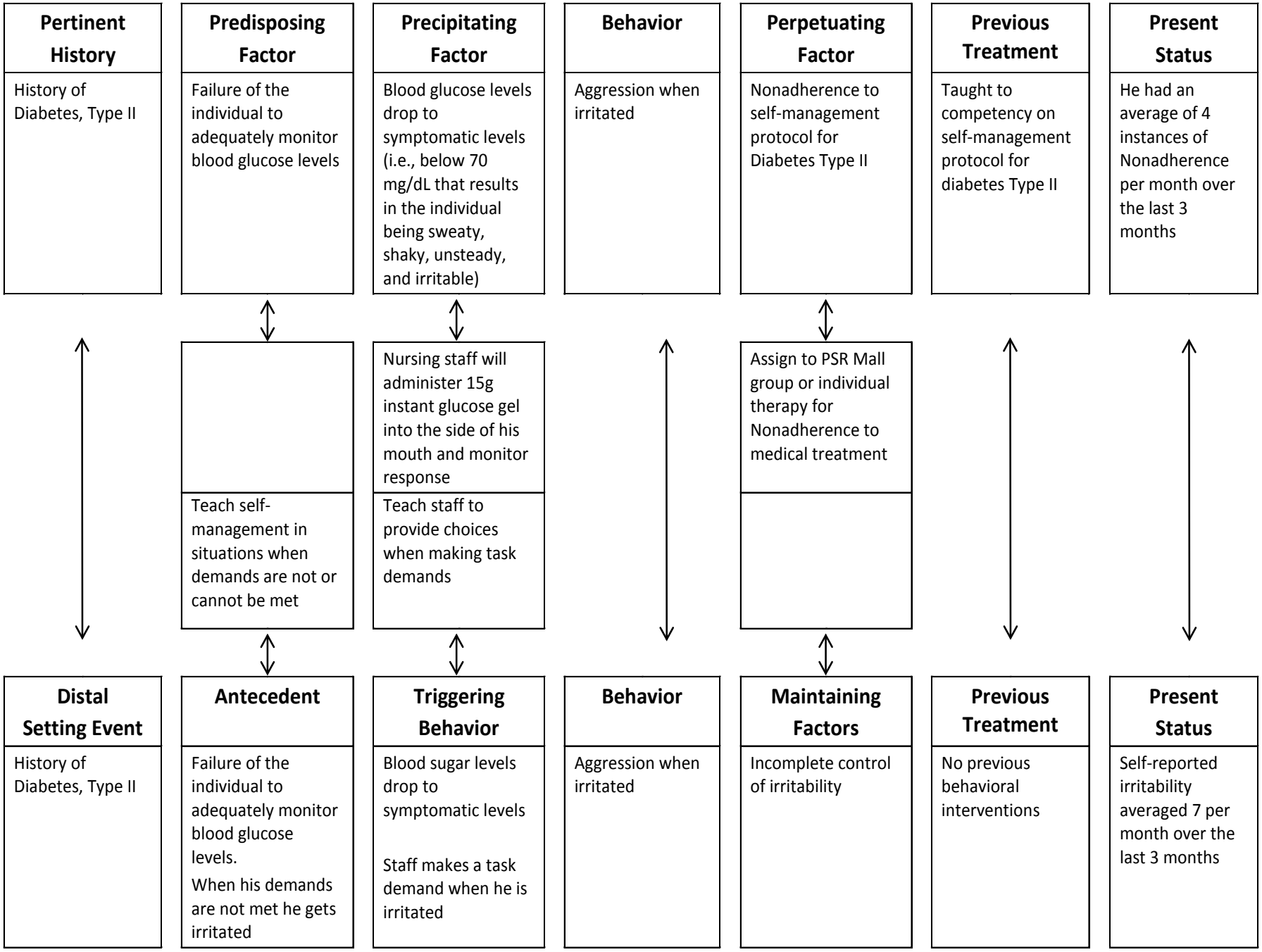
In the third row, the 6Ps are translated into behavioral options. Once the case formulation is completed, the PBS team will be able to assess, develop hypotheses of the possible antecedents, triggers, and maintenance factors for the target behavior. In a manner similar to that described above, the PBS team should be able to develop possible interventions for the antecedent conditions, triggering behaviors, and maintenance factors. These are recorded in the bottom cells of the middle row.

The two examples show how the case formulation can help the RPT and PBS team to develop interventions. In these examples, we illustrate how we can derive interventions for aggressive behavior, with each showing a different set of predisposing, precipitating and perpetuating factors, and consequently different treatment options.

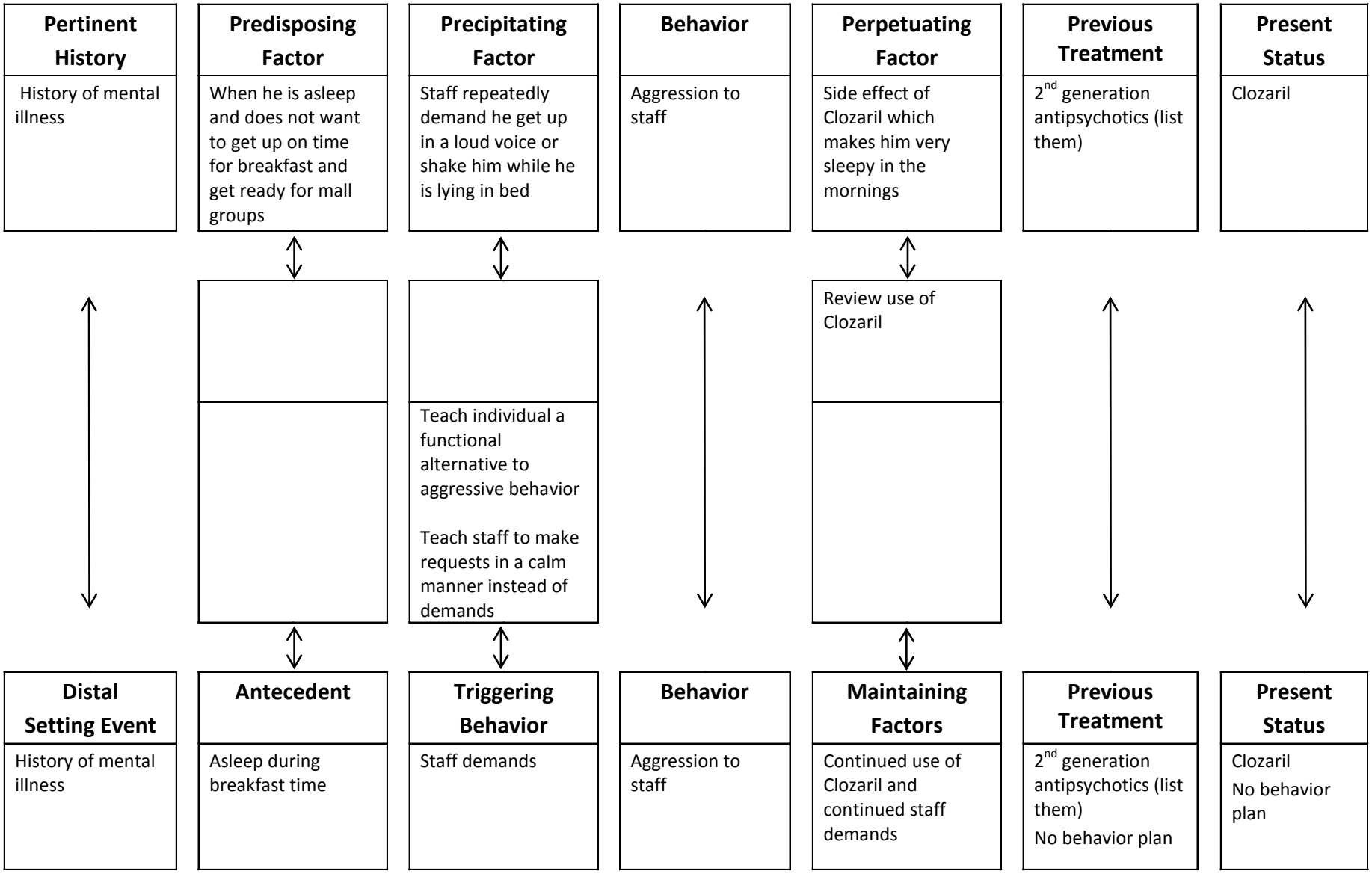
6Ps and PBS WORKSHEET



Example 1


Pertinent History
History of Diabetes, Type II
Predisposing Factor
Failure of the individual to adequately monitor blood glucose levels
Precipitating Factor
Blood glucose levels drop to symptomatic levels (i.e., below 70 mg/dL that results in the individual being sweaty, shaky, unsteady, and irritable)
Behavior
Aggression when irritated
Perpetuating Factor
Nonadherence to self-management protocol for Diabetes Type II
Previous Treatment
Taught to competency on self-management protocol for diabetes Type II
Present Status
He had an average of 4 instances of Nonadherence per month over the last 3 months
Nursing staff will administer 15g instant glucose gel into the side of his mouth and monitor response
Assign to PSR Mall group or individual therapy for Nonadherence to medical treatment
Teach self-management in situations when demands are not or cannot be met
Teach staff to provide choices when making task demands
Distal Setting Event
History of Diabetes, Type II
Antecedent
Failure of the individual to adequately monitor blood glucose levels.
When his demands are not met he gets irritated
Triggering Behavior
Blood sugar levels drop to symptomatic levels
Staff makes a task demand when he is irritated
Behavior
Aggression when irritated
Maintaining Factors
Incomplete control of irritability
Previous Treatment
No previous behavioral interventions
Present Status
Self-reported irritability averaged 7 per month over the last 3 months

Example 2


Pertinent History
History of mental illness
Predisposing Factor
When he is asleep and does not want to get up on time for breakfast and get ready for mall groups
Precipitating Factor
Staff repeatedly demand he get up in a loud voice or shake him while he is lying in bed
Behavior
Aggression to staff
Perpetuating Factor
Side effect of Clozaril which makes him very sleepy in the mornings
Previous Treatment
2nd generation antipsychotics (list them)
Present Status
Clozaril
Review use of Clozaril
Teach individual a functional alternative to aggressive behavior
Teach staff to make requests in a calm manner instead of demands
Distal Setting Event
History of mental illness
Antecedent
Asleep during breakfast time
Triggering Behavior
Staff demands
Behavior
Aggression to staff
Maintaining Factors
Continued use of Clozaril and continued staff demands
Previous Treatment
2nd generation antipsychotics (list them)
No behavior plan
Present Status
Clozaril
No behavior plan

8. PSR MALL and INDIVIDUAL THERAPY

8.1 Psychosocial Rehabilitation Mall (PSR Mall)

Schedule each individual to attend four hours of mall groups a day (i.e., two hours in the morning and two hours in the afternoon each weekday) in a Psychosocial Rehabilitation Mall (PSR Mall) that is usually in an off-residential location. These services are directly linked to the individual's assessed needs and documented in the intervention section of his or her IRP. The interventions include treatment, rehabilitation, and enrichment needs of the individuals. Services provided in the PSR Mall include groups, individual therapy and activities designed to help with symptom management, personal skills development, and life enrichment. The PSR Mall capitalizes on clinical and support staff resources from the entire hospital, to provide a larger diversity of interaction and more realistic experiences for all individuals.

A PSR Mall is a centralized approach to delivering services that enables a hospital to maximize the therapeutic time of the individuals it serves by providing an array of mental health services that an individual can select from and attend. Mall interventions are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the individual. Thus, a PSR Mall extends beyond the context of a building or place, and its services are based on the needs of the individual, and not the needs of the program, the staff, or the hospital. PSR Malls are designed to ensure that each individual receives intensive and individualized services to promote his or her increased wellness, enhanced quality of life, and the ability to thrive in the community. All decisions regarding what is offered in a PSR Mall are driven by the needs of the individuals served. Mall services are provided in an environment that is culturally sensitive and strength-based.

A PSR Mall group should be a minimum of 20mins and a maximum of 50mins to be counted as 1 hour of active treatment. The same rule applies to formally scheduled individual therapy. Brief contact with psychiatrists and other clinical staff for less than 20 mins can be scheduled, but these do not count towards the required 20 hours of active treatment. Anything less than 20 mins is typically provided in the therapeutic milieu, and need not be specified in any detail in the interventions.

8.2 Choice of Mall Groups

The choice of a PSR Mall group begins with an assessment of the individual's needs in terms of treatment, rehabilitation, and enrichment. Assessed needs are written as Goals for the individual. Each Goal has at least one Objective, which is written in terms of what the *individual* needs to do, and for each objective there is at least one intervention—a PSR Mall group or individual therapy. In addition, it is expected that what is taught in the PSR Mall or individual therapy is reinforced in the therapeutic milieu. The individual makes a choice of PSR Mall group based on a selection of the relevant mall groups or individual therapies identified by his or her RPT. This information is found in the PSR Mall Catalog of mall groups and individual therapies.

For example, when an individual has an objective to learn a coping strategy, the RPT should:

1. Review the PSR Mall catalog for all groups that teach coping strategies and find likely groups (or individual therapy) that would enable the individual to learn the required coping strategy
2. Sort out any qualifiers and narrow down the choices (e.g., by stage of change, cognitive level, learning style, group size, mode of presentation, time of group)
3. Present to the individual the relevant groups. Describe to the individual the characteristics of the relevant groups
4. Request that the individual choose one group for this objective, and
5. Assign the individual to the group the individual has chosen.

The choice is not between what the individual would like to do (e.g., play volleyball) and a PSR Mall group (e.g., coping skills group), but between groups (or individual therapy) that the RPT has identified would help the individual fulfill an assessed need for treatment, rehabilitation, or enrichment. However, group selection can include simultaneous consideration of what the individual likes to do and what the individual needs to be able to do (i.e., they do not always have to be mutually exclusive). For example, if the individual likes to play sports, but needs to learn anger management, then an appropriate group may be anger management through tai chi or power yoga. If she likes to play music, but needs to learn social interaction skills, then she may benefit from a social interaction through rhythm instruments group. This can further facilitate motivation and promote adherence to and participation in groups that individuals need to attend in order to meet discharge, and recovery goals and objectives.

The total number of groups, and frequency of attending groups is linked to the individual‘s discharge criteria, and mental and cognitive status. For example, if the individual needs to control his or her physical aggression as a condition of discharge, it would help the individual to have a higher dosage of an anger management group. Thus, the individual may be scheduled to attend an anger management groups three times a week, but only one volleyball group a week, as an enrichment activity. Similarly, if an individual has been admitted for competency restoration, the dosage could be at least one Mall group per day, depending on mental and cognitive status.

8.3 Levels of Support in PSR Mall Services

The following terms describe the level of support available in a particular Mall activity. The Recovery Planning Team (RPT) determines the level of support an individual needs in a particular Mall activity given that individual’s cognitive level, strengths and weaknesses. The RPT psychologist is responsible for providing the PSR Mall the individual’s level of cognitive functioning.

1. **Advanced:** Mall activities labeled as “advanced” would be reserved for those individuals who can self-start and direct their own learning with little assistance. These individuals might also be able to teach others.
2. **Independent:** Mall activities labeled as “independent” are aimed at individuals who have the basic skills necessary to maintain in a Mall activity and do not require any special assistance in learning. These individuals could listen to a facilitator, take basic notes, ask questions, and answer questions without much stress or difficulty. Individuals in an independent Mall activity could take a written pre- and post-test.

3. **Assisted:** Mall activities labeled as "assisted" are aimed at individuals who have learning deficits that may require additional support (i.e., reading/writing deficits, poor listening comprehension, short attention spans), but have the basic skills necessary to maintain in a Mall activity. The content of these courses would not require individuals to do much independent work (i.e., homework) unless a study hall or tutor was available to assist at other times. The in-group content of these classes may include more activities and experiential exercises (i.e., games, role plays) than traditional "chalk and talk" groups.
4. **Supported:** Mall activities labeled as "supported" provide the highest level of support to an individual. Individuals appropriate for these activities struggle to function independently in most regards, particularly when it comes to learning. Supported activities might include individuals who do not possess even the most basic skills to participate effectively in a Mall activity (i.e., sitting still for periods of time, turn taking, tolerating others). The staff to individual ratio in these Mall activities would probably be no more than 1:3.

8.4 Requesting New Mall Groups

Once PSR Malls are fully functional at a hospital, there will be ample choice of mall groups for all individuals. However, sometimes you will find that an individual needs to attend a group not currently offered in the PSR Mall. If a needed course is not listed in the PSR Mall catalog, the RPT should request assistance from the Mall Coordinator who will respond to the request directly to the RPT within 24 hours. If a new group cannot be established in a timely manner, the RPT should provide the individual with alternative choices in terms of what is currently available. One of the tenets of psychosocial rehabilitation is that no individual is denied access to a group or individual therapy that the RPT has appropriately identified as needed for the individual's recovery.

8.5 Delivery of Interventions in Groups

The majority of services offered in the PSR Mall are in a group format. Although the group is the context for providing treatment, rehabilitation, or enrichment activities, the majority of the groups do not have a group objective. That is, all groups in core service areas have a theme or focus (e.g., job skills, ADL skills, social skills, coping skills, anger management), but each individual's objective is taught within the group. For example, in a social skills group, Katrina may have an objective to refine turn-taking skills in dyadic interactions while Angela may have an objective to increase her social conversations. In some cases, the group objective may be the same as the individual's objectives. For example, a group objective may be to teach individuals to play basketball and all individuals enrolled in the group may have an objective in their IRP to learn to play basketball as an enrichment activity. However, the group facilitator should report each individual's monthly progress towards meeting his or her IRP objective in terms of his or her participation and achievement on the *PSR Mall Facilitator Progress Note* (see Appendix 5).

8.6 Individual Therapy

If the RPT assesses an individual as requiring individual therapy, that individual should be provided individual therapy. The requirements for individual therapy are exactly the same for PSR Mall groups. That is:

1. There is an objective in the IRP that requires the individual to participate in individual therapy for a specific purpose
2. The objective states how progress will be measured (i.e., as evidenced by _____)
3. The intervention corresponding to the objective specifies who will provide the individual therapy
4. The individual's progress is assessed prior to his or her scheduled RPTC, and
5. The therapist completes the *PSR Mall Facilitator Progress Note* and makes it available to the individual's RPT prior to the scheduled IRP review.

The individual's progress should be quantified as much as possible for both groups and for individual therapy. Some hospitals may require that individual therapy be provided outside of regular PSR Mall hours because of staffing issues. Individual therapy provided as a requirement in the IRP will be counted as a part of the individual's active treatment regardless of when or where the therapy is provided.

8.7 Non-Adherence to Therapy

All individuals should be scheduled in their IRP to attend 20 hours of therapy each week-day by the 60-day IRP, or there should be clinical justification documented in the Present Status section for fewer scheduled hours. While individuals do not have the option of unilaterally dropping out of scheduled group or individual therapy, they often do. If an individual is non-adherent to IRP for more than four hours of groups in a week (excluding weekends and holidays), the RPT should develop alternative strategies for encouraging the individual to re-engage in them. The team may refer the individual for assessment of the reasons for non-adherence, and subsequent treatment using cognitive behavior therapy specifically designed for this purpose (e.g., Kemp, 1996, 1998), narrative restructuring therapy (e.g., Singh & Wahler, 2006), motivational interviewing (e.g., Miller & Rollnick, 2002), node-link mapping, or other evidence-based interventions. This assumes that some of these services are offered in the PSR Mall. If an individual is non-adherent to IRP, but at a rate less than 4 hours a week (excluding weekends and holidays), the RPT should investigate the reasons for non-attendance, and offer the individual further choices to resolve his or her reluctance to attend scheduled groups or individual therapy. In either case, non-adherence to IRP and actions taken by the RPT should be documented in the Present Status section of the individual's IRP.

8.8 Reporting Progress

Facilitators of each group and individual therapy should complete a *PSR Mall Facilitator Progress Note* on each individual served in their group or in individual therapy. The progress note should provide evidence that the individual is making (a) no progress, (b) minimal progress, (c) acceptable progress, (d) very good progress, or (e) the objective has been achieved. If minimal or no progress is being made, there should be some comment or

explanation of the reasons for it. The individual cannot remain on the same intervention for more than two consecutive months unless there is acceptable progress or documentation why progress may be slow. Note that, although providers can only measure progress toward one specific objective, the group itself is also a means of ongoing reassessment of the individual. Therefore, any ancillary observations noted during group participation about the individual's functional status or response to interventions that could possibly be important to communicate to other team members, and valuable in informing recovery planning, can also be added under comments to IRP.

The *PSR Mall Facilitator Progress Note* should be completed and made available to the individual's RPT before each scheduled RPTC. These notes are required for the 30-day, 45-day, 60-day, monthly, quarterly, and annual RPTCs. Only one note per group is required for each RPTC.

8.9 Changing Objectives

An objective should be changed when the individual meets the performance and termination criteria set in his or her IRP (i.e., as evidenced by _____). Change the group or individual therapy as soon as the individual's RPT meet at a regularly scheduled RPTC and ascertain from the *PSR Mall Facilitator Progress Note* that the individual has met the criteria on a specific objective. Only the individual and the individual's RPT can make the decision to change objectives and interventions. The individual can move on to the next objective as soon as the process of selecting the next group or individual therapy is made. The individual shall not wait until the end of the mall cycle (or term) to make this change. Make scheduling changes in the weekends and inform the new group facilitators or therapists prior to the individual's admission to a group or individual therapy.

In the case of an individual making minimal or no progress, the individual's RPT should discuss this with the individual at a regularly scheduled RPTC and jointly make changes in either the objective or the intervention. These changes are documented in the individual's IRP.

8.10 Responding to Change in Status

Review and revise an individual's IRP according to the RPTC schedule (see Section 3.3). However, an individual's RPT is also required to review and revise the IRP, as needed, under other special circumstances. The individual's RPT should review any major change in status within 24 hours of the event, and determine if changes in the IRP are needed. For example, if an individual is placed in seclusion or restraint more than three times in any four-week period, the individuals RPT should review and revise, as necessary, that individual's IRP within three business days of the third restraint. Individual instances of change in status (e.g., single instance of aggression) can be incorporated in the individual's IRP at the next scheduled RPTC.

Documentation of Seclusion and Restraints
The RPT should assess the situation and document the following in the Present Status section: 1. A review of the incident or triggered behavior within 24 hrs. of its occurrence. 2. Immediate interventions to protect the individual and/or others, including but not limited to, special precautions and/or PRN/Stat medications, as clinically appropriate.

3. Psychiatric and other interventions to decrease the risk and optimize treatment on an ongoing basis, including but not limited to adjustment of regular medication regimen.
4. Initiate follow-up, as clinically appropriate.

9 RECOVERY PLANNING TEAM CONFERENCE PROCESS

The recovery planning process is designed to be simple and meaningful. The conferences run well if there is good training, practice, and team effort. The one thing that RPTs must keep in mind is to stay focused on each individual's particular recovery needs. Make the conference focused and pertinent. Do not let the recovery planning document take your focus away from the individual. Decide what is important to discuss with each individual, and then focus on a few critical goals when meeting with the individual, and briefly touch upon the rest of the goals. This will speed up the process and flow of the conference and keep the conference focused and relevant. It will help if you can schedule the majority of the individuals in your care in at least one of the mall groups run by the team members. This will help your collective knowledge of each individual. With good training, regular practice, and a positive attitude you can get the RPTCs done effectively and efficiently.

9.1 Scheduling

The RPT Leader or Facilitator is responsible for the structural integrity of the RPTCs. This includes the following:

1. Scheduling of the RPTCs
2. Ensuring that
    a. conferences begin on time,
    b. all members are present, and
    c. if a member is not present, his or her written report is made available to the RPT at the beginning of the conference
3. A RPT recorder is specified, and
4. The individual has been invited to attend his or her IRP review.

RPTCs for each individual are automatically scheduled based on admission date. However, teams are allowed ±3 business days from the date scheduled, depending on weekends and holidays, and other practical considerations. All RPT members are responsible for collectively determining when RPTCs will be held. Each RPT should designate days and times during which RPTCs will be held in their Unit/Program, and they should adhere to this schedule. If there is a change in the routine RPTC schedule, the RPT Leader or Facilitator should notify the individual, RPT members, Program Director, the program representative responsible for posting the schedule on the local hospital intranet, family members and significant others as appropriate, RPTC observers, and outside agencies. It is the RPTs responsibility to keep schedule changes to a minimum.

9.2 Attendance at RPTC

The RPTC should occur at the scheduled time, even if all team members are not present. The requirement is that *all* team members be present. The RPT is composed of the individual, psychiatrist, clinical psychologist, registered nurse, social worker, rehabilitation therapist, and a direct care staff (i.e., health services technician, forensic services technician). In addition, others such as dietitian, pharmacist, teacher, county caseworkers, family members and significant others, as appropriate) and community representatives may also participate. The individual

may choose to be his team's facilitator, or a clinical professional who is involved in the care of the individual may facilitate the RPTC. It is the responsibility of the team to begin all RPTCs at the scheduled time regardless of an absent RPT member. If the RPT psychiatrist cannot be present, the Clinical Director should be notified so that a replacement psychiatrist can fill in for the team psychiatrist.

9.3 Timelines

The schedule for the Initial Recovery Plan and the Individualized Recovery Plans is presented in Section 3.3.

9.4 Sequence of Activities during RPTCs

There are many ways of undertaking RPTCs. RPTs achieve best outcomes in terms of the quality of IRPs and functional outcomes for the individuals served when they follow a specific sequence of activities. Here is an example of one format:

1. Prior to the RPTC, the RPT Leader or Facilitator should have:
    a. synthesized the discipline-specific assessments and consultations, and
    b. communicated the results of the assessments and consultations to the RPT members;
2. The RPT should begin promptly at the scheduled date and time.
3. The RPT leader should identify a recorder who is responsible for transcribing the conference as it occurs. If it is the 15-day IRP, the recorder should begin a new IRP template for that individual; if it is a subsequent IRP, the recorder can edit the most recent version of the individual's IRP. The recorder should use the computer and projector that are provided for this purpose. Handwritten IRPs are not acceptable in the DBHDD hospitals.
4. The RPT should identify key questions or issues to address with the individual.
5. The RPT should review risk factors (findings of the Suicide Risk Assessment, elopement risk) and complete or update the individual's clinical risk profile, as necessary.
6. The RPT should invite the individual to attend his or her RPTC, and state the reason for the conference. For example, the conference is to discuss how the individual is doing on specific objectives and interventions, determine what the individual needs and how the RPT may facilitate this for the individual, and discuss how the individual is doing in terms of progress toward discharge.
7. During the RPTC, the RPT Leader or Facilitator should
    a. ensure that all team members present a concise and non-redundant summary of the results of their new assessments prior to the discussion of objectives and interventions,
    b. review and update the individuals diagnosis, and
    c. ensure that the Present Status section of the case formulation is updated during the RPTC and that other sections in the case formulation are updated as clinically indicated, and the section on Discharge Process.

8. The RPT should update the Life Goals based on discussion prior to the conference and, when appropriate, link to treatment, rehabilitation and enrichment goals.
9. The RPT should review progress on all objectives and interventions, and make appropriate revision to the individual's IRP.
10. The RPT should review with the individual progress on each discharge criterion, and what the individual will need to do to meet each applicable criterion.
11. The RPT should request additional evaluations, information, or consultations, as clinically necessary.
12. The RPT should answer any questions the individual may have, and thank him or her for attending the RPTC.
13. The individual should receive a completed and signed copy of his or her revised IRP.
14. The RPT should discuss any outstanding issues that were not covered and complete all required documentation, and sign the revised IRP.

9.5 Language

A minority of individuals we serve are unable to speak or understand English. For them, we need to provide services in their primary or preferred language. You may need to use an interpreter or a cultural broker for this purpose (Singh et al., 1999). If the individual's preferred language is not the same as the primary language, it may be wise to go with the preferred language.

9.6 Documentation

The Initial Recovery Plan must be in the individual's medical record within 24 hours of admission. The 72-hr Initial Recovery Plan update should be in the individual's medical record within 24 hours of the RPTC. The Individualized Recovery Plan should be completed, printed, and signed by all participants immediately following the RPTC. The completed IRP must be in the individual's medical record within 48 hours. Handwritten IRPs are *not* acceptable.

9.7 Appointment Cards

The RPT should inform the individual about his or her next RPTC and issue a completed appointment card. An example of an appointment card is presented below.

Front	Back
Name: _____ ☐ 15-day ☐ 30-day ☐ 45-day ☐ 60-day ☐ Monthly ☐ Quarterly ☐ Annual ☐ Transfer Your next RPTC is scheduled for: Date: _____ Day: _____ Time: _____	Things to think about before my next conference: ➢ What are my life goals? ➢ What are my objectives? ➢ Am I meeting my objectives? ➢ Am I making progress on my discharge criteria?

10 ENGAGEMENT

In the context of recovery, engagement is the process of involving an individual (patient) to fully participate not only in the process of treatment, but also in its content. Clinicians often rely on their therapeutic alliance with the individual to involve and motivate the individual to engage in treatment. We will cover some general methods staff can use for this purpose in the therapeutic milieu, focus on specific ways of engaging the individual in the RPTCs, and finally in implementing their IRP in the PSR Mall groups and in individual therapy.

In the Therapeutic Milieu

You may have noticed that we have really great conversations when the person we are interacting with is fully attentive to what we are saying. Body language is a good indicator of an engaged listener. The disengaged listener typically looks away more often than looking at the speaker, makes negative facial expressions, and looks bored. The inattentive listener is more interested in interrupting the speaker with his own thoughts, questions, arguments, or criticisms than in listening fully to what the speaker has to say.

Depending on the context, there are a number of things that we can do to be an effective listener, thereby engaging the individual, and enhancing his recovery. Here are a few methods.

Be Fully Attentive. An individual can be difficult to engage in conversations about his therapy when he is involved in his preferred activities—such as watching TV, playing games, or other activities of his choice. It would be better if we asked him to meet with us at a specific time and place when neither of us is involved in other activities.

Similarly, sometimes when an individual approaches us with questions about his treatment and we are engaged in other activities, we are not fully attentive to his needs. For example, if the TV in the day room distracts us, other individuals in the hallway, or when we are making notes in the nursing station, we tend to either ignore the individual, or only partially respond to him. One way of engaging the individual would be to suggest another time or place when we will be able to discuss the individual's issue without disruption.

Avoid Premature Cognitive Commitment to a Response. Occasionally, our minds are made up even before an individual has completed stating his issue—we have already made a cognitive commitment to a certain response and therefore we are not really listening to the individual. Indeed, in some instances, we may even interrupt the individual with our own thoughts on the matter, especially if we disagree with the individual. Being interrupted with a negative response can be very frustrating to the individual, reducing future probability of engagement. Even if we disagree with the individual, or cannot fulfill the individual's request or demand, it is always better to carefully listen to the content of what the person is saying (as opposed to how he is saying it), understand the issue from the individual's perspective, and then respond to the individual explaining the reason for our decision—especially if it is negative. The individual is more likely to be engaged with us if he knows that we listened, tried to understand the issue from his perspective, and explained the rationale for our decision.

Reflect and Summarize. There are simple ways of letting the individual know that we have listened to him and tried to understand what he is trying to tell us. For example, some of us use reflection and summarization. *Reflection* involves making supportive comments during the conversation that shows you are actively listening to the individual.

Example:

Individual: I try to tell the nurses that I need a pen to do my homework for my Coping Skills group, but they refuse to give it to me. In fact, most of the time, they just sit in the nursing station with the doors closed chatting and pay me no mind. I bang on the door, and then they tell me I am being a nuisance. There is just no way of getting better in this place!

Staff Member: It must be very frustrating for you dealing with staff members that do not help you in your recovery.

Summarizing involves restating in a nonjudgmental manner the overall point that the individual is making. It is really helpful when the individual takes his time to make the point, or is so upset about something that he is unable to make his point clearly. It not only shows that you are engaged with him, but also may enable him to get clarity in his thinking.

Example:

Individual: You know, I have had so many medications for my psychosis that I am sick of it. None of them work for heaven's sake! I keep telling my psychiatrist that he needs to do a better job of getting me the right meds, but no, he has now given me Clozaril. It is doing me no good. Just the other day, I hit Mrs. Falconer when she demanded I get up at 7am. She came in while I was sleeping, and yelled at me to get up. "Get up now, Tommy. Get up for breakfast!" she kept yelling. I was sleepy and this irritated the hell out of me, so I got up, gave her the back of my hand, sent her screaming, and went back to sleep. Next thing I know a bunch of others came in, hauled me out of bed, and put me in restraints. Now what did I do? The meds made me do it. Man, I am sleepy and so drowsy in the mornings. I told my doc, but he says he can't help me. So what am I supposed to do? I cannot do anything when I am so sleepy.

Staff Member: So it seems your major problem is that because Clozaril makes you sleepy in the mornings, you have difficulty getting up in time for breakfast.

Ask Pertinent Questions. In everyday conversation, we ask pertinent questions to make sure we understand what people are talking about. Sometimes we fail to do this with individuals in our care because we assume we already know what they are talking about. Furthermore, we are less likely to ask questions when we are busy, or if the individual brings the same issue to our attention repeatedly. By asking clarifying questions, we can engage the individual and show we are interested in what he has to say. It is better to ask *open-ended* questions (i.e., those that promote conversation) rather than *closed-ended* questions (i.e., yes/no questions). Of course, we should not be asking questions just for the sake of asking questions, because the individual is likely to perceive it as insincerity on our part.

Display Receptive Body Language. One example of appropriate use of body language is to look at the individual when talking to him or when he is talking to you. Making faces, sighing, looking away, or paying attention to his peers or other staff when he is talking to you, ignoring him when he is knocking at your door, and so on indicates to the individual that what he has to say is not important. Instead, you can increase engagement through good use of body language, such as making appropriate eye contact, facing the individual, paying attention to him and not simultaneously engaging in other activities, displaying facial expressions that show interest in what he is saying, nodding to show you understand, and so on.

Be Open to Alternatives. As staff members, we tend to get rigid with unit or program rules, and see the rules in all or nothing terms. However, there are instances when an individual expresses needs that make clinical sense, but may fall in a grey area of rules. By listening to the individual, we can be creative in fulfilling his needs without breaking the unit or program rules. This will show the individual that we are truly invested in his recovery and value him as a person.

Be in the Present. How often have we said or heard other staff say, "Oh, that is just Tim. He is always complaining." It is best to engage the individual on the present issue and not to taint it with past behavior of the individual. Focusing on the past only reinforces a negative staff attitude that reduces therapeutic alliance with the individual. We do not see the individual in the present moment because we are stuck in the past!

Get Past the Blame. Sometimes when an individual comes to us about his issues, such as losing points or dropping a level, we tell him that he asked for it by misbehaving. This kind of staff behavior does not encourage more positive behavior by the individual in future. Indeed, it may build resistance to change. It may be better to focus on suggesting how the individual can earn his points back or work at regaining his level. It is always better to motivate the individual to try harder, to do better, and to keep his focus on recovery even when the going gets tough. Reassure the individual that we are all here to assist and support the individual's journey to recovery. After all, we are here to foster hope and not to blame the individual for missteps to recovery.

Avoid Using Absolutes. In some of our thoughtless moments, we describe other's behavior in absolute terms, e.g., "You are *always* getting into trouble!" or "You can *never* get it right." Using absolutes is not only wrong in practical terms because there are always exceptions, but also decreases the individual's motivation to change because he eventually comes to believe what he hears. At the very least, the individual is likely to get very frustrated with such comments, because he believes that we cannot see him for what he is able to do. A good alternative is to focus on the individual's current behavior in the context in which it occurs. Instead of saying "You are always a troublemaker," we could say, "You got into trouble because you pushed Roberta." Stating it this way helps us to focus on the individual's behavior rather than labeling the individual.

This is a sampling of methods that we can use to engage the individual in the therapeutic milieu, and we are sure that you can come up with many more examples. The main thing we want to emphasize is that we can positively engage the individual in his recovery by creating an environment that fosters hope. Our behavior directly and indirectly affects how well the individual will engage with us in his journey towards recovery.

During Recovery Planning Team Conferences

The methods we have described above for engaging the individual in the therapeutic milieu also applies during RPTCs.

The RPT is responsible for fully engaging the individual in the recovery planning process. The typical sequence to follow involves (a) preparation prior to the individual being invited to join the RPTC (Phase 1) and (b) collaboratively reviewing and updating his IRP (Phase 2).

Phase I involves updating the assessments, reviewing risk factors—any target behaviors (e.g., aggression, suicide, A/N/E, and so on) arising during the review period, and identifying key questions or issues the team wants to raise with the individual. Phase I should take only a few minutes.

Remember that you may discuss assessment updates before the individual joins the RPT in Phase 1, but NO diagnostic or mental status assessments are undertaken with the individual during the recovery planning process in Phase 2.

Phase 2 involves engaging the individual to review and update his or her IRP. The review and update should include, but not be limited to the following:

a. Diagnostic update, as clinically indicated
b. Present Status of the clinical case formulation, with other sections as necessary
c. Progress on each discharge criterion—engage the individual in a brief discussion of what he needs to do to meet each applicable criterion, and
d. Progress on each Goal, Objective and Intervention using the PSR Mall Facilitator Progress Notes

Before completing Phase 2, ask the individual if he or she has any questions and fully answer them. Be sure to ask if there is something more the team can do to help his or her recovery process. If he or she makes a request or suggestion, do respond fully to it and note it in the Present Status section. Set up the next RPTC date, and offer a copy of the updated IRP to the individual before he or she departs.

In the PSR Mall

A majority of individuals attend, participate, and learn new skills in their assigned mall groups. Their engagement is dependent on a number of factors, including personal motivation, the goodness of fit between what the individual needs and what is offered, the nature of the group, the ability of the group facilitator to make the group process and learning interesting, boredom factor, and personal variables (e.g., medication effects, cognitive level, stage of change). A group facilitator can enhance engagement by using various “tested” techniques that have proven to be effective teaching tools. We will briefly discuss just four of them.

Cold Call. Group facilitators like to engage all members in their group by asking questions, waiting for a show of hands, and then asking someone who has raised his hand. However, this often leads to only a few individuals to actively participate while others drift into inattention and to other activities (e.g., sleep, day dreaming). What would be ideal is if all individuals in the group pay attention and anticipate being called upon to answer questions, regardless of whether they raise their hands or not. Cold Call is a system that enables all group members to pay attention, prepare answers in their minds to all questions, and respond only when called upon.

A prerequisite for Cold Call is that the group facilitator has the names of all group members. The procedure is simple: Ask a question, and then call on the group member you want to answer the question regardless of whether his hand is raised or not. After a short while, the group members will realize that you may call on anyone in the class, so everyone must be ready to answer the question. First, it will increase engagement. Second, it will decrease and eventually eliminate inattention and day dreaming by the group members. Third, it will increase learning time because the group facilitator does not have to ask a question, wait for individuals to raise their hand, ask individuals other than the usual three or four members to raise their hand, ask an individual to respond, and then wait for an answer. In Cold Call, you ask a question, and then immediately ask an individual to respond. Third, Cold Call enables the group facilitator to distribute the questions broadly across the group members. It signals to them that not only are they likely to be asked but that the group facilitator is interested in their answers and opinions. They better be prepared!

If used skillfully, Cold Call can be used very productively to encourage engagement by individuals who are shy, or reluctant to raise their hands. If used consistently, it is predictable—it builds an expectation that anyone can be asked a question. Thus, it is a positive behavior change technology; group members begin paying more attention and mentally preparing their answers in anticipation of being asked a question. Some group facilitators keep a visible chart that tracks who has been called upon, thereby sending a clear message that everyone gets their share of questions, and that engagement is an expectation, not a choice.

Scaffolding. Most groups have individuals at different cognitive levels, with varying degrees of knowledge of the topic covered by the group. Scaffolding can be paired with Cold Call and used very effectively, especially if the group facilitator begins with simple questions and progresses to more difficult ones in each session. This enables the group facilitator to engage all group members at their skill level, reinforcing what they already know and challenging them to learn more by listening to others in the group with more knowledge of the topic.

Typically, a group facilitator begins with a simple question that is at the skill level of a group member to whom the question is directed. Once this individual is engaged, the group facilitator “unbundles” a single larger question into a series of graduated but smaller questions, and directs the questions at the skill level of successive group members, ending with the most difficult question directed at the most accomplished group member. The sequence involves calling on several, but not necessarily all, group members in rapid succession with incrementally more difficult questions. Scaffolding enables the group facilitator to parse a question to multiple group members instead of just one, thus increasing group engagement, learning and

cohesion. One useful strategy is to begin with what the group members learned in prior sessions, and then moving the questions systematically into the topic that is to be covered in the present session. This enables the group members to think their way into the next topic.

Cold Call and Scaffolding work best if the group facilitator asks a question, follows it with a pause while the group members formulate their responses, and then asks a specific individual to answer the question—i.e., Question, Pause, Name. This ensures that every group member hears the question and mentally prepares the answer in anticipation of being asked to respond. If the sequence is changed and the individual's name is called first, there is some likelihood that all other group members will sit back with a sigh, knowing that they have been excused from answering at least this question!

Call and Response. In many cultures, call and response is a form of spontaneous verbal and nonverbal interaction between a speaker and listener(s) in which the statements (calls) of the speaker are punctuated by responses from the listeners. Group facilitators can utilize this form of engagement in a number of ways. For example, the group facilitator can ask a question and ask all members of the group to respond together. The group facilitator can ask questions in rapid succession, and ask different individuals from the group to respond to each question. Another form of this involves the group facilitator directing a question to a specific person, who responds correctly, and then asking the same question to the entire group for a response. This is akin to high-energy performance where there is a lot of fun because the entire group is involved in calling out the answers in rapid succession to the group leader's questions. It invigorates the entire group, motivates high attendance, and enables learning to occur in the context of positive engagement.

Everybody Writes. In some groups, the group facilitator describes the topic, and follows it with a question to the group. When there is silence, the group facilitator is either flustered or simply answers it and moves on. This is not atypical in our mall groups. One way of engaging the group members is to give them some time to respond to the question by asking them to write their responses before discussing the answers verbally. Once the group members have had time to write their responses, the group facilitator can use Cold Call and Scaffolding to elicit the group's responses, e.g., "What did you write, Max?" This will promote engagement, both in terms of writing and responding verbally. Using a Participant Workbook will serve this purpose beautifully!

These are just some ways of engaging individuals in Mall groups in the PSR Mall. The methods we choose will depend on contextual factors—nature of topic, group characteristics, motivational level of the participants, cognitive status, skill level of the group facilitator, and so on. However, regardless of how well we do, a minority of group members will be non-adherent. They may refuse to attend the group, or attend but refuse to participate. These individuals may require different kinds of interventions to get them incrementally or fully engaged.

These individuals can be engaged through techniques such as ***Motivational Interviewing, Narrative Restructuring Therapy, Cognitive Behavior Therapy, Node Link Mapping***, and other specialized interventions. These forms of interventions are best delivered by trained therapists

and thus will not be discussed here. It is not our expectation that regular group facilitators will be required to use these techniques.

11 MONITORING AND AUDITING

11.1 Process Monitoring

Complete this observation form for all types of Individualized Recovery Planning meetings. Present your findings to the team members and provide mentoring, as needed. Begin your feedback with a summary of what the team did right, and then follow with suggestions regarding other items where the team can strengthen its performance. Discuss any differences of opinion between your observations and the team members' perceptions of their performance. Ensure your feedback is not delivered to or received by the team in a negative light.

RPTC OBSERVATION FORM				
Individual's Name:		**ID Number:**		**Program and Unit:**
RPTC Date:	**Type of Review:**	**☐15-Day**	**☐30-Day**	**☐45-Day** **☐60-Day**
		☐Monthly	**☐Quarterly**	**☐Annual** **☐Transfer**
Primary Observer:		**Secondary Observer:**		**Time:**

Instructions:
A trained independent observer completes the Recovery Planning Team Conference (RPTC) Observation. The RPT may also complete the RPTC Observation Form as a Do-Confirm checklist (i.e., have a team member use the checklist to confirm that all process action steps were completed, with quality). This is for self-check and the data are not used for any other purpose.

The primary observer will observe randomly chosen RPTCs, such that each RPT in a hospital is observed at least once per month. Only the primary observer's data are inputted into the hospital's Plato database, and timely feedback provided to the RPTs.

#	IRP Process Actions	YES	NO	INSTRUCTIONS
				Criteria for rating YES or NO
PHASE 1—without the individual				
1	Present or update assessment data			Score as Yes if any team member presents or updates assessment, or states there are no updates Score as NO if the above condition is not met.

2	Review or update risk factors (including violence, suicide and elopement risk)			Score as Yes if any team member reviews or updates risk factors or specific incidents, or states that there are no updates Score as NO if the above condition is not met.
3	Identify key questions or issues to address with the individual			Score as Yes if any team member asks if there are any key questions or issues that need to be addressed with the individual, or identifies key questions or issues to address with the individual Score as NO if the above condition is not met.
4	Invite the individual to attend the RPTC			Score as Yes if the individual is invited to attend the RPTC Score as NO if the above condition is not met.
PHASE 2—with the individual present				
5	Review or update the diagnosis			Score as Yes if the psychiatrist or psychologist reviews or updates the diagnosis, or states there is no change in the diagnosis Score as NO if the above condition is not met.
6	Update the Present Status Section of the Case Formulation, and other sections as indicated			Score as Yes if the team makes changes in the Present Status section as well as in any other section of the Case Formulation Score as NO if the above condition is not met.
7	Review each discharge criterion and discharge plan			Score as Yes if the team discusses or updates with the individual each discharge criterion, and the discharge plan Score as NO if the above conditions are not met.

8	Review with the individual what he or she needs to do to meet each discharge criterion			Score as Yes if the team reviews with the individual what he or she needs to do to meet each discharge criterion Score as NO if the above condition is not met.
9	Review progress and update each goal, objective and intervention using the PSR Mall Facilitator Progress Note			Score as Yes if the team discusses or reviews goals, objectives and interventions with the individual Score as NO if the above condition is not met.
10	Answer any questions the individual may have			Score as Yes if the team asks the individual if he or she has any questions, and responds to any questions asked by the individual Score as NO if the above conditions are not met.
11	Engage the individual in a clinically meaningful manner			Score as Yes if the team's interaction with the individual was aligned with his or her mental status and cognitive abilities, and the team attempted to engage the individual in a recovery-focused, clinically meaningful manner. Score as NO if the above conditions are not met.
12	Schedule and give appointment card to the individual for his/her next RPTC			Score as Yes if the team facilitator schedules and gives an appointment card to the individual for his or her next RPTC Score as NO if the above condition is not met.
13	Offer a copy of the IRP to the individual.			Score as Yes if the team facilitator offers the individual a copy of his or her IRP Score as NO if the above condition is not met.

11.2 Chart Auditing

The hospital's discipline-specific monitors undertake the chart audits. They audit 10% of randomly chosen IRPs and provide feedback to the RPTs within a week of the audit. The monitors should present their audit findings to the team members and provide mentoring, as needed. They should begin the feedback with a summary of what the team did right, and then follow with suggestions regarding other items where the team can strengthen its performance. Discuss any differences of opinion between the team members and the independent rater. Ensure the feedback is not delivered or received in a negative light.

The chart audit data should be entered in the Plato database following each audit.

IRP CLINICAL CHART AUDIT					
Individual's Name:		**ID Number:**		**Program and Unit:**	
IRP Date: **Type of Review:** ☐ **15-Day** ☐ **30-Day** ☐ **45-Day** ☐ **60-Day** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ **Transfer**					
Primary Reviewer:		**Secondary Reviewer:**		**Time:**	
Instructions: The Recovery Planning Team (RPT) may complete the IRP Clinical Chart Audit as a Do-Confirm checklist (i.e., do the IRP, and then confirm that everything that was supposed to be done was done with quality) following each Recovery Planning Team Conference (RPTC). This is for self-check and the data are not used for any other purpose. In addition, experienced clinicians (i.e., discipline-specific monitors) will independently audit IRPs on a monthly basis. They will audit 10% of randomly chosen IRPs, and only their data are inputted into the hospital's Plato database, and timely feedback provided to the RPTs.					
#	MONITORING STATEMENTS	YES	NO	N/A	INSTRUCTIONS
	N = All individuals in each type of IRP **n = Number audited**				**Where will you find it?** **What criteria are we looking for to rate a YES, NO, or N/A?**
1	The IRP was completed on time (check one): a. ☐ 15-day b. ☐ 30-day c. ☐ 45-day d. ☐ 60-day e. ☐ monthly f. ☐ quarterly g. ☐ annual				*Cover page* Score as YES if the date of the IRP falls within the specified timeframe (i.e. IRP criterion ± 3 days) Score as NO if the above condition is not met.

2	Pertinent History includes three clearly sequenced sections (i.e., personal history; psychiatric, behavioral, and medical history; and legal history), incorporates all relevant available information, and is not redundant				*Case Formulation: Pertinent History* Score as YES if the Pertinent History section includes all relevant information in the three sections and is not redundant. Score as NO if the above conditions are not met or only partially met.
3	The Predisposing Factors include any identified risk factors that may predispose the individual to possible negative outcomes in the absence of interventions				*Case Formulation: Predisposing Factors Psychiatric, Behavioral and Medical Risk Profile* Score as YES if there is alignment among the individual's psychiatric, behavioral and medical risk profile, Pertinent History, and the predisposing factors in the case formulation. Score as NO if the above condition is not met or only partially met. Score as NO if the individual's Psychiatric, Behavioral and Medical Risk Profile is not available in the chart. Score as N/A if the individual has no identified predisposing factors.
4	The Precipitating Factors include the precipitating factors for the individual's instant offence (if applicable) and most recent hospitalization, and any identified risk factors that may precipitate the occurrence or exacerbation of a psychiatric disorder, maladaptive behavior, or medical condition				*Case Formulation: Precipitating Factors Psychiatric, Behavioral and Medical Risk Profile* Score as YES if there is alignment among the individual's psychiatric, behavioral and medical risk profile, Pertinent History, and the precipitating factors in the case formulation. Score as NO if the above condition is not met or only partially met. Score as NO if the individual's Psychiatric, Behavioral and Medical Risk Profile is not available in the chart. Score as N/A if the individual has no identified precipitating factors.

5	The Perpetuating Factors include any identified risk factors that may continue to perpetuate adverse conditions or outcomes for the individual. In some cases, the perpetuating factors may include one or more precipitating factors				*Case Formulation: Perpetuating Factors Psychiatric, Behavioral and Medical Risk Profile* Score as YES if there is alignment among the individual's psychiatric, behavioral and medical risk profile, Pertinent History, and the perpetuating factors in the case formulation. Score as NO if the above condition is not met or only partially met. Score as NO if the individual's Psychiatric, Behavioral and Medical Risk Profile is not available in the chart. Score as N/A if the individual has no identified perpetuating factors.
6	Previous Treatment includes a synthesis of previous psychopharmacological and psychosocial treatments, and their outcomes				*Case Formulation: Previous Treatment Previous IRPs* Score as YES if the previous treatments section presents a synthesis of treatments used during the individual's current admission, or within the last 12 to 24 months, including the effects and side effects of specific medications and psychosocial treatments for identified symptoms or target behaviors. Score as NO if the above conditions are not met or are only partially met. Score as N/A if previous treatments are unknown.

7	The Present Status includes a succinct description of the individual's status across the required domains				*Case Formulation: Present Status* Score as YES if the Present Status includes a. Symptom status, with reference to psychiatric disorders, maladaptive behaviors, and psychological distress, along with current interventions and response b. Symptom status, with reference to medical conditions, along with current treatment and a medication side effects update c. Psychiatric, medical, or behavioral risk profile d. Incident and triggered events, including reviews and recommendations by the PRC and FRC as applicable e. The individual's functional status, including a description of the individual's attendance and participation in the PSR Mall and enrichment activities f. Cultural issues that may impact treatment and wellness, and g. Current legal status, as applicable. Score as NO if the above conditions are not met or only partially met.
8	The Preferred Method of De-escalation includes pertinent information from the individual's Personal Safety Interview				*Preferred Method of De-escalation* *The individual's Personal Safety Interview* Score as YES if there is alignment between the individual's preferred methods of de-escalation as stated in his/her Personal Safety Interview, or in subsequently obtained information. Score as NO if the above condition is not met or is only partially met. Score as NO if a Personal Safety Interview is not available in the chart. Score as N/A if the individual has no preferred method of de-escalation.
9	The most current diagnostic information is provided for all five Axes				*Diagnosis* Score as YES if the most current diagnostic information is included for all five Axes. Score as NO if the above condition is not met or only partially met.

10	The individual's Life Goals are stated, preferably in the individual's own words				*Individual's Life Goals* Score as YES if the individual's life goals are stated, preferably in the individual's own words, or there is a statement that the individual declined to state his or her life goal Score as NO if the above conditions are not met.
11	The Reason for Admission is stated fully				*Reason for Admission* Score as YES if a. for forensic admissions, the individual's legal status and the alleged behavior that accounts for the legal status are stated, or b. for civil commitments, the individual's clinical condition and behavior that warranted hospitalization are stated fully. Score as NO if the above conditions are not met.
12	The Discharge Criteria for the individual's anticipated placement are stated				*Discharge Criteria for Anticipated Placement* Score as YES if the individual's Discharge Criteria includes the following: a. the anticipated placement (specific or generic) b. what the individual must do to be discharged, and c. state them in behavioral and/or measurable terms. Note that (c) above may be relaxed if the individual will more easily understand simpler language. Score as NO if the above conditions are not met or only partially met.

13	The Discharge Plan describes what the staff will do to enable the individual to be discharged				*Discharge Plan* Score as YES if the Discharge Plan is written in terms of action steps (with time lines) the hospital and other agency staff (as indicated) will engage in that will assist the individual to be discharged expeditiously to the next level of care. Score as NO if the above conditions are not met or only partially met.
14	The Discharge Barriers describe what prevents the individual from being discharged				*Discharge Barriers* Score as YES if the Discharge Barriers clearly describe current personal and system issues that hinder the individual's placement in the next level of care. These issues generally include any precipitous actions of the individual that may thwart imminent placement, and systems barriers (e.g., lack of appropriate housing, court determinations, lack of funding). Score as NO if the above conditions are not met or only partially met.
15	The Discharge Process reviews provide an interval update of the individual's discharge criteria and discharge plan				*Discharge Process Reviews* Score as YES if the Discharge Process reviews provide a 1:1 update on each item in the individual's Discharge Criteria and the Discharge Plan. Score as NO if the above conditions are not met or only partially met.
16	Goal statements describe the individual's condition and a goal for the individual linked to the condition.				*Goals* Score as YES if a randomly chosen goal statement clearly states what the "problem" is, and what the individual's goal is. Score as NO if the above conditions are not met or only partially met.

17	The Objectives state what the individual will do to achieve his or her goal				*Objectives* Score as YES if each learning-based objective (linked to the Goal chosen in #16 above): a. is directly linked to the goal statement; b. is stated in behavioral, observable, and/or measurable terms, c. has a performance criterion, d. has a termination criterion, and e. states where outcomes will be documented. Score as NO if the above conditions are not met or only partially met.
18	The Interventions state what the staff will do to assist the individual achieve his or her objective				*Interventions* Score as YES if each active treatment intervention linked to each Objective in item #17 above): a. is directly linked to the objective, and states b. the name of a staff member who will facilitate the intervention, c. the title of the intervention, d. the time and days of the intervention, e. location of the intervention, and f. what the provider will teach. Score as NO if the above conditions are not met or only partially met.
19	Deferred Issues list all issues that have been deferred, with a rationale for deferral				*Deferred Issues* Score as YES if the items from a prioritized list of goals and objectives have been deferred, with a clinical or administrative rationale for the deferral. Score as NO if the above condition is not met or only partially met. Score as N/A if no items have been deferred.
20	Social Support lists all individuals the individual has nominated as a part of his or her social support group				*Social Supports* Score as YES if the Social Support list is completed, or there is a statement that the individual prefers not to provide the names of his or her social support group members Score as NO if the above conditions are not met or only partially met.
COMMENTS:					

11.3 Feedback to RPTCs

The hospital's monitors who undertake RPT observations should provide feedback to the RPTs immediately following an observation. They should discuss their observations and provide mentoring, as needed. Begin the feedback with a summary of what the team did right, and then follow with suggestions regarding other items where the team can strengthen its performance. Discuss any differences of opinion between the team members and the independent observer. Ensure the feedback is not delivered or received in a negative light.

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APPENDIX 1: STRENGTH-BASED CONVERSATIONS

STRENGTH-BASED CONVERSATIONS

Name of Individual: Age:
Hospital ID#: Admission Date:
Unit/Program: DOB:
Dates of Conversation: Facilitator:
Respondent(s), if other than individual (e.g., parents, advocates, siblings):

You can use this instrument as the basis of conversations with an individual in recovery. It is usually advisable to hold the conversation in a pleasant area, preferably in a social setting where the individual feels comfortable. Invite the individual to have something to eat or drink (e.g., coffee, soda, water) when you have one of these conversations, or when you are engaged in some task that does not require focused attention (e.g., a walk on the grounds). Make notes following, but not during, the conversation. The areas you should cover are determined by the type of information you need to assist the individual with his or her recovery. For example, if you want to know something about his or her life goals, you can use the Miracle Question and the possibility questions, or if you are interested in knowing how the individual will handle discharge, focus on the discharge questions as the basis of the conversation. You can use these conversations like a "focused assessment," developing conversations around only those areas that are most pertinent at the time.

Survival Questions:

1. How have you managed to survive or thrive, thus far, given all the challenges you have had to contend with?

2. What is going well for you right now?

3. What are you willing to do to make things work well for you?

Support Questions:

4. Who are the special people on whom you can depend?

5. Who is important to you in your life?

Exception Questions:

6. In the past, when you felt that your life was better, more interesting, or more stable, what about your world, your relationships, and your thinking was different or special? [Several issues are embedded in this one]

Possibility Questions:

7. What do you want out of life?

8. What is important to you in your life?

9. What makes life worth living for you?

10. What are your hopes, visions, and aspirations?

11. If things were different, what would you wish for?

12. If you had three wishes, what would they be?

13. What are you willing to do to make your wishes come true?

Esteem Questions:

14. When people say good things about you, what are they likely to say?

15. What do you think is unique about you that people should know?

Discharge Questions:

16. Are you anxious about being discharged?

17. Do you have any fears about being discharged?

18. What can we do to make it easier for you to live in the community?

19. Who can you count on in the community to be there for you?

20. What are you willing to do to make this transition successful?

Housing Questions:

21. What sort of housing arrangements have worked for you in the past?

22. Under ideal conditions, where would you like to live?

23. When you lived in the community, what sort of place did you live in?

24. What sort of place would you like to live in when you are discharged? Why?

25. How can we help you to find a place like this?

26. What are you willing to do to live in a place like this?

Employment Questions:

27. What jobs have you had in the past?

28. Which one(s) did you like the best? Why?

29. What sort of work would you like to do in future?

30. How can we help you get this kind of work?

31. What are you willing to do to get this kind of work?

Daily Activities Questions:

32. What do you do in a regular day?

33. What did you do before you were hospitalized (. . . or before your current hospitalization or in your previous Unit)?

34. What would you like to do in the future?

35. What are you willing to do make this possible?

General Conversation Questions:

36. What makes you happy?

37. Is religion or spirituality important in your life?

38. What are your priorities in life?

39. Who are the most important people in your life?

Life Goal Questions:

40. The MIRACLE QUESTION is often a good way to stimulate thinking about life goals and aspirations:
Suppose that while you are sleeping tonight a miracle happens. The miracle is that the issues that you have (e.g., being incarcerated, having mental illness, homelessness) are somehow solved, but you don't know that because you are asleep.

a. What will you notice different tomorrow morning that will tell you that a miracle has happened?

b. What is the first thing you will notice after the miracle happens?

c. What might your … (family member, friend) notice about you that would give him the idea that things are better for you?

d. When he notices that, what might he do differently?

e. When he does that, what would you do?

Complied for workshops on Strength-Based Conversations
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APPENDIX 2: IRP TEMPLATE

INDIVIDUALIZED RECOVERY PLAN

Regional Hospital

INDIVIDUAL'S NAME:		**ID NUMBER:**	
ADMISSION DATE:		**DATE OF CONTINUOUS ADMISSION**	

DATE:

☐ **15-Day** ☐ **30-Day** ☐ **45-Day** ☐ **60-Day**

☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ **Transfer**

LEGAL STATUS:

CASE FORMULATION:

Pertinent History
Predisposing Factors
Precipitating Factors
Perpetuating Factors
Previous Treatments and Response
Present Status

PREFERRED METHOD OF DE-ESCALATION:

DIAGNOSIS:

Axis I		Date of Diagnosis:
Axis II		Date of Diagnosis:
Axis III		
Axis IV		
Axis V	Current GAF:	Last Quarterly GAF:

INDIVIDUAL'S LIFE GOALS:

DISCHARGE PROCESS:

REASON FOR ADMISSION:

DISCHARGE CRITERIA FOR ANTICIPATED PLACEMENT:

Anticipated Placement:
Discharge Criteria:

DISCHARGE PLAN:

DISCHARGE BARRIERS:

(Delete or add blank rows in each section as needed)

GOAL # 1		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 2		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 3		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 4		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 5		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 6		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

(Delete or add blank rows in each section as needed)

GOAL # 7		DATE INITIATED:

OBJECTIVES:

OBJ. #	OBJECTIVE DESCRIPTION	REVIEW DATE

INTERVENTIONS:

INT. #	INTERVENTION DESCRIPTION

DEFERRED ISSUES:

SOCIAL SUPPORT:

Relationship to Individual in Recovery	Contact Person	Telephone

TEAM MEMBERS PRESENT					
NAME	**P-Code**	DISCIPLINE		**SIGNATURES**	**DATE**
		Individual			
		Psychiatry			
		Psychology			
		Social Services			
		RN			
		LPN			
		Dietitian			
		PT			
		OT			
		SLT			
		AT			
		Other Rehab Therapy Staff			
		Family Member			
		Advocate			
		Friend			
		PBS Team Representative			
		Primary Care Physician			
		APRN/PA			
		Advocate Non-Staff			
		HST/FST/CNA			
		Peer Specialist			
		Other Staff			
		Other Non-Staff			

Individual (Patient) Attendance: Please enter the Name and Participation Code (P-Code).

Participation Codes:

FP – Full Participation
MP – Moderate Participation
NP – No Participation

☐ The individual's Recovery Planning Team has determined he/she has met his/her discharge criteria on this date: (specify date)
☐ The individual was offered a signed copy of his/her Individualized Recovery Plan.
☐ The individual accepted a copy of his/her Individualized Recovery Plan.

INDIVIDUALIZED RECOVERY PLAN REVIEW

INDIVIDUAL'S NAME:		**ID NUMBER:**	
REVIEW PERIOD:	From To		

UPDATES on OBJECTIVES:	*(Date and describe the progress the individual has made on each objective during this review period).*	
Goals	Objectives	Summary of Progress/Actions Taken for Each Objective
1.	1.	
	2.	
	3.	
2.	1.	
	2.	
	3.	
3.	1.	
	2.	
	3.	
4.	1.	
	2.	
	3.	
5.	1.	
	2.	
	3.	
6.	1.	
	2.	
	3.	
7.	1.	
	2.	
	3.	

SIGNIFICANT EVENTS DURING THE REVIEW PERIOD:	*(List any events that may impact recovery planning or discharge).*

TEAM MEMBERS PRESENT					
NAME	P-Code	DISCIPLINE		SIGNATURES	DATE
		Individual			
		Psychiatry			
		Psychology			
		Social Services			
		RN			
		LPN			
		Dietitian			
		PT			
		OT			
		SLT			
		AT			
		Other Rehab Therapy Staff			
		Family Member			
		Advocate			
		Friend			
		PBS Team Representative			
		Primary Care Physician			
		APRN/PA			
		Advocate Non-Staff			
		HST/FST/CNA			
		Peer Specialist			
		Other Staff			
		Other Non-Staff			

Individual (Patient) Attendance: Please enter the Name and Participation Code (P-Code).

Participation Codes:

FP – Full Participation
MP – Moderate Participation
NP – No Participation

☐ The individual's Recovery Planning Team has determined he/she has met his/her discharge criteria on this date: (specify date)
☐ The individual was offered a signed copy of his/her Individualized Recovery Plan.
☐ The individual accepted a copy of his/her Individualized Recovery Plan.

APPENDIX 3: PERSONAL SAFETY INTERVIEW

Personal Safety Interview

INSTRUCTIONS: Interview individual to complete this form or provide form to the individual to complete (if preferred).

1. Calming Strategies: It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate activities that have worked for you, or that you believe would be the most helpful to you:

Voluntary alone time in your room ❒	Deep breathing exercises ❒	Reading a book ❒
Quiet time ❒	Wrapping up in a blanket ❒	Watching TV ❒
Sitting by the nurses station ❒	Listening to music ❒	Pacing the halls ❒
Talking with another individual ❒	Going for a walk with staff (if privileges allow) ❒	Exercise ❒
Talking with staff ❒	Putting hands in cold water ❒	Taking a shower ❒
Punching a pillow ❒	Putting ice on wrists ❒	Other (Please List):
Writing in a diary/journal ❒	Writing on arm with red marker ❒	
Calling a friend or family member ❒	Lying down with cold face cloth ❒	

2. What are some of the things or "triggers" that make you angry or very upset that may cause you to escalate?

Being Touched ❒	Bedroom door open ❒	Particular time of day (When?)
Loud noise ❒	Being isolated ❒	Time of year (When?)
People in uniform ❒		Being around ❒men ❒women
Not having control (explain):		
Other (Please list):		

3. Do you have preferences or concerns regarding who serves you (such as gender, race, language, culture)? If yes, describe:

   _____

   _____

4. How would I know if you are getting upset?

   _____

   _____

5. Seclusion and Restraint:
   Have you ever been placed in a seclusion room? ☐ Yes ☐ No
   Have you ever been restrained? ☐ Yes ☐ No
   If yes, what led up to the incident(s)? Tell me about the experience(s) for you:

   _____

   _____

6. Is there anything you find helpful in emergency situations that could prevent seclusion or restraint being used? If yes, describe:

_____
_____

7. Do you have any medical conditions or physical disabilities and limitations that may place you at risk if seclusion or restraint is used? If yes, describe:

   _____
   _____

8. If you have to be placed in seclusion or restraint to help keep you and others safe, would you want us to notify someone? If yes, what is that person's name and telephone number and his/her relationship to you?

   _____
   _____

9. Does it bother you if people get close to you and touch you? ☐Yes ☐No If yes, describe:

   _____
   _____

10. Trauma History:
    Have you experienced any incidents of: (a) Physical abuse? ☐ Yes ☐ No
    (b) Sexual abuse? ☐ Yes ☐ No
    If yes, are there things that remind you of the abuse and are difficult for you or cause you to act differently? If yes, describe:

    _____
    _____

    Would you find it helpful to discuss these issues with staff? ☐Yes ☐ No
    Would you like more information on these issues in classes or support groups? ☐Yes ☐ No

11. Is there anything else you would like to tell me or discuss? If yes, describe:

    _____
    _____

_____ _____ _____
Date/Time Individual's Signature RN's Signature (Print and sign name)

Additional Comments: *Use the space below to write additional information for any of the items on page 1. Specify which item number from the previous page you are responding* to:

APPENDIX 4: MATCHING INTERVENTIONS TO STAGES OF CHANGE

Stages of Change Continuum and Matching of Interventions

Stages of Change Continuum	Approaches to Recovery
Stage 1: Precontemplation	
• Denial • Defensive • Unwillingness to change • Feels coerced into treatment • Pressured by others to seek treatment • Uncommitted or passive in treatment • Unaware of having a disease, disorder, disability or deficit • Unaware of the causes and consequences of the disease, disorder, disability or deficit • Unaware of the need for treatment and rehabilitation • Lack of motivation to engage in treatment and rehabilitation • Pros of the behavior outweigh the cons	• Consciousness-raising interventions, e.g., sharing observations, confronting the individual with specific consequences of their behavior • Therapeutic alliance or relationship building with the practitioner; understanding and emotional relationship • Non-possessive warmth—the practitioner relates to the person as a worthwhile human being; shows unconditional acceptance of the person (as opposed to the behavior, e.g., addiction, offense) • Empathic understanding—extent to which the practitioner understands what the individual is experiencing from the individual's frame of reference • Catharsis—expression of emotion; practitioner engages in active listening skills, empathic observations, and gentle confrontation (reality checks) • *Motivational Interviewing*—a person-centered, directive method for enhancing intrinsic motivation to change by helping the individual to explore and resolve his or her "issues"; facilitator helps the individual to resolve his or her ambivalence with regard to change. Based on four general principles for practitioners: express empathy, develop discrepancy, roll with resistance, and support self-efficacy. • *The Intervention*—confronting the individual in a nonjudgmental, caring and loving manner • *Node-Link Mapping*—a visualization process tool that enables facilitators and individuals to develop and study the relationships between and among nodes (circles or squares) that contain elements

	of ideas, feelings, actions or knowledge. Builds alliance between facilitator and individual, focuses the individual's attention on areas of concern, and enhances treatment readiness • Facilitator approaches--authoritarian approaches to behavior change lead to greater resistance to engage in change • Facilitator emotional well-being—poor emotional well-being inhibits an individual's progress, positive well-being facilitates positive intervention outcomes
Stage 2: Contemplation	
• Aware of their issues ("problems") • Knows the need for change • Not yet committed to change • Wants to know more about his/her issues • Not yet ready to engage in change process • Thinks about engaging in change process • May have attempted to take action in the past • May be distressed with his/her situation • May express a desire to take control of the situation • Assesses pros and cons of his/her behavior and of making changes	• Continue with precontemplative stage consciousness-raising interventions and slowly introduce new interventions • Receptive to Bibliotherapy interventions • Receptive to educational interventions • *Presuppositional Questions* (from Solution Focused Therapy)—used to encourage individuals to examine and evaluate their issues, situation, or predicament. Facilitators can use presuppositional questions to think about change in a non-threatening context. • *Circular Questions*—used in a non-threatening manner to ask a question about the individual's issues, situation or predicament from the perspective of an outsider. • *Miracle Questions* (from Solution Focused Therapy)—used as a method to assist an individual in imaging change and with goal setting. Classic example: "Suppose you go to bed tonight, and while you are asleep a miracle happens and all your issues, situations, or predicaments disappear. Everything is resolved to your liking. When you wake up in the morning, how will you know that the miracle happened? What would be the first thing you would notice that is different?

Stage 3: Preparation	
• Ready to change—behavior and attitude • Needs to set goals and priorities for future change • Receptive to recovery plans that include specific focus of objectives and intervention plans • Ready to engage in rehabilitation • Engaged in change process • Cons of not changing outweigh pros	• Continue with contemplative stage awareness enhancing interventions and slowly introduce new interventions • Facilitators encourage the individual's sense of "self-liberation" and foster a sense of personal recovery by taking control of his or her life • Discrimination Training and Stimulus Control interventions can be introduced at this stage. The facilitator enhances the individual's awareness of the conditions that give rise to his issues, situations or predicaments. Focus is on the presence or absence of antecedents, setting events, and establishing operations. • *Scaling Question* (from Solution Focused Therapy)—used as a tool by the individual to "buy into" the recovery planning process. Facilitators can use it to obtain a quantitative measure of the individual's issues, situation or predicament, as perceived and rated by the individual and then assist the individual to think about the next step in the change process. Example: "On a scale of 1 to 10, with 1 being totally not ready and 10 being totally ready, how would you rate your current readiness to be discharged to the community?" If the individual self-rates as a 4, the facilitator can follow this up with, "During the next month, what steps can you take or what can you work on to get from 4 to 5?" Scaling questions can be used to (a) obtain a quantitative baseline, (b) assist the individual to take the next step in the process of recovery, and (c) encourage the individual to achieve recovery by successive approximations (i.e., in incremental steps—one point at a time, one month at a time).

Stage 4: Action	
• Committed to and is engaged in change process • Demonstrates motivation to change • Follows suggested change processes and activities • Makes successful efforts to change • Develop and implement strategies to overcome barriers • Requires considerable self-effort • Noticeable behavioral change takes place • Target behaviors are under self-control, ranging from a day to six months	• Cognitive-behavioral approaches • Explore and correct faulty cognitions—catastrophizing, overgeneralizing, magnification, excessive responsibility, dichotomous thinking, selective abstraction • Learning-based approaches • Action-oriented approaches • Skills and support rehabilitation
Stage 5: Maintenance	
• Meets discharge criteria • Maintains wellness and enhances functional status with minimum professional involvement • Lives in environments of choice • Is empowered and hopeful • Engages in self-determination through appropriate choice-making • Develops and implements strategies to sustain and enhance wellness • Avoids relapse through positive action • Expresses fear or anxiety about relapse • Avoids high risk behaviors or situations that may trigger relapse • Engages in a variety of wellness activities • Seeks social supports for maintaining wellness	• Adapt and adjust to situations to facilitate maintenance • Develop and use personal wellness recovery plans • Utilize coping skills in the rhythm of life, without spiraling down (i.e., if substance use is a problem, cope with distressing or faulty cognitions without using drugs) • Continue with dynamic change process • Accept that change is a spiral rather than a linear process • Strengthen social supports and build alliances in the community • Learn about mindfulness, especially unconditional acceptance, loving kindness, compassion for self and others, and letting go • Practice and use mindfulness strategies in daily life

APPENDIX 5: PSR MALL FACILITATOR PROGRESS NOTE

PSR MALL FACILITATOR PROGRESS NOTE			
Individual:	ID# :	Program:	Unit:
Goal from IRP #:			
Objective from IRP #:			
Intervention from IRP #:			
Cognitive Level: ☐ Advanced ☐ Independent ☐ Assisted ☐ Supported			
For Substance Abuse only: Stage of Change material is presented at: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5			
Reporting Period (Start and End Date):		Day(s) of Week: ☐ M ☐ T ☐ W ☐ Th ☐ F	
		Session Time:	
		Total Sessions Scheduled: Attended:	
Average level of participation for reporting period:			
☐ 1 - Chooses not to participate			
☐ 2 - Remains in group but does not participate			
☐ 3 - Participates minimally with numerous prompts			
☐ 4 - Participates well with minimal prompts			
☐ 5 - Participates actively and/or independently			
Individual's progress toward Objective during the reporting period:			
☐ 1 - No progress. Reassess suitability of this objective and/or intervention (see suggested alternative[s] below)			
☐ 2 - Minimal progress. Continue with this intervention (see data-based explanation in the Comments below)			
☐ 3 - Acceptable progress. Continue with this intervention (see data-based explanation in the Comments below)			
☐ 4 - Very good progress. Continue with this intervention (see data-based explanation in the Comments below)			
☐ 5 - Objective has been met. Assign new objective and/or intervention (see suggestions below)			
Comments to IRP:			
Print the name of the person who completed this form:			
Name of Group Facilitator or Individual Therapist	Signature	Title	Date
Name of Group Co-Facilitator	Signature	Title	Date

PSR MALL FACILITATOR PROGRESS NOTE INSTRUCTIONS

The PSR Mall Facilitator Progress Note is to be completed by the Primary Group Facilitator or Co-Facilitator (or therapist in Individual Therapy) immediately prior to the individual's scheduled Recovery Planning Team Conference (RPTC) during which the Recovery Planning Team (RPT) will review his or her progress on each objective and associated intervention. The individual's RPT must have this information before every scheduled RPTC following the development of the 15-day Individualized Recovery Plan (IRP). It is important that each Progress Note include an individualized assessment of progress made by the individual on a specific objective based on interventions specified in the individual's IRP for that objective. The Progress Note should be written in behavioral and measurable terms, and strive to provide both quantitative and qualitative data on progress made during the reporting period.

Progress Notes are filed in the individual's medical records for three months before being purged.

DATA FIELDS	IDENTIFYING DATA
Individual	Enter the individual's last name, first name, and middle initial
ID#	Enter the relevant detail for this individual
Program	Enter the relevant detail for this individual
Unit	Enter the relevant detail for this individual
Goal from IRP	Enter the specific Goal as identified in the individual's IRP
Objective from IRP	Enter the specific Objective as identified in the individual's IRP
Intervention from IRP	Enter the specific Intervention(s) as identified in the individual's IRP
Cognitive Level	Enter the individual's level of cognitive functioning as determined by the team psychologist
Stage of Change	Only for those groups on Substance Abuse, state the individual's stage of change: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; and 5 = maintenance
Reporting Period	Enter the period covered in this Progress Note (start and end dates)
Days of the Week	Enter the days this particular group or individual therapy is held
Session Time	Enter the average length of groups or individual therapy during this reporting period
Total Sessions Scheduled	Enter the total number of sessions scheduled during the reporting period
Total Sessions Attended	Enter the total number of sessions attended by the individual during the reporting period for which the individual was present for more than 20 minutes
Average Level of Participation	Check the box that reflects the usual level of participation, on average, for this individual during this reporting period
Individual's Progress Toward Objective During this Reporting Period	Check the box that best reflects the individual's progress on his or her specific objective for this group or individual therapy.

Comments to RPT	Provide comments to back up your assessment (above) of the individual's current status. This should include quantitative data (e.g., pre-test and post-test scores, scores on relevant rating scales), qualitative information showing progress (e.g., role plays, behavioral rehearsal, demonstration, self-report to facilitator or co-facilitator), and social validation data (i.e., has the change been noticed by the individual's significant others, e.g., staff, family members). See detailed instructions below.
Print Name of the Person who Completed this Form	Print your name
Name of Group Facilitator or Individual Therapist	Print name, sign, and date
Name of Group Co-Facilitator	Print name, sign, and date

PSR MALL FACILITATOR PROGRESS NOTES INSTRUCTIONS FOR COMMENTS TO RPT		
1. Check the box that best reflects the individual's progress on his or her specific objective for this group or individual therapy and best reflects the facilitator's recommendation to the RPT for the individual's continued enrollment in the current group or an alternate group/service. 2. If an individual fails to make progress after 2 months, the objective and/or intervention may need to be revised, if indicated.		
EXAMPLE 1: No Progress Jared has made no progress towards meeting his objective as evidenced by his inability to name any side effects of his antiepileptic medication during the last 2 months. Although Jared's objective may be suitable, the level at which this material is presented in this group may not be beneficial for him. Jared may want to enroll in the Introduction to Medical Health & Wellness group to better help him meet his objectives.		
Question Sequence	**Step-by-step Development**	**Statement Format**
What the individual did or did not do/experience?	State if the individual has made progress towards meeting his/her objective.	Jared has made no progress towards meeting his objective. . .
How do you know?	Write "is evidenced by" followed by quantitative data (e.g., pre-test and post-test scores, scores on relevant rating scales), qualitative information showing progress (e.g., role plays, behavioral rehearsal, demonstration, self-report to facilitator or co-facilitator), and social validation data (i.e., has the change been noticed by the individual's significant others, e.g., staff, family members).	. . . as evidenced by his inability to name any side effects of his antiepileptic medication
For how long?	State the time period.	. . . during the last 2 months.
Is the objective suitable?	State whether this objective is suitable for this individual as written.	Although Jared's objective may be suitable,. . .
Is the level or nature of group appropriate?	State whether the level or nature of the group matches the current functioning of the individual.	. . . the level at which this material is presented in this group may not be beneficial for him.
What can this individual do differently to meet his/her objective?	State whether the objective needs to be revised and/or the individual needs re-assignment to an alternative group.	Jared may want to enroll in the Introduction to Medical Health & Wellness group to better help him meet his current objective.

EXAMPLE 2: Minimal Progress

Heather has made minimal progress towards meeting her objective as evidenced by her sleeping for 8 hours on 1 out of 3 nights per week during this month. As Heather's objective is suitable and the level of this group is appropriate, she should continue in this group next term until she meets her objective or fails to make progress after 2 months at which time objective and/or intervention may be revised.

Question Sequence	Step-by-step Development	Statement Format
What the individual did or did not do/experience?	State if the individual has made progress towards meeting his/her objective.	Heather has made minimal progress towards meeting her objective . . .
How do you know?	Write "is evidenced by" followed by quantitative data (e.g., pre-test and post-test scores, scores on relevant rating scales), qualitative information showing progress (e.g., role plays, behavioral rehearsal, demonstration, self-report to facilitator or co-facilitator), and social validation data (i.e., has the change been noticed by the individual's significant others, e.g., staff, family members).	as evidenced by her sleeping for 8 hours on 1 out of 3 nights per week . . .
For how long?	State the time period.	. . . during this month.
Is the objective suitable?	State whether this objective is suitable for this individual as written.	As Heather's objective is suitable . . .
Is the level or nature of group appropriate?	State whether the level or nature of the group matches the current functioning of the individual.	and the level of this group is appropriate, . . .
What can this individual do differently to meet his/her objective?	State whether the objective needs to be revised and/or the individual needs re-assignment to an alternative group.	she should continue in this group next term until she meets her objective or fails to make progress after 2 months at which time objective and/or intervention may be revised.

EXAMPLE 3: Acceptable Progress

NO COMMENTS REQUIRED

EXAMPLE 4: Very Good Progress

NO COMMENTS REQUIRED

EXAMPLE 5: Objective Has Been Met

Jim has met the objective for this group as evidenced by him scoring 8 of 10 baskets during each of 10 free-throw practice sessions this month. Jim should consider taking the Basketball: The Fundamentals of Playing group with Mr. Bookman on Tue & Th at 10:40 to practice his new skills during a regular game.

Question Sequence	Step-by-step Development	Statement Format
What the individual did or did not do/experience?	State if the individual has made progress towards meeting his/her objective.	Jim has met the objective for this group . . .
How do you know?	Write "is evidenced by" followed by quantitative data (e.g., pre-test and post-test scores, scores on relevant rating scales), qualitative information showing progress (e.g., role plays, behavioral rehearsal, demonstration, self-report to facilitator or co-facilitator), and social validation data (i.e., has the change been noticed by the individual's significant others, e.g., staff, family members).	as evidenced by him scoring 8 of 10 baskets during each of 10 free-throw practice session . . .
For how long?	State the time period.	. . . this month.
Is the objective suitable?	State whether this objective is suitable for this individual as written.	
Is the level or nature of group appropriate?	State whether the level or nature of the group matches the current functioning of the individual.	
What can this individual do differently to meet his/her objective?	State whether the objective needs to be revised and/or the individual needs re-assignment to an alternative group.	Jim should consider taking the Basketball: The Fundamentals of Playing group with Mr. Bookman on T & Th at 10:40 to practice his new skills during a regular game.