SECTION - THERAPY SERVICES
ADMINISTRATIVE DIRECTIVE NO. 446
(Replaces A.D. No. 446 & 516 dated 8/9/07 & 1/11/07)

Effective Date: March 20, 2008

SUBJECT: WELLNESS AND RECOVERY PLANNING TEAM (WRPT)

I. PURPOSE

A. The purpose of this Administrative Directive (A.D.) is to define the organization, functions and responsibilities of the Wellness and Recovery Team (WRT).

B. The primary role of the WRPT is to facilitate the Individual's recovery. The WRPT's primary objective is to provide individualized, integrated therapeutic and rehabilitation services that optimize the Individual's recovery and ability to sustain himself in the most integrated, but appropriate setting. This is based on the Individual's strengths and functional and legal status. The WRPT shall support the Individual's ability to exercise his liberty interests, including the interests of self determination and independence as is required by conditions and needs of the Individual-served.

II. AUTHORITY

California Welfare and Institutions Code, Section 4312; California Administrative Code; California Code of Regulations, Title 22, Division 5; Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and the Wellness and Recovery Manual (WRM), V.2, March, 2007.

III. POLICY

Each Individual will have a comprehensive, individualized Wellness and Recovery Plan (WRP) based on the integrated assessments of the various disciplines including Psychiatry, Psychology, Nursing, Rehabilitation Therapy, and input from the Individual. Wellness and recovery services shall be created to address the Individual's needs and to assist the Individual in meeting their specific wellness and recovery goals, consistent with generally accepted professional standards of care. Such plans will be developed and reviewed on a timely basis as described in the WRM (03/2007) in collaboration with the Individual.

IV. METHOD

Overview of the Wellness and Recovery Planning Process:

A. A WRP is created in a timely fashion as outlined on page 2 of this A.D. and in the WRM, V.2, March, 2007, page 6, and revised over time by the WRT that documents a comprehensive case formulation for each Individual. The formulation is based on interdisciplinary assessments and specifies the Individual's focus of hospitalization, assessed needs and describes the interventions the staff will utilize to assist the Individual to achieve his goals/objectives based on the Individual's strengths and preferences.

1. The Admission Wellness and Recovery Plan (A-WRP) is developed by the admitting physician and the registered nurse within 24 hours of admission based on admission assessments.

2. Subsequently, additional WRPs are developed and discussed at Wellness and Recovery Planning Conferences (WRPC) at defined schedules.

3. The initial Master WRP is developed and a WRPC held within 7 days of admission, based on Integrated Assessments.

4. WRPs are reviewed and incrementally completed and conferences held as new information and clinically indicated assessments become available, but finalized by the 60th day following admission.

5. WRP reviews and conferences are performed every 14 days during the first 60 days of admission and every 30 days thereafter. The third monthly review is a Quarterly Review and the 12th monthly review is the Annual Review.

6. The WRP reviews and revisions are reviewed by the WRTs at the WRPC scheduled.

a. The WRPT consists of the Individual served, the treating Psychiatrist, Psychologist, Rehabilitation Therapist, Social Worker, Registered Nurse, and Licensed Psychiatric Technician who know the Individual best. The WRPT membership is dictated by the particular needs and strengths of the Individual in the team's care. Therefore, as appropriate, the Individual's family, guardian, advocates, attorneys, Conditional Release Program (CONREP) representative, and other staff may attend the Individual's WRPC.

b. The Team should include only team members with case loads not exceeding 1:15 in admissions teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time. All team members should be verifiably competent in the development and implementation of interdisciplinary WRPs.

c. The WRPC may be led by the Psychiatrist or Psychologist or other clinical professional who is significantly involved in the care of the Individual.

d. The Team functions in an interdisciplinary fashion and assumes responsibility for the Individual's rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.

e. The Team leader ensures that 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 therapeutic and rehabilitation services.

f. The leader ensures that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results.

g. The Team leader is responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.

V. WRT GUIDELINES

A. Individuals have substantive input into their WRPs.

B. Recovery and enrichment services are goal directed, individualized, and based on an informed knowledge of the individual's psychiatric, medical, and psychosocial factors and prior response to services.

C. The WRP considers individualized needs, is strengths-based, assesses motivation to change, and enhances the individual's mental health and quality of life.

D. WRPs are based on a comprehensive case formulation that is derived from interdisciplinary assessments. Specifically:

1. The case formulation includes a review of pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history; and the present status.

2. The case formulation considers biomedical, psychosocial, and psycho-educational factors.

3. The case formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of recovery interventions.

4. The case formulation considers cognitive assessment and other assessment center results when appropriate.

5. The case formulation enables the WRT to reach informed decisions about each Individual's treatment, recovery, enrichment and wellness needs, the type of setting to which the Individual should be discharged, and the changes that will be necessary to achieve discharge.

VI. GOALS AND OBJECTIVES

A. The WRT develops and prioritizes reasonable and attainable goals/objectives that consider the Individual's needs and strengths. If identified needs are not addressed, a rationale is stated.

B. The WRT documents the objectives in the WRP in behavioral, observable, and/or measurable terms.

C. The WRT includes all objectives from the Individual's current stage of change to the maintenance stage for each focus of hospitalization, as appropriate.

D. The WRT ensures that there are interventions that relate to each objective, specifying the provider, and the target date to assist the Individual to meet his needs.

E. The WRT assigns appropriate interventions throughout the Individual's day and strives to deliver a minimum of 20 hours of active treatment assignments per week.

F. Each time the WRPT meets for a WRPC, the Department of Mental Health (DMH) "WRPC Task Tracking Form" (MH-C 9009) is used to track all decisions to gather information (e.g., outside agencies, consultations), to conduct further assessments (e.g., psychological assessments, diagnostic interviews, cognitive screening, neuropsychological assessments), to record a decision to obtain a referral (e.g., consult with Positive Behavior Specialist [PBS] Team, neurological consult, medical consult) or to list other steps the WRPT is taking to provide appropriate services.

VII. INTERVENTIONS

A. Interventions are:

1. Provided in a manner consistent with each Individual's cognitive strengths and limitations.

2. Provided five days a week for a minimum of four hours a day for each Individual.

3. Provided in the evenings as additional activities that enhance the Individual's quality of life.

4. IVs are provided, along with necessary accommodations for Individuals with special medical problems.

5. Consistently reinforced by staff in the therapeutic milieu.

6. Individualized and group exercise and recreational options are provided.

7. Documented by group facilitator progress notes describing progress towards meeting their WRP objective in terms of participation and achievement on the DMH Psycho-Social Rehabilitation (PSR) Mall Facilitator Monthly Progress Note (see DMH PSR Mall Manual).

8. Documented by individual therapists for individual therapy. The Individual's progress is measured monthly prior to the Individual's scheduled WRPC; and the Therapist completes the DMH PSR Mall Facilitator Monthly Progress Note and makes it available to the Individual's scheduled WRPT prior to the scheduled monthly WRP review.

VIII. WRP REVISIONS

A. WRPs are revised as appropriate based on the Individual's progress, or lack of progress, as determined by the scheduled monitoring of identified criteria or target variables.

B. WRT objectives are revised as needed, to reflect the Individual's changing needs and new interventions are developed to facilitate attainment of new objectives when old objectives are achieved or when the Individual does not make progress toward achieving these objectives.

C. The WRT bases progress reviews and revision recommendations on data collected as specified in the WRP.

IX. MONITORING

A. The quality and adherence to Professional Standards of Care of Team meetings is monitored by direct observation using trained Quality Improvement monitors who have met Criteria Based Performance Standards. All team monitors use DMH Monitoring Form (MH-C 9008). The quality of Team Clinical Chart completion is conducted by trained auditors using DMH WRP clinical Chart Auditing Form (MH-C 9007). Chart auditors must meet DMH guidelines for monitoring reliability and performance as assessed by previously trained auditors.

B. Each Senior Psychologist in collaboration with the Program Director has responsibility for the effective functioning of the Teams and ensures that policies and procedures consistent with generally accepted professional standards of care are followed.

C. WRP Team Responsibilities are outlined in the WRP manual, March, 2007, Table 5.1.

Original Signature on File in QID

PAM AHLIN
(Acting) Executive Director

Cross Reference(s):
A.D. No. 434 Active Treatment Interventions
A.D. No. 438 Clinical Outcome Evaluation System

MH-C 9007 Chart Auditing Form (DMH Website)
MH-C 9008 DMH Monitoring Form (DMH Website)
MH-C 9009 WRPC Task Tracking Form (DMH Website)