DMH WELLNESS AND RECOVERY PLAN MANUAL

INSTRUCTIONS FOR WELLNESS AND RECOVERY TEAM MEMBERS

Version 2.0

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1. GENERAL PRINCIPLES

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Each State Hospital provides coordinated, comprehensive, individualized protections, services, supports and treatments (collectively "therapeutic and rehabilitation services) for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning services set forth below, each state hospital has established and implemented standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan (Wellness and Recovery Plan).

The Wellness and Recovery Plan (WRP) is the blueprint that provides each individual a roadmap for his or her recovery while he or she is in the hospital. It is a dynamic document that changes as the individual progresses from an inpatient hospital setting to the next level of care. Typically, a new admission may move through four overlapping treatment phases: acute, stabilization, stable, and recovery. Given a focus on recovery, the WRP is person-centered and the primary role of the Wellness and Recovery Planning Team (WRPT) is to facilitate the individual's recovery. Person-centered planning assumes that the individual will take increasing responsibility for his or her recovery process as treatment progresses until he or she is able to resolve his or her focus or foci of hospitalization, overcome specific discharge barriers, and transition to the next level of care. The recovery process utilizes and builds on the individual's strengths and enables him or her to use skills and coping strategies to maintain or work towards an increasing state of wellness. The focus is not on achieving a "cure," but on enabling the individual to use personal strategies and strengths to enhance functional status and to maintain and enhance quality of life.

The WRP process offers the individual, family members and relatives, the individual's significant others, and authorized representatives full opportunity to participate meaningfully in the recovery and discharge process. The WRP, developed by the individual and his or her WRPT, is individualized, person-centered, strength-based, and demonstrates respect for personal choices, hopes, cultural and spiritual values, beliefs, and practices. As a general rule, the individual should actively participate in planning his/her recovery, understand the completed plan, and agree with its goals and objectives. The individual's signature on the WRP is necessary, but not sufficient to show that these conditions have been met. Thus, the individual's level of participation, understanding, and agreement will need to be documented in the Interdisciplinary Note (IDN) by the WRPT leader. As the individual begins recovering from the specific symptoms of mental illness, and personal consequences of the mental illness and effects of hospitalization, the WRPT members should encourage and facilitate the individual to lead his or her WRPT in reviewing and revising his or her WRP.

1.1 Wellness and Recovery Planning Team (WRPT)

The WRPT membership is dictated by the particular needs and strengths of the individual in the team's care. However, at a minimum, the team will ensure that:

a. The primary objective is the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain

himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.

b. It is led by a clinical professional who is involved in the care of the individual. The team leader:

   i. ensures the team functions in an interdisciplinary fashion;
   ii. ensures appropriate parameters for participation by the individual in his or her treatment, rehabilitation and enrichment;
   iii. assumes the primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care;
   iv. 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;
   v. ensures that 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 review;
   vi. ensures that team members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions;
   vii. ensures that the Present Status section of the case formulation is updated during the WRP team meetings and that other sections in the case formulation are consequently updated as clinically indicated; and
   viii. ensures that the scheduling and coordination of assessments and team meetings, the drafting of the WRP, and the scheduling and coordination of necessary progress reviews are undertaken in a timely manner.

c. It consists of a stable core of consistent and enduring team members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse, psychiatric nurse practitioner, LVN, and licensed psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and other staff (e.g., primary care or medical/surgical physician, dietitians, dentists, physical therapists, speech and language pathologists, and pharmacy staff).

d. It includes core WRP members with a case load not exceeding 1:15 on admission teams (new admissions of 60 to 90 days) and, on average, 1:25 on all other teams at any point in time.

e. It includes staff that is verifiably competent in the development and implementation of interdisciplinary WRPs.

1.2 The Wellness and Recovery Plan (WRP)

The implementation of the WRP policies and procedures shall be consistent with generally accepted professional standards of care. Specifically:

a. Individuals have substantive input into the WRP process including, but not limited to, input as to mall groups and therapies appropriate to their WRP.

b. Individuals know their roles, right and responsibilities with regard to the development of their WRP and that they are engaged in the development and revision of their WRPs.

c. Wellness and recovery planning provides timely attention to the needs of each individual, in particular:

   i. initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plans [A-WRP]) are completed within 24 hours of admission based on Admission Assessments;
   ii. master therapeutic and rehabilitation service plans (Wellness and Recovery Plans [WRP]) are developed within 7 days of admission, based on Integrated Assessments;
   iii. the WRPs are reviewed and incrementally completed as new information and clinically indicated assessments become available, but finalized by the 60th day following admission; and
   iv. WRP reviews 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.

d. Treatment, rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.

e. WRPs are based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation:

   i. is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;
   ii. supports the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR Checklist;
   iii. addresses pertinent history, predisposing, precipitating and perpetuating factors; previous treatment history, and present status, and that the above information is aligned with the interdisciplinary assessments;
   iv. considers biomedical, psychosocial, and psychoeducatoinal factors, as clinically appropriate, for each of the factors covered in (iii) above;
   v. considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;
   vi. addresses the strengths of the individual and the system;
   vii. enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs;
   viii. includes the type of setting to which the individual should be discharged, and the changes that will be necessary to optimize treatment, rehabilitation, and enrichment outcomes in order to achieve discharge;
   ix. identifies foci, objectives, treatment, rehabilitation, and enrichment interventions; and
   x. integrates all the information in a coherent narrative.

f. The WRP specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions).

g. The WRP is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the WRPT:

   i. develops and prioritizes reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths

and address the individual's identified needs and, if any identified needs are not addressed, provides a rationale for not addressing the need;

ii. ensures that the objectives and interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);

iii. stages the applicable objectives and writes the objectives in behavioral, observable, and/or measurable terms;

iv. includes all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization (demonstrates a pathway to achieving the identified focus for Foci 1, 3, and 5);

v. ensures that there are interventions that relate to each objective (except for Health Maintenance in Focus 6), specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;

vi. implements interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week; individual therapy (including medical appointments) or group therapy included in the individual's WRP shall be provided as part of the 20 hours per week;

vii. maximizes, consistent with the individual's recovery needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate (are least restrictive and considers the individual's independence); and

viii. ensures that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the WRP and needs of the individual.

h. WRPs are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the WRPT:

i. revises the focus of hospitalization and objectives, as needed, to reflect the individual's changing needs and develops new interventions to facilitate attainment of new objectives when current objectives are achieved or when the individual fails to make progress toward achieving these objectives;

ii. documents specific rationale for continuing with an objective for more than two months in the absence of demonstrable progress;

iii. reviews the needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors); the frequency of revisions correspond to changes in the individual's functional status and risk factors (including the Triggers in the Key Indicators).

iv. ensures that the review process includes a monthly assessment of progress on current objectives related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and

v. bases progress reviews and revision recommendations on data collected as specified in the WRP (such as documentation of the individual's progress as evidenced by symptom reduction, participation in individual therapy, attendance at mall groups, and achievement of objectives in individual therapy and psychosocial mall groups); and

vi. reviews and modifies, within three business days, an individual's therapeutic and rehabilitation service plan if the individual is placed in seclusion or

restraints more than three times in any four-week period, as well as other high-risk Triggers from the Key Indicators.

1.3 Therapeutic and Rehabilitation Services

The implementation of the WRP policies and procedures shall be consistent with generally accepted professional standards of care. Specifically:

a. Individuals in need of positive behavioral supports in school or other settings receive such supports consistent with generally accepted professional standards of care.

b. Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:

   i. is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;
   ii. has documented objectives, measurable outcomes, and standardized methodology;
   iii. is aligned with the individual's objectives that are identified in the individual's WRP;
   iv. utilizes the individual's strengths, preferences, and interests;
   v. focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;
   vi. is provided in a manner consistent with each individual's cognitive strengths and limitations;
   vii. provides progress reports for review by the Wellness and Recovery Team as part of the WRP review process;
   viii. is provided five-days-a-week, for a minimum of four-hours-a-day (i.e., 2 hours in the morning and 2 hours in the afternoon each week-day), for each individual or two-hours a day when the individual is in school, except days falling on state holidays;
   ix. is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;
   x. routinely takes place as scheduled;
   xi. includes, in the evenings and weekends, additional activities that enhance the individual's quality of life (i.e., enrichment activities); and
   xii. is consistently reinforced by staff on the therapeutic milieu, including living units.

c. Adequate, individualized and group exercise and recreational options are provided, consistent with generally accepted professional standards of care.

d. Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's medical record.

e. Each individual's WRP identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], psychiatric nurse practitioner, licensed vocational nurses ["LVNs"] and licensed psychiatric technicians [LPT]) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.

f. If it serves children and adolescents, they receive services consistent with generally accepted professional standards of care.

g. Therapy relating to traumatic family and other traumatic experiences, as clinically indicated.

h. Reasonable, clinically appropriate opportunities to involve their families and significant others in treatment and treatment decisions.

i. Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.

j. Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.

k. Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.

l. Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors or equivalent.

m. Transportation and staffing issues do not preclude individuals from attending appointments.

n. Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.

o. Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;

p. Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services; they will be provided a copy of the WRP when appropriate based on clinical judgment. The contraindication for providing a copy of the WRP must be documented in the psychiatrist's progress note.

q. The staff shall educate individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.

r. WRP Teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.

The implementation of the WRP policies and procedures shall ensure that system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use are consistent with generally accepted professional standards of care. In particular, WRP policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation.

1.4 Discharge Planning and Community Integration

The implementation of the WRP policies and procedures shall be consistent with generally accepted professional standards of care. Specifically:

a. The WRPT identifies at the 7-day WRP conference, and addresses at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:

   i. those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;
   ii. the individual's level of psychosocial functioning;
   iii. any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and
   iv. the skills and supports necessary to live in the setting in which the individual will be placed.

b. The WRPT ensures that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.

c. The WRPT ensures that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:

   i. measurable interventions regarding these discharge considerations;
   ii. the staff responsible for implementing the interventions; and
   iii. the time frames for completion of the interventions.

d. The WRPT ensures that transition supports and services are provided consistent with generally accepted professional standards of care. In particular, the WRPT ensures that:

   i. individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements, and
   ii. individuals receive adequate assistance in transitioning to the new setting.

e. For all children and adolescents it serves, the hospital shall:

   i. develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months, and
   ii. establish a regular review forum, which includes senior administrative staff, to assess the children and adolescents identified in (i) above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.

1.5 Cultural Issues

There are at least two critical issues that must be considered in wellness and recovery planning. These include each clinician's cultural bias and the individual's explanatory model of mental illness.

a. Clinician's Cultural Bias
   One aspect of wellness and recovery planning includes self-analysis by the clinicians of their own cultural biases towards mental illness itself, as well as towards individuals with mental illness. In this, WRPTs should be guided by the work of Hughes (1992) who has

provided an excellent outline for such an inquiry. As summarized by Gaw (2001, pp. 16-17), the outline includes the following considerations:

i. What about this individual's appearance or behavior makes me *think* what I am seeing and hearing is pathology?
ii. What are the sources of the putative "pathologic" characterization?
iii. What label(s) am I subconsciously applying to this person, and where did these labels come from?
iv. What social class or group am I *assuming* the person belongs to, and what do I know about that? What are my own prejudices about that group, and where do such characterizations come from—childhood directives and role-modeling, family-inculcated out-group attitudes, scanning of current events that may reinforce preexisting stereotypes?
v. Other than "pathology," what other hypotheses come to mind to explain this unusual behavior?
vi. What other label could I use to describe this behavior instead of pathology?
vii. What are the circumstances of the *referral* (if a referral), and what is the descriptive *spoken* language used by other health care providers in conveying information about the person?
viii. What labels and summary inferences are used in the person's medical record or in the referral? How many of the empirical observations such labels purport to reflect can I recreate from the written record (knowing that a medical record needs to be highly selective in the amount of data reported)?
ix. What do I know about the clinician or clinicians making such comments in the record?

Information from the individual, in terms of the his or her explanatory model of mental illness, and the clinician's self-analysis provide the initial context for developing a cultural case formulation, outlines and examples of which can be found in the *Diagnosis and Statistical Manual of Mental Illness* (DSM IV-TR; APA, 2000, pp. 897-898).

b. The Individual's Explanatory Model of Mental Illness
All assessments should include an evaluation of cultural and spiritual issues of the individual that may impact assessment, rehabilitation, and recovery. While a separate assessment of these issues is not mandatory, at a minimum, the psychosocial assessment should include some information on religion and spiritual beliefs and how these beliefs may impact the individual's current condition and inform his or her psychological and social support needs. Further, there should be some assessment of his or her cultural strengths and challenges that will moderate or mediate his or her treatment. For example, knowledge of the individual's belief system may help the substance abuse counselor to decide whether the individual would be a good candidate for certain self-help groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), which use spiritual principles to maintain sobriety in their members.

Another useful cultural approach is to begin the process by learning about the individual's understanding of her psychiatric disabilities. Many years ago, Dr. Arthur Kleinman, a psychiatrist and medical anthropologist at Harvard Medical School, developed a set of eight questions that elicits a person's explanatory model of their illness or disorder. As noted by Anne Fadiman (1997), in her wonderful book on cross-cultural medicine, "The first few times I read these questions they seemed so obvious I hardly noticed them; around the fifteenth time, I began to think that . . . they might actually be a work of genius" (p. 260). Her list of Kleinman's eight questions, applied to mental illness, is as follows:

i. What do you call the disorder (—use the individual's term)?
ii. What do you think has caused the disorder?
iii. Why do you think it started when it did?
iv. What do you think the disorder does? How does it work?

v. How severe is the disorder? Will it have a short or long course?
vi. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?
vii. What are the chief problems the disorder has caused?
viii. What do you fear most about this disorder?

Asking the individual these questions in conversations, rather than in a structured or semi-structured interview, will elicit an abundance of cultural information that can be used by clinicians in selecting assessments, developing interventions, and assessing outcomes that are aligned with those of the individual. In addition, more detailed information can be obtained later in strength-based conversations. That may inform the wellness and recovery planning process.

REVIEW QUESTIONS
• What is the primary role of the WRPT?
• What is the role of the individual with regard to Wellness and Recovery Planning?
• What are the responsibilities of the clinical professional who leads the WRPT?
• What is the core membership of the WRPT?
• What are the 10 components of a well written case formulation?
• What are the prescribed functions of the WRPT?
• What are the requirements for revising the WRP?
• What are the 12 requirements for implementing psychosocial rehabilitation services?
• What is the language requirement for providing family therapy services?
• Is the WRPT required to provide a copy of the individual's WRP to the individual?
• What should the WRPT do if an individual persistently refuses to participate in therapeutic and rehabilitation services?
• What the four issues with regard to an individual's discharge that WRPTs should discuss at the 7-day and all subsequent WRP Conferences?
• What are the two critical issues that WRPTs should consider in Wellness and Recovery Planning?
• What are the eight questions clinicians should consider when assessing their own cultural biases towards mental illness and towards the individual with mental illness?
• What are the eight questions that WRPT members can ask to better understand the individual's concept of his or her mental health issue(s)?

2. BRIEF DEFINITIONS

WHAT YOU WILL LEARN
• Definitions of terms and concepts used in Wellness and Recovery Planning

2.1 The Admission Wellness and Recovery Plan (A-WRP)

The Admission Wellness and Recovery Plan (A-WRP) is developed by the admitting physician and the registered nurse at the time of admission. Based on the Admission Assessment, the A-WRP includes prioritized needs, foci of hospitalization, objectives and interventions that will be reviewed when the master Wellness and Recovery Plan (WRP) is developed on the 7th day of admission.

2.2. Wellness and Recovery Plan (WRP)

The master Wellness and Recovery Plan (WRP) is developed by the WRPT on the 7th day of admission and is based on the findings of the Integrated Assessments and an evaluation of the individual's response to the A-WRP. It provides direction for treatment, rehabilitation and enrichment activities, and addresses the individual's focus of hospitalization, objectives, and interventions.

2.3 The Wellness and Recovery Planning Team (WRPT)

The Wellness and Recovery Planning Team (WRPT) has consistent and enduring members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse, psychiatric nurse practitioner, LVN and licensed psychiatric technician who know the individual best. For school age children and adolescents, one of the individual's teachers should also be considered an enduring team member. As appropriate, the individual's family, guardian, advocates, attorneys, and other staff may attend the individual's WRPC. The individual may be the designated team leader, or the WRPC may be led by a clinical professional who is involved in the care of the individual.

2.4 The Wellness and Recovery Planning Conference (WRPC)

The Wellness and Recovery Planning Conference (WRPC) is convened to develop or review the WRP.

2.5 Case Formulation (6 Ps)

The WRP includes a comprehensive case formulation for each individual. This formulation is based on interdisciplinary assessments and specifies the individual's focus of hospitalization (i.e., goals), assessed needs (i.e., objectives) and how the staff will assist the individual to achieve his or her goals/objectives (i.e. interventions) based on the individual's strengths, preferences and interests. The 6 P's is a phenomenological approach to case formulation. It is based on facts and includes no value judgments. The 6P's include pertinent history, predisposing factors, precipitating factors, perpetuating factor, previous treatment and response, and present status.

REVIEW QUESTIONS
• What is the A-WRP?
• What is the WRP?
• What is the WRPT?
• What is WRPC?
• What are the 6Ps in the case formulation?

3. ASSESSMENTS

WHAT YOU WILL LEARN
• Timelines for various assessments
• To identify an individual's strengths and how they can be used to enhance an individual's recovery
• The purpose of WRPC Task Tracking Form
• The concept of stages of change and how it can be used to enhance an individual's recovery

3.1 Admission Assessment

The Admission Assessment is completed by the admitting physician/psychiatrist and nurse/nurse practitioner. It is completed within the first 24 hours of admission. Parts of the nursing assessment can be completed within the first 8 hours of admission.

3.2 Integrated Assessments

The Integrated Assessment is completed by the WRPT psychiatrist, psychologist, rehabilitation therapist, social worker, and the registered nurse. The clinical professional who is the WRPT leader synthesizes the assessments before the next team meeting and provides a holistic picture of the individual's assessments at the WRPC on the 7th day. This synthesis incorporates other assessments, including admitting assessments (admission history and physical examination), suicide risk assessment, other risk assessments, input from the individual (as much as possible depending on his/her mental health within the first seven days), his/her family (as appropriate) and community sources, as necessary and appropriate. Depending on the individual's needs, the WRPT may request additional assessments, including those from the core disciplines as well as from a primary care or medical/surgical physician, psychiatric technician, clinical pharmacist, dietician, vocational rehabilitation specialist, teacher, or other professionals. An assessment of cultural, ethnic, and spiritual issues of the individual that may impact assessment, and psychosocial and medical care, is typically included in the psychosocial evaluation. Further, there should be some assessment of the individual's strengths and challenges that will moderate his/her recovery.

The Admission Assessment and the Integrated Assessments are not to be temporally combined. That is, these assessments should not be undertaken at the same time.

All assessments, including forensic assessments, are conducted prior to and not during a WRPC.

3.3 Clinically Indicated Assessments

Once the Integrated Assessments have been completed and discussed, the WRPT may request further assessments as clinically indicated. These assessments are tracked on the DMH WRPC Task Tracking Form (see p. 16).

3.4 Cognitive Assessments

All adolescents and adults with cognitive impairments (e.g., developmental disabilities, dementia, 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 WRPT information and recommendations that will enable the team to assist the individual in making appropriate choices with regard to treatment, psychosocial rehabilitation, and enhancement activities. These assessments should be in the form of a cognitive screening or a psychological report and referred to in the Present Status section of the individual's case formulation.

3.5 Strengths

The individual's strengths provide the basis for developing psychosocial interventions and providing social and instrumental supports. 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.

a. The Strengths-Based Conversation is a 45-item protocol that clinicians can use as a basis for holding a conversation with the individual. 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.

b. An individual's strengths may emerge from discussions of his/her Life Goals.

c. An individual's Life Goals should be discussed prior to, but **not** during a WRPC.

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

3.6 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/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. Stage of change does not assess the individual's capacity to change because that quality is a given in all individuals.

a. The University of Rhode Island Change Assessment (URICA) is one tool which assesses the Individual's stage of change. The URICA may be completed by a staff member who has the greatest rapport with 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., aggression, substance use, mental illness).

b. An individual's stage of change may be determined clinically by a skilled clinician without using a rating scale.

DMH WRPC Task Tracking Form

Instructions: Each time the WRPT meets for a WRPC, this sheet is used to track all decisions to gather information (e.g., from outside agencies, family members, consultations), to conduct further assessment (psychological assessment, diagnostic interviewing, cognitive screening, neuropsychological assessments), to record a decision to obtain a referral (e.g., consult with PBS Team, neurological consult, EEG, hearing test) or to list other steps the WRPT is taking to provide appropriate services. Please fill in the information in the columns below. Please fill in the "Date Completed" and "Where in the chart..." columns when you have that information.

Name of Individual:

Date initiated and reason for gathering information.	What information, tests, documentation needs to be obtained?	When is this to be completed by?	Who is responsible for doing this (list name and discipline)?	Date this has been completed.	Where in the chart can we find this information?

3.7 Assessment Schedule

	Days from Admission	Assessments	Clinically Indicated Assessments
Admission Wellness and Recovery Plan (A-WRP)	1	Admission Assessments. Some nursing assessments may be completed within 8 hrs of admission.	Risk and other assessments
	5	Integrated Assessments. All completed and sent to WRPT leader	Risk and other assessments
First Wellness and Recovery Planning Conference (WRPC) to develop the initial WRP	7	Assessments are synthesized and presented to the WRPT by the team leader. 7-day WRP developed.	Risk and other assessments
Second WRPC to review and further develop the WRP	14	Further assessments, as needed, until about the 60th day	Assessments related to specific clinical questions that arise from the Integrated Assessments, case formulation, and progress of the individual
Third WRPC to review and further develop the WRP	28		As noted above
Fourth WRPC to review and further develop the WRP	42		As noted above
Fifth WRPC to review and finalize the WRP	56-60		As noted above.
1st quarterly WRPC	90		As noted above. Add: Individual's self-ratings on recovery-focused rating scales. Risk and other assessments.
Monthly WRPC	120		As noted above for first WRPC
Monthly WRPC	150		As noted above
2nd quarterly WRPC	180		As noted above. Add: Individual's self-ratings on recovery-focused rating scales. Risk and other assessments.
Monthly WRPC	210		As noted above for monthly WRPC
Monthly WRPC	240		As noted above
3rd quarterly WRPC	270		As noted above. Add: Individual's self-ratings on recovery-focused rating scales. Risk and other assessments.
Monthly WRPC	300		As noted above for monthly WRPC
Monthly WRPC	330		As noted above

Annual WRPC	360-365		As noted above. Add: Individual's self-ratings on recovery-focused rating scales. Risk and other assessments.
First monthly WRPC of 2nd year and so on			Begin with monthly cycle for 2nd year

REVIEW QUESTIONS

- Who completes the Admissions Assessments?
- Who completes the Integrated Assessments?
- What are clinically indicated assessments?
- What form is used to track clinically indicated assessments?
- What are a person's strengths?
- What instrument can be used to measure an individual's stage of change in a specific area of life functioning?
- What is the schedule of assessments that are undertaken for WRPs?

4. WELLNESS AND RECOVERY PLAN SCHEDULE

WHAT YOU WILL LEARN

- The schedule of WRPCs from the date of admission
- The schedule of WRPCs for transfers

4.1 Admission Wellness and Recovery Plan (A-WRP)

The A-WRP is completed within 24 hours of admission based on the Admissions Assessment.

4.2 Wellness and Recovery Plan (WRP)

The master WRP is completed on the 7th day of admission based on the Integrated Assessment and an evaluation of the individual's response to the A-WRP. The WRP continues to be incrementally developed over the course of the first 60 days of admission as new information and further, clinically indicated, assessments are completed.

4.3 Wellness and Recovery Plan Conferences (WRPC)

Meetings	Days in Review Cycle	Days from Admission	WRP Requirements
Admission Wellness and Recovery Plan (A-WRP)	1	1	Complete A-WRP within 24 hrs based on psychiatry and nursing assessments.
First Wellness and Recovery Planning Conference (WRPC) to develop the initial WRP	7	7	Give Integrated Assessments and the initial DSM-IV-TR Checklist to WRPT leader by the 5th day. Develop the WRP on the 7th day based on current information and assessments. Request clinically indicated assessments at this time. The individual, with the assistance of WRPT, allocates BY CHOICE points.
Second WRPC to review and further develop the WRP	7	14	Review and update WRP based on additional information and assessments. Include review of BY CHOICE data Facilitate the individual to re-allocate BY CHOICE points
Third WRPC to review and further develop the WRP	14	28	As above.
Fourth WRPC to review and further develop the WRP	14	42	As above. Update objectives and interventions using data from the *DMH PSR Mall Facilitator Monthly Progress Notes*.
Fifth WRPC to review and ***finalize*** the WRP	14	56-60	As above. Update objectives and interventions using data from the *DMH PSR Mall Facilitator Monthly Progress Notes*. Document specific rationale for continuing with an objective for more than two months in the absence of demonstrable progress. Review PBS or Behavior Guidelines data, as indicated.

1st Quarterly WRPC	30	90	Complete new assessments prior to WRPC. Review assessments, BY CHOICE data, MOSES, and outcomes for the preceding quarter. Review PBS or Behavior Guidelines data, as indicated. Review and include the individual's recovery-focused self-assessments for the preceding quarter. Update diagnosis, life goals, case formulation (especially present status), discharge criteria, and foci of hospitalization, objectives, and interventions, as indicated.
Monthly WRPC	30	120	Review BY CHOICE data and point allocations and outcomes for the previous month. Update objectives and interventions using data from the *DMH PSR Mall Facilitator Monthly Progress Notes*. Review PBS or Behavior Guidelines data, as indicated.
Monthly WRPC	30	150	As for monthly WRPC
2nd Quarterly	30	180	As for 1st quarterly WRPC
Monthly WRPC	30	210	As for monthly WRPC
Monthly WRPC	30	240	As for monthly WRPC
3rd Quarterly	30	270	As for quarterly WRPC
Monthly WRPC	30	300	As for monthly WRPC
Monthly WRPC	30	330	As for monthly WRPC
First Annual	30	360-365	Complete annual reviews prior to WRPC. Review assessments, BY CHOICE data, PBS data, MOSES, and outcomes for the preceding year. Review and include the individual's recovery-focused self-assessments for the preceding year. Update diagnosis, life goals, case formulation (especially present status), discharge criteria (discuss why the individual has not been discharged), and foci of hospitalization, objectives, and interventions, as indicated.
First Monthly WRPC of 2nd year and so on			

4.4 WRPC for Transfers

When an individual is transferred between units and/or programs, the WRPC is scheduled on the 7th day and then placed on a 30-day WRPC cycle from the original admission date. If the transfer is made within 7 days of a scheduled Monthly or Quarterly WRPC, the WRPT may complete the Monthly or Quarterly WRP in lieu of the 7-day WRP review. If the transfer is made within the first 60 days of the admission, the scheduled WRPC sequence should be continued. Furthermore, if an internal transfer occurs within the first 60 days of admission, the receiving WRPT must also be an Admission Unit (i.e., the WRPT must have a 1:15 staffing ratio) so that assessments and development of the WRP can continue.

4.5 WRPC for Readmissions

Some individuals may be discharged and readmitted to the hospital for a number of reasons (e.g., court returns, outside medical care). When an individual is readmitted in less than 90 days, the A-WRP is completed within the first 24 hours and the first WRPC is scheduled on the 7th day following readmission. If the assessments indicate no major changes in the individual's condition, the individual should be placed

on a monthly WRPC review cycle from the date of admission. If the assessments indicate major changes in the individual's condition, follow the new admission sequence of WRPCs. In either case, the assessment findings should be documented in the Present Status section of the individual's WRP. For readmissions longer than 90 days, treat the individual as a completely new admission.

REVIEW QUESTIONS

- What is the general schedule of WRPCs?
- When is the first WRPC scheduled following a transfer?

5. WRP TEAM MEMBER RESPONSIBILITIES

WHAT YOU WILL LEARN

- The individual's responsibilities
- Responsibilities of the clinical staff across disciplines

5.1 WRP Team Responsibilities at 7-Day, 14-day, Monthly, Quarterly, and Annual Reviews

RESPONSIBILITIES	Individual	Psychiatrist	Psychologist	Social Worker	Rehab Therapist	Registered Nurse	Psychiatric Technician
1. The team member is in attendance	X	X	X	X	X	X	X
2. The Present Status of the case formulation is updated, including diagnosis (based on DSM-IV-TR Checklist)	X	X	X	X	X	X	X
3. The WRPC Task Tracking Form is reviewed	X	X	X	X	X	X	X
4. DMH WRP Attachment Forms are reviewed		X	X	X	X	X	X
5. Objectives and interventions are discussed.		X	X	X	X	X	X
6. Risk assessment data are discussed		X	X	X	X	X	X
7. BY CHOICE points are reallocated	X	X	X	X	X	X	X
8. PBS data are discussed, if applicable			X				
9. MOSES data are discussed						X	X
10. Medical conditions and medications are discussed		X				X	X
11. Individual's questions are answered		X	X	X	X	X	X
12. All changes to the WRP are discussed with the individual		X	X	X	X	X	X
13. Progress toward discharge and what the individual needs to do prior to the next conference is discussed		X	X	X	X	X	X
14. An appointment card is given to the individual for the next WRP conference						X	X

REVIEW QUESTIONS

- What are the responsibilities of the individual at each of the WRPCs?
- What are the responsibilities of the clinical staff across disciplines at each of the WRPCs?

6. DMH WRP FORM TEMPLATE

WHAT YOU WILL LEARN

- The format of the DMH Wellness and Recovery Plan
- Forms associated with the DMH Wellness and Recovery Plan

The DMH WRP template, DMH WRP Attachment Form, Medical Conditions Form, and the Temporary Conditions Form are presented in Appendix A. All of these forms are currently on a MS Word template that will eventually be web-based and available on the DMH website.

REVIEW QUESTIONS

- Do you know how to use the DMH Wellness and Recovery Form template?
- Identify the ancillary forms are attached to the DMH Wellness and Recovery Form template?

7. COMPLETING THE DMH WRP FORM

WHAT YOU WILL LEARN
• The key components of the DMH Wellness and Recovery Plan
• The essential content of each component of the DMH Wellness and Recovery Plan

The WRP includes the following components: diagnosis, case formulation, life goals, discharge criteria, focus of hospitalization, objectives and interventions for each issue identified in the focus of hospitalization.

7.1 Diagnosis

a. Include all five DSM-IV-TR Axes.
b. The diagnoses of record are listed in the individual's most recent WRP.
c. Include the diagnoses developed by the psychiatrist or psychologist for the 7-day WRP. The five Axes are revised at any WRPC if the individual's condition changes due to therapy or as new assessment data or other pertinent information become available. The psychologist, with contribution from other team members, will complete the DSM-IV-TR Checklist that validates the individual's diagnoses.
d. Include the appropriate DSM IV-TR diagnostic codes before listing each Axis I and Axis II diagnosis.
e. Document differential diagnosis. Resolve "deferred" or "rule-out" diagnoses in a timely manner (i.e., within 60 days) through clinically appropriate assessments. Document justification for a valid "NOS" diagnosis.
f. Document justification for a valid "No Diagnosis" on either Axis I or Axis II.
g. Document the original 7-day Axis I and Axis II diagnoses and subsequent revisions and rationale in the psychiatrist's psychiatric evaluation or progress notes. The diagnostic formulation in the psychiatrist's progress notes should include, at a minimum, (i) two or three sentences that summarize relevant historical and mental status data, and (ii) two or three sentences that provide a synthesis of the information gleaned from the assessment that supports DSM-IV-TR diagnosis. For example, in an individual diagnosed with dementia, the psychiatrist/psychologist should indicate the presence of multiple cognitive deficits, decline in executive functions, and deterioration when compared to a previous level of functioning. Another example is a diagnosis of substance-induced mental disorder. In this case, the psychiatrist should indicate a specific cluster of symptoms in the context of substance use and their absence during periods of abstinence.
h. Include the Axis I and Axis II diagnoses in Focus 1 and/or Focus 3
i. List in Axis III only those medical conditions that affect Axis I and II psychopathology or their management. These will be listed again under Focus 6 with other medical conditions, excluding temporary medical conditions.
j. List in Axis IV the stressor(s) for the individual for the past 12 months. Use the DSM-IV-TR categories; these may be the individual's risk factors and have implications for discharge and community integration. These stressors should be linked to the individual's objectives and corresponding interventions.
k. Report the Global Assessment of Functioning (GAF) score in Axis V based on the team's collective assessment of the individual. As clinically indicated, the individual should participate in determining his or her GAF score. The last Quarterly GAF is also included. The GAF form on page 25 can be used for this purpose. If an individual is positive for any of the five (5) problem areas within a score range, he or she is given a score within that range even if he or she is functioning at higher levels in other problem areas.

GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF)

Problem Areas → Score Ranges ↓	Disturbance of Functioning in School, Work, Socially & Personally	Disturbance of Emotion	Communication Impairment	Danger to Self or Others	Delusions / Hallucinations
100 - 91	Superior functioning in all areas	**********	**********	**********	**********
90 - 81	Good functioning in all areas	Minimal symptoms: e.g., mild anxiety prior to a test	**********	**********	**********
80 - 71	Slight impairment: e.g., falling behind in schoolwork	Transient & expectable reaction to stress, e.g., difficulty concentrating after an argument	**********	**********	**********
70 - 61	Some difficulties: e.g., occasional truancy or theft within the household	Mild symptoms: e.g., depressed mood, mild insomnia	**********	**********	**********
60 - 51	Moderate difficulties: e.g., few friends; conflicts with peers or co-workers	Moderate symptoms: e.g., flat affect, occasional panic attacks	Circumstantial speech	**********	**********
50 - 41	Serious impairment in one area: e.g., no friends; unable to keep job; shoplifting	Serious symptoms: e.g., obsessional traits	Circumstantial and / or tangential	Suicidal ideations	**********
40 – 31	Major impairment in several areas	Major impairment in mood	Illogical, obscure, irrelevant	Suicidal ideations	Impaired reality testing
30 - 21	Inability to function in almost all areas	Grossly inappropriate or impaired	Sometimes incoherent	Suicidal preoccupation	Behavior influenced by auditory or visual hallucinations and/or delusions
20 - 11	Occasionally fails to maintain minimal personal hygiene: e.g., smears feces	Grossly inappropriate or impaired	Largely incoherent or mute	Some danger of hurting self or others, e.g., attempts without clear expectation of death; violent	Behavior influenced by auditory or visual hallucinations and/or delusions
10 - 1	Persistent inability to maintain minimal personal hygiene	Grossly inappropriate or impaired	Largely incoherent or mute	Persistent danger of severely hurting self or others	Behavior influenced by auditory or visual hallucinations and/or delusions
0	Inadequate information	**********	**********	**********	**********

7.2 Legal Status

a. State the code number(s) in the Legal Status section.
b. Write out the complete status, e.g., PC 1370 (Incompetent to Stand Trial).

7.3 Case Formulation

Develop a phenomenological case formulation based on the 6P format. The WRPT should undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. The factors are not mutually exclusive and will vary with each individual. For example, substance abuse can be a precipitating factor, a perpetuating factor or both. Overall, the case formulation should contain at least the following: (a) a brief summary of the precipitants to hospitalization; (b) the individual's strengths; (c) likely discharge placement; (d) the necessary and sufficient goals and outcomes of inpatient treatment; and (e) barriers that will need to be resolved to achieve specific clinical outcomes and transition to the next level of care. This formulation provides the basis for collaboration with the individual in the development of the WRP. The DMH WRP Case Formulation Worksheet (see page 27) should be used to sketch out the pertinent details before the WRPT synthesizes and writes the actual case formulation.

Consider the following issues when synthesizing the data and developing the case formulation:

a. Is the information (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) aligned with the assessments?
b. Is the case formulation interdisciplinary (i.e., does the information reflect participation by all relevant disciplines?)
c. Does the case formulation include a review and analysis of important clinical factors across multiple domains (medical, psychiatric, behavioral, functional status, and quality of life) that are relevant to the WRP?
d. Does the case formulation support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists
e. Does the present status section of the case formulation adequately summarize needs of the individual in the three main domains: treatment, rehabilitation and enrichment?
f. Does the case formulation identify required changes in individual, providers and systems to optimize treatment, rehabilitation and enrichment outcomes?
g. Does the case formulation discuss the individual's current status with regard to his or her discharge criteria?
h. Is there evidence of proper analysis of information (i.e., does the case formulation allow adequate identification of foci, objectives, interventions?)
i. Is there proper linkage within different sections of the case formulation?
j. Does the case formulation account for strengths of the individual, providers and the system?
k. Does the case formulation include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status?
l. Does the case formulation include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors?

The case formulation can be structured as follows:

7.3.1 Pertinent history

Describe pertinent history in the following sequence:

a. Personal: Begin with a brief sketch of the individual (social history, e.g., age, education, employment, family of origin, course of life, current support system).

DMH WRP CASE FORMULATION WORKSHEET

6Ps	Bio-Medical	Psychosocial	Psychoeducatoinal
Pertinent History			
Predisposing Factors			
Precipitating Factors			
Perpetuating Factors			
Previous Treatment & Response			
Present Status			

b. Psychiatric: Follow with a brief description of the individual's history of mental illness (brief psychiatric history, course of illness)
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).

7.3.2 Predisposing factors

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

a. Biological considerations (e.g., prenatal and genetic factors, complications during pregnancy or delivery, mother's use of substances during pregnancy)
b. Psychosocial considerations (e.g., parental divorce or separation, family dynamics)
c. Emotional, physical, or sexual abuse
d. Medical illnesses/risks
e. Head trauma

7.3.3 Precipitating factors

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

a. The precipitating factor(s) of the initial event which led to first hospitalization
b. The precipitating factor(s) which led to current hospitalization
c. The precipitating factor(s) which led to any forensic involvement
d. Medication non-adherence
e. Medical conditions
f. Major psychosocial stressors
g. Substance and alcohol abuse

7.3.4 Perpetuating factors

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

a. Personality disorders
b. Chronic medical conditions
c. Substance and alcohol abuse
d. Current status of psychiatric disorder(s)
e. Family issues
f. Non-adherence to treatment protocol, including medication regimen.
g. Physical and therapeutic milieu, e.g., overcrowding, behavior of staff and peers, lack of choice
h. Lack of social supports
i. Lack of needed treatment
j. Axis IV stressors

7.3.5 Previous treatment

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

a. Include treatments utilized during the course of the individual's psychiatric illness, response to previous treatments, adverse effects of psychotropic and other medications, culture-based treatments, and psychosocial interventions
b. The information addressed here is all-inclusive in terms of history of treatment
c. Information from the last quarterly Present Status is integrated here to expand all-inclusive response to therapeutic and rehabilitation services

7.3.6 Present status

Describe present status 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, and behavioral factors/psychological distress. For each of the disorders, include current interventions and response (include medications and psychosocial interventions). Update on the status of any behavioral interventions (Behavior Guidelines, PBS plans) and BY CHOICE point allocation.
b. Document findings of assessments of status of psychiatric, medical and behavioral risk factors (e.g. suicide, assault) or other vulnerabilities covered under predisposing, precipitating, and perpetuating factors.
c. Describe all medical conditions, with an update on their current status and treatment. Update medication side-effects, including data from most recent MOSES.
d. Describe functional status in terms of what the individual is able to do at present, e.g., self-care, adherence to WRP, skills, and strengths. Include a description of the individual's attendance and participation in PSR Mall and enrichment activities.
e. Describe cultural issues that may impact the individual's interventions and wellness, general wellness concerns, and areas in need of further intervention.
f. Describe current legal status as related to discharge status.
g. Describe progress towards discharge status and any barriers to discharge. State how the team is helping to overcome the barriers.
h. Review the individual's self-assessment of recovery (quarterly).
i. If there is a DMH WRP Attachment Form for the individual during the review period, describe the issue (e.g., new maladaptive behavior, medical condition, a Key Indicator has been triggered) and how it has been resolved (i.e., the issue has been resolved during the review period and no further action is necessary, further assessments have been requested, or the issue has been incorporated in the objectives and intervention sections of the WRP).

7.4 Life Goal

The Life Goal is a statement of the individual's vision of recovery, including dreams, hopes, and aspirations. It also includes the individual's desire for further education and occupational skills. Life goals are best stated as a quotation in the individual's own words. If the individual is unable to or does not want to express his or her life goals, state it as such. However, steps need to be taken to encourage the individual to begin developing his or her life goals within the first 60 days of admission. This effort should be documented in the Present Status section of the individual's WRP. Further, an individual may express his or her life goals in terms of what he or she hopes to achieve during inpatient hospitalization; however, this is not a life goal, but a short-term goal. The individual's life goals should be discussed and ascertained prior to, but not during any WRPC. It is best elicited by staff who knows the individual well, such as the individual's Case Manager. The information on Life Goals is best obtained in conversations with the individual, over time, and later included in the WRP. The Strength-Based Conversation is an ideal tool to facilitate the process of understanding the individual's Life Goals. In addition, the Strength-Based Conversation can also assist in identifying strengths which staff can use in their interventions to help the individual meet his or her objectives. The individual's Life Goals should be linked to appropriate Foci of Hospitalization, as appropriate, corresponding Objectives, and relevant Interventions.

7.5 Discharge Criteria

Discharge planning begins at admission to the hospital. The hospital's discharge criteria are the admission criteria for the next level of care. The discharge criteria describe the improvements in the individual's behavior and symptoms that should occur as a result of the interventions provided in order to transition to the next level of care, typically into the community or another agency. The criteria should be individualized and written in behavioral, observable and/or measurable terms.

They must be written in simple and clear language the individual can understand and reflect what he or she must do in order to be discharged to a specific place. Avoid writing discharge criteria that cannot be met. In addition, avoid writing a criterion that does not pass the Dead Man's Test, i.e., a criterion that a dead man will be able to achieve—in the negative, e.g., Ms. Coleman will not hit others for 6 months. This could be better stated as, "Ms. Coleman will be able to control her anger and not hit anyone for 6 months."

The discharge criteria for individuals who are Not Guilty by Reason of Insanity must be aligned with the criteria that CONREP uses for release to the next level of care (e.g., dangerous behaviors, if currently relevant; understanding of their mental illness and its role in the offense; understanding of the seriousness of the offense). CONREP will usually present their criteria in behavioral, observable and/or measurable terms. If not, then the WRPT may have to rephrase the CONREP criteria in behavioral, observable and/or measurable terms, as necessary. The criteria for individuals who are Incompetent to Stand Trial must be aligned with the legal requirements for their discharge and other mental health criteria that the WRPT deems essential.

7.6 Focus of Hospitalization

The focus of hospitalization documents the reasons why the individual was admitted and quality of life issues that can be enhanced while the individual is at the hospital. The foci are divided into 11 arbitrary categories for ease of documentation:

1. Psychiatric and Psychological
2. Social Skills
3. Dangerousness and Impulsivity
4. Hope and Spirituality
5. Substance Abuse
6. Medical, Health and Wellness
7. Legal
8. School and Education
9. Occupational Skills
10. Leisure and Recreation
11. Community Integration

Each focus of hospitalization is described in behavioral and/or measurable terms. For example, nonspecific signs and symptoms (e.g., depressed) or general statements (e.g., lacks insight) can be individualized by adding, "As shown by . . .," "As demonstrated by. . .," "In response to . . .," "As manifested by. . .," or "As evidenced by. . . ." Adding the clarifiers will prompt the WRPT members to include the individual's observable behaviors and activities.

The following suggestions may help you in developing each focus of hospitalization:

1. Psychiatric and Psychological
    a. Write the focus in this manner: *James has hallucinations as evidenced by him talking to a person who is not present and self-report of hearing voices.*
    b. If the WRPT has completed the DSM-IV-TR Checklist of symptoms, team members can describe sequentially each symptom that James exhibits in behavioral and/or measurable terms.
    c. If symptoms are currently well-managed, include a statement to this effect (e.g., this symptom is well controlled by current interventions).

2. Social Skills
    a. Write the focus in this manner: *James does not use turn-taking in conversations as evidenced by interrupting others when they are in conversation.*
    b. Include general social interaction skills
    c. Include self-esteem issues

3. Dangerousness and Impulsivity
    a. Write the focus in this manner: *James hits staff when he does not get his cigarettes when he wants them.*
    b. Include instrumental aggression and destructive behaviors
    c. Include suicidal and homicidal behaviors

4. Hope and Spirituality
    a. Write the focus in this manner: *James has lost all hope of ever being discharged because he has been turned down four times by CONREP for community placement.*
    b. Include all issues dealing with reviving hope in the individual. The individual may have lost hope of getting better due to his mental illness, of getting a job due to the stigma of mental illness or as a result of the consequences of having a serious and persistent mental illness, or of being discharged from the hospital due to various issues.
    c. Include all issues dealing with spirituality (and religion).
    d. Individualized "pastoral counseling" is included here. If the individual attends a church, temple, or other house of worship that is available to everyone, this is not included.

5. Substance Abuse
    a. Write the focus in this manner: *James has a history of using cocaine and was under its influence when he committed the crime that resulted in his most recent arrest and current admission to this hospital.*
    b. Specify the drugs involved
    c. An individual having a history of substance abuse, or engaged in substance abuse many years ago, may not need to have a substance abuse focus if he or she has successfully completed the required self-management training in substance abuse.

6. Medical, Health and Wellness
    a. Write the focus in this manner: *James has asthma as evidenced by staff observation and self-report of shortness of breath during daily activities and upon physical exertion.*
    b. List all medical problems (except for Temporary Conditions, defined as medical conditions that last up to 10 days, or as defined by each hospital but not exceeding 30 days)
    c. List temporary medical conditions on the Temporary Conditions Form
    d. List Health Maintenance conditions, as clinically indicated
    e. Health Maintenance conditions do not need Objectives and Interventions. The nurses will simply follow the doctor's orders. Write the Health Maintenance focus in this manner: *Health Maintenance Condition (i.e., list all current conditions for this individual): Treat as per doctor's orders.*
    f. Include self-care needs, as indicated.

7. Legal
    a. Write the focus in this manner: *James was admitted because he was judged to be incompetent to stand trial (PC 1370).*
    b. Use this focus only for those individuals committed for a legal reason for which a course of training has to be provided as a requirement of the commitment.

8. School and Education
    a. Write the focus in this manner: *One of James' life goals is to attend a community college for which he needs to have a GED.*
    b. Include educational areas addressed in the individual's Life Goals

c. Include any educational activities the individual would like to engage in that may assist in his or her recovery or enhancement of quality of life.

9. Occupational Skills
    a. Write the focus in this manner: *James has expressed a vocational interest in computer graphics.*
    b. If an individual has expressed an interest in learning a particular trade or vocational skill, it should be included in this focus.
    c. Typically all vocational and industrial therapy (IT) placements should be included in this focus so that it can counted towards an individual's active treatment hours.

10. Leisure and Recreation
    a. Write the focus in this manner: *James enjoys playing basketball and wants to practice and play basketball with his peers.*
    b. If an individual is using leisure and recreation activity for rehabilitation, it should be listed under the appropriate focus, but not in Focus 10. For example, playing volleyball to lose weight should be considered under Focus 6 (Medical, Health and Wellness) because it is a part of his habilitation plan and the outcome is measured by a change in weight and not time engaged in playing volleyball.
    c. Any item listed under this focus is provided during scheduled Mall hours and counted as a part of the individual's active treatment.

11. Community Integration
    a. Write the focus in this manner: *James has been a long-term resident in psychiatric hospitals and is fearful of being discharged to a new place where he will not have his usual social supports.*
    b. Issues addressed in this focus include when an individual wants to remain in the hospital, does not want to go to jail when required to, and fear of community placement. Administrative reasons (i.e., shortage of community homes) are not included here and should be dealt with at an administrative level by staff (and not the individual).
    c. Only for individuals on civil commitments, address the issue of providing them services in the most integrated, non-institutional setting. Write the focus in this manner: *James needs to practice shopping, banking and money management skills in the community.*

7.7 Objectives

Each objective must be defined or stated in behavioral, observable and/or measurable terms. When objectives are stated in this way, it provides the individual and staff with specific thresholds for measuring outcomes of interventions. The objectives are written in relation to what the individual will be able to do within a specific time frame. Learning is enhanced if the focus is on a small number of objectives, especially if the individual has cognitive deficits.

There may be one or more objectives for each focus of hospitalization. Sometimes, these objectives may be sub-divided into smaller steps. Regardless of the number of objectives, each one should

a. be stated in behavioral, observable and/or measurable terms. For example, if it is a frequency count, specify the time frame (i.e., hour/day/week) and the schedule for data collection. Remember to include baseline measures against which the data can be evaluated or compared. Specify who will collect the data. Be realistic and do not burden the level-of-care staff with excessive data collection. Try to use data that are already being collected for other purposes (e.g., use of PRN meds; seclusion/restraint).
b. be linked to the focus of hospitalization

c. pass the "dead man's test." For example, "James will not hit a staff member for one month" is not a good objective because a dead man can pass this test! To make it acceptable, this objective can be paired with another that requires James to actually learn a skill in a socially acceptable manner to manage his assaultive behavior
d. have a time frame (review date) for assessment of progress
e. be written in terms of what the individual will do, and
f. be attainable given the individual's current level of functioning (e.g., cognitive status or stage of change).

7.7.1 Objectives for an Individual with a Maladaptive Behavior

If an individual has a maladaptive behavior, the team psychologist may develop Behavior Guidelines or the PBS team may develop a PBS Plan for the individual and staff as specified in the PBS Manual. The Objective in the individual's WRP may read as follows:

Angela will learn to manage her anger by utilizing coping strategies as evidenced by weekly self-report to her case manager every Friday at 3pm, and data on angry outbursts as recorded by staff in the nursing progress notes.

7.7.2 Stages of Change

In some core areas of mental health (e.g., psychiatric disorders, psychological distress, dangerousness and impulsivity, and substance abuse) we assess the individual's understanding of his or her mental illness and willingness to engage in treatment and rehabilitation. This requirement is specific to Focus 1, 3 and 5.

The following are the five stages of change as conceptualized in one model:

a. **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 of their psychiatric or behavioral challenges.
b. **Contemplation** is the stage in which individuals are aware that a challenge exists and are seriously thinking about overcoming it, but have not yet made a commitment to take action.
c. **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 year.
d. **Action** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their challenges. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
e. **Maintenance** is the stage in which individuals work to prevent relapse and consolidate the gains attained during action. For addictive behaviors, this stage extends from six months to an immediate period past the initial action.

Transitions between the stages of change are effected by a set of independent variables known as the process of change. The model also incorporates a series of intervening or outcome variables. These include decisional balance (i.e., the pros and cons of change), self-efficacy (i.e., confidence in the ability to change across problem situations), situational temptations to engage in the problem behavior, and behaviors which are specific to the problem area. Also included among these intermediate or dependent variables would be any other psychological, environmental, cultural, socioeconomic, physiological, biochemical, or even genetic variables or behavior specific to the problem being treated.

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. The following table provides general guidelines for selecting appropriate interventions. The table does not provide an exhaustive list of relevant interventions.

Stages of Change Continuum and Matching of Interventions

Stages of Change Continuum	Approaches to Psychiatric Rehabilitation
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 • Nonpossessive 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"; practitioner facilitates 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 practitioners 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 practitioner and individual, focuses the individual's attention on areas of concern, and enhances treatment readiness • Practitioner approaches–authoritarian approaches to behavior change lead to greater resistance to engage in change • Practitioner 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") • Know the need for change • Not yet committed to change • Want to know more about their issues • Not yet ready to engage in change process • Thinking about engaging in change process • May have attempted to take action in the past • May be distressed with their situation • May express a desire to take control of the situation • Assessing pros and cons of their 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. Practitioners can use presuppositional questions to think about change in a non-threatening context. As an example, consider an individual who thinks he does not have a problem and is waiting to be released to CONREP. The practitioner's presuppositional question could be, "Let's agree that what you are saying is true . . . 'How would you know when you are ready to be released to CONREP?'" • *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. Consider the individual used in the example above. The practitioner may ask: "How would the CONREP representative know when you know that you are ready to be released?" • *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 • Need to set goals and priorities for future change • Receptive to treatment plans that include specific focus of interventions, 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 • Practitioners 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 practitioner 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 treatment planning process. Practitioners 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 CONREP?" If the individual self-rates as a 4, the practitioner 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	
• Meet discharge criteria • Be discharged • Maintain wellness and enhance functional status with minimum professional involvement • Live in environments of choice • Be empowered and hopeful • Engage in self-determination through appropriate choice-making • Develops and implements strategies to sustain and enhance 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

• 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	• 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

For objectives that are staged (i.e., those for Focus 1, 3 and 5), there is a requirement that the first objective begin at the individual's current stage and end with the anticipated maintenance stage. For example, an individual who is at the precontemplation stage with regard to substance abuse will have his or her first objective at the precontemplation stage, followed successively by objectives at the contemplation, preparation, action and maintenance. However, the interventions associated with the objectives need to be written only for the objective that is active. Thus, for the individual at the precontemplation stage, interventions linked to the objective at the precontemplation stage should be listed in the intervention section of the WRP.

For objectives that are staged, the staging begins at the 7-day WRPC. If data are available, an objective at the individual's current stage of change is developed and the individual is given a choice of relevant groups (and/or individual therapy) to attend. As the individual settles in and as the WRPT has time to undertake further assessments, additional objectives are developed at successive WRPCs until the 60th day of admission by which time the individual's WRP must be completed, including objectives to the anticipated maintenance stage.

7.8 WRP Interventions

Once the Foci of Hospitalization are categorized in the 11 domains and the objectives developed, the WRPT collaborates with the individual to develop interventions linked to the objectives. Typically, individuals with mental illness can be helped to stabilize their condition and recover more rapidly with a small number of treatment objectives at a time. The optimum number of objectives has to be determined for each individual depending on his or her strengths and current functional status. One method of prioritizing treatment objectives is to first develop interventions to meet the individual's discharge criteria, followed by interventions for secondary issues that may contribute to discharge and, finally, by interventions for other conditions that will continue to enhance the individual's quality of life.

An individual will have several interventions, with each one being linked to a specific objective which, in turn is linked to a specific focus of hospitalization. The links and numbering system is illustrated on page 38.

Interventions are specific treatments, rehabilitation, and enrichment activities that the individual receives or participates in that will improve his or her mental and physical health, as well as enhance his or her quality of life. In general, these may include the following four generic areas:

a. psychopharmacologic interventions
b. behavioral interventions
c. rehabilitation and therapy groups, individual therapy, educational and social support groups, vocational and employment training, and
d. specific milieu supports and services that assist the individual to meet his or her treatment objectives.

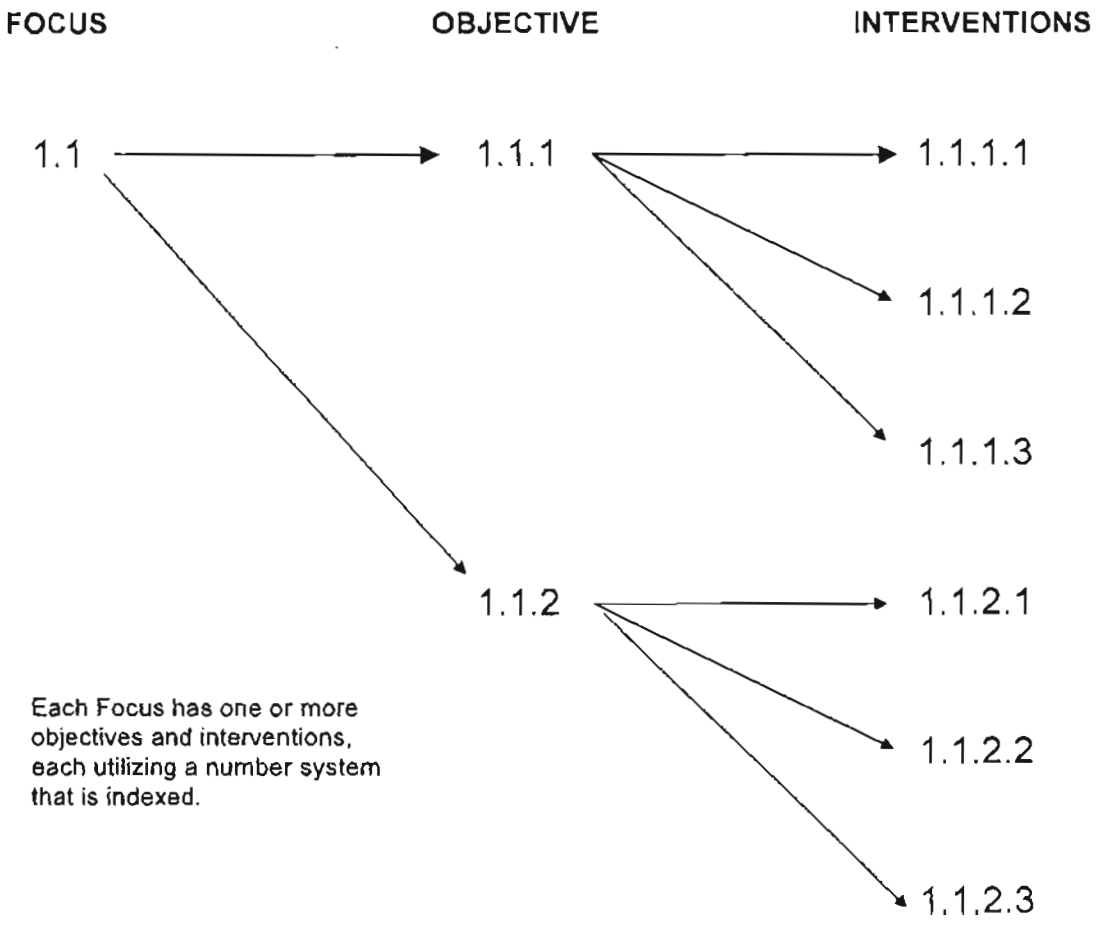
An example of how this can be done is presented on page 39. Begin at the top and, for each objective, ask the question on the top left and follow through until you are done with this objective.

Just as the Objectives are stated in terms of what the individual will do to meet his or her recovery needs, the Interventions are stated in terms of what the staff will do to assist the individual to meet his or her

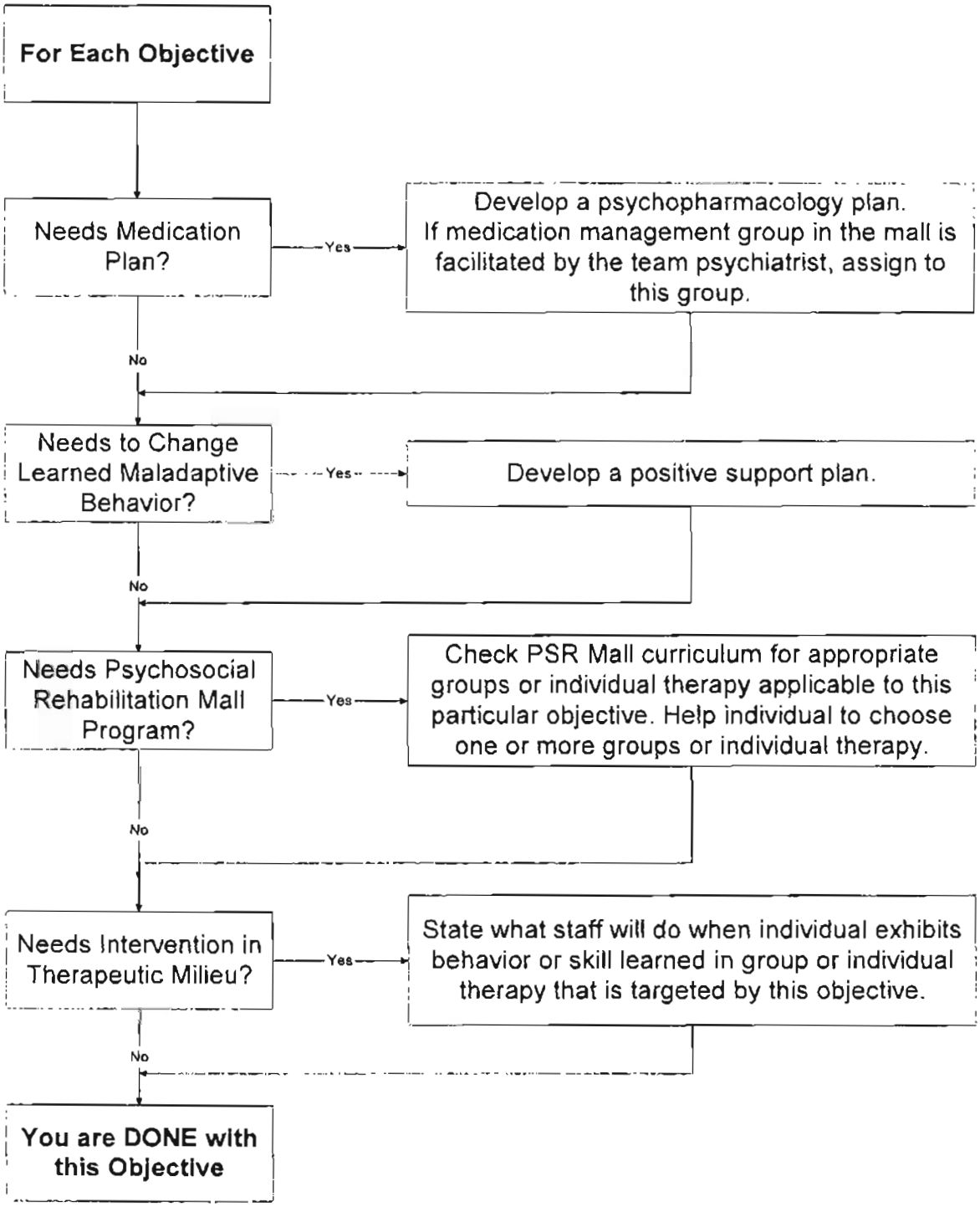
recovery objectives. The frequency, duration, and specific providers (i.e., group facilitators or individual therapists) for each intervention must be specified. All active treatments must be indicated and should total a minimum of 20 hours for adults and 10 hours for adolescents (during school terms) each week.

Interventions are typically provided in mall groups and in individual therapy. The purpose of each mall group or individual therapy must be specified by linking it to a specific objective in the individual's WRP. The rationale for assigning the individual to a psychosocial rehabilitation group must be specific to that individual. The individual's objectives drive the selection of the mall groups listed in the interventions. In essence, the WRPT must be able to justify why a particular intervention is being prescribed to that individual. The objectives in the WRP should be the individual's recovery goals rather than the goals of the specific mall group. Intervention outcomes must be observable and/or measurable. Outcome data should be available for scheduled WRP reviews (14 days, monthly, quarterly, and annual) so that the WRPT can make data-based changes in the recovery objectives, interventions, or both.

NUMBERING SYSTEM FOR WELLNESS AND RECOVERY PLAN



Flowchart for Developing Interventions



7.8.1 Linking Strengths to Interventions

Strength is any attribute of an individual that can be used in achieving his or her treatment objectives. It need not be limited to socially valued attributes (e.g., education, intelligence) because any thing the individual has or does can be a strength, even challenging behaviors, disorders, and deficits can be used as strengths if viewed in a positive perspective. A strength should generally be an attribute of the individual rather than a factor that may be a support to them (e.g., Jenny wants to return to her family as soon as possible). Motivational strengths or attributes that make the individual want to meet his or her recovery objectives are of particular importance. Strengths such as "has interested family" or "has disability income" may be relevant for some issues, but they are more likely to be relevant to discharge planning than meeting the discharge criteria.

An individual's strengths should be used in formulating interventions that are designed to help the individual meet his or her recovery objectives. Challenges are those variables that may provide a barrier to successful outcome of a given objective. While an individual may have specific challenges (e.g., high rates of problem behavior that may preclude attending a social skills training group; lack of GED to obtain employment), generally, any variable that can be a strength for one objective may be a challenge for another. It all depends on how well the individual is able to utilize his or her strengths to minimize his or her challenges in meeting specific objectives. Specific strengths of the individual must be incorporated in the interventions.

7.8.2 Interventions for an Individual with a Maladaptive Behavior

If an individual has a maladaptive behavior, the team psychologist may develop Behavior Guidelines or the PBS team may develop a PBS Plan for the individual and staff as specified in the PBS Manual. The intervention in the individual's WRP may be written as follows:

All staff will implement Angela's Behavior Guidelines (or PBS Plan) in all settings as specified in the Behavior Guidelines (or PBS Plan) order. All staff will collect outcome data as specified. Angela's WRPT psychologist will report on her progress at her monthly WRPC and update the Present Status of the case formulation.

7.8.3 Objective and Intervention for non-adherence to WRP

If an individual is non-adherent to WRP for more than 20% of the interventions in 7 consecutive days (excluding weekends and holidays), the WRPT should develop alternative strategies for encouraging the individual to re-engage in them. The team may refer the individual for 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.

The ***objective*** in the individual's WRP may be written as follows:

Ms. Vida Bailey will participate in individual Narrative Restructuring Therapy and learn to take ownership of her behaviors. Her learning will be evidenced by scores on narrative clarity and credibility, and quarterly scores on the URICA—stages of change.

The intervention in the individual's WRP may be written as follows:

Dr. Robert Wahler will engage Ms. Bailey in Narrative Restructuring Therapy on an individual basis, every Tuesday, from 2 to 3 pm, in the John Wooden room at the PSR Mall. Dr. Wahler will record the therapy sessions and provide monthly data (i.e., narrative clarity and credibility) or quarterly data (i.e., URICA—stages of change) on progress to her WRPT until Ms. Bailey chooses to resume the WRP interventions she refused earlier.

7.8.4 Active Treatment

Active treatment is any formal group or individual therapy provided in response to an objective in the individual's WRP. To be counted as active treatment for an individual, data must show that the individual attends the scheduled group or individual therapy. A minimum of 20 hours of active treatment must be provided during the scheduled mall hours. On-site or off-site medical treatment during Mall hours may be counted towards an individual's 20 hours of active treatment. Additional hours of active treatment may be provided outside of mall hours. The group or individual therapy may be treatment, rehabilitation or an enrichment activity (i.e., activities linked to Focus 10) linked to a specific objective in the individual's WRP. Active treatment does not include informal activities provided in the therapeutic milieu even though they may be related to the same objective. Court leave, consultations, and assessments are not counted as active treatment.

REVIEW QUESTIONS
• What is the timeframe for resolving "deferred" and "rule-out" diagnoses?
• What is the documentation requirement for "NOS" diagnosis?
• What are the requirements for "No Diagnosis" on Axis II?
• What are the 6Ps in the Case Formulation?
• What should be included in each of 6Ps?
• Is the individual's Life Goal discussed and ascertained during a WRPT?
• What are the individual's Life Goals linked to?
• When does discharge planning begin?
• How should the discharge criteria be written?
• What is covered in each of the 11 foci of hospitalization?
• Are the objectives written for the individual or for the staff?
• What are the three foci that require specification of stages of change?
• What is the requirement for writing objectives that are staged?
• Are the interventions written for the individual or for the staff?
• Are the strengths specified in the objectives or the interventions?
• What is the WRPTs responsibility when an individual is non-adherent to WRP for more than 20% of the interventions in 7 consecutive days?
• What is the minimum number of active treatment hours that must be provided to each individual during scheduled Mall time?

8. Nursing Care Plans for Medical, Health and Wellness

WHAT YOU WILL LEARN

- Focus 6 Objectives are written in exactly the same manner as all other objectives in the WRP
- Incorporation of the Nursing Care Plans into the WRP

Focus 6—Medical, Health and Wellness--includes the Axis III medical conditions and all other medical conditions that require intervention, as identified in the Medical Conditions Form. It lists all current medical conditions, diseases, symptoms, and special nursing and health maintenance needs of the individual, excluding temporary conditions. Focus 6 planning for medical conditions is initiated by a registered nurse (RN) or the primary care or medical/surgical physician, with input from the individual and WRP team members, as appropriate. In the WRP, the traditional nursing care plans are incorporated under Focus 6 and written in exactly the same format as the other foci (see Section 7.6). No nursing diagnosis is needed in this format. Each item under Focus 6 is linked to specific Objectives (see Section 7.7) and the Objectives are linked to specific Interventions (see Section 7.8). The numbering of the Focus, Objectives and Interventions follow the same rules as for the other foci (see Section 7.8—Numbering System for Wellness and Recovery Plan). The objectives in Focus 6 are not presented in terms of stages of change; they are presented in terms of the individual's current status, followed by successive steps needed to achieve health and wellness. Given the specialized nature of the interventions, they may be developed in advance and inserted into the WRP, following a discussion with the individual and the WRPT, at the WRPC.

A linked set of examples for Focus 6, Objectives and Interventions are presented below:

FOCUS: 6.1	Janet has an increased risk for constipation caused by her current psychotropic medications and would like to learn to reduce that risk as evidenced by her statement "I don't know if I should take my medications because they stop me from going to the bathroom. I haven't gone at all in the last 3 days."
Objective 6.1.1	Janet will learn to identify three ways to promote regular healthy bowel movements as evidenced by documentation of her description of this information in the interdisciplinary notes.
Objective 6.1.2	Janet will learn to take her medication and have regular bowel movements as evidenced by her report in sponsor group that she knows she can maintain healthy regular bowel movements while taking her medications.
Intervention 6.1.1.1	Josie Smith, RD, will offer Janet a class, Diet for Healthy Living, in the Mall on Mondays and Thursdays at 10:00 am in Room 73. Ms Smith will use Janet's desire to maintain regular bowel movements as a strength in teaching this course.
Intervention 6.1.1.2	Vicki Vinki, RN, will teach Janet during their twice weekly 15-min meetings four things that cause constipation and five ways to reduce the risk by February 12, 2007. Nurse Vinki will use as a strength Janet's desire to learn how to manage her health care issues.
Intervention 6.1.2.1	Dr. Mark Becker, psychiatrist, will teach Janet in their monthly 15-min meetings how her medications affect bowel movements. Janet's desire to understand how to prevent constipation and still follow her WRP plan will be used as a strength in this intervention.

Intervention 6.1.2.2 Richard Simmons, RT, will include Janet in the Monday, 10 to11 am, walking group. Mr. Simmons will use as a strength Janet's desire to have regular bowel movements.

Intervention 6.1.2.3 Jenny Craig, RD, will assist Janet in setting up a dietary plan that would reduce risk for constipation. Ms. Craig will use as a strength Janet's desire to find dietary items besides prune juice that will help reduce risk of constipation.

Intervention 6.1.2.4 Unit staff will assist Janet in monitoring signs and symptoms of possible constipation and, if present, discuss with Janet how she may prevent them from occurring. Unit staff will use as a strength Janet's desire to be an active participant in managing her health maintenance plan.

Focus 6 conditions are assessed for progress as clinically indicated. The results of these assessments are reviewed and incorporated in the Present Status section of the Case Formulation (see Section 7.3) at each scheduled conference review (see Section 4.3). The registered nurse (or primary care or medical/surgical physician) is responsible for updating the WRPT on these assessments.

8.1 DMH WRP Attachment Form

The DMH WRP Attachment Form is used to record any emergent medical, behavioral or psychiatric condition that may occur in-between scheduled WRP reviews. A nurse or any other qualified clinician may complete the DMH WRP Attachment Form, inform the WRPT and other unit staff, and attach the completed form to the individual's WRP. If the issue is resolved prior to the next scheduled WRPC, then only an update in the Present Status section of the Case Formulation is required. If the issue is still current, the WRPT discusses the issue and incorporates it into the revised WRP (i.e., the WRPT may decide to open a new Focus 6 condition in the individual's WRP). If the issue requires further assessments or consultations, these can be tracked on the WRP Task Tracking Form.

8.2 Medical Conditions Form

The Medical Conditions Form tracks all medical conditions, and special nursing and health maintenance needs of the individual. This list provides a record of new and resolved medical conditions. The list includes all Axis III and non-Axis III medical conditions. The physician will enter all medical and health maintenance conditions on this list and document known allergies and medical alerts. RN will enter all special nursing conditions. All temporary medical conditions are tracked on the Temporary Conditions Form.

8.3 Temporary Conditions Form

The Temporary Conditions Form tracks all physical conditions that are defined as short term (i.e., not exceeding 30 days) and neither recurring nor chronic in nature. This list provides a record of new and resolved temporary conditions (TC).

The following are not temporary conditions and should be included in the Medical Conditions Form:

- Chronic recurring temporary conditions: Conditions which recur more than once per quarter shall not be designated as temporary conditions, even if they are short-term conditions. After the first occurrence, these conditions should be listed on the Medical Conditions Form.
- Recurrence of a condition previously entered on the Medical Conditions Form: If the condition was previously entered on the Medical Conditions Form, even if the condition is short-term, it shall not be designated as a temporary condition.
- Temporary conditions do not involve infective processes requiring systemic antibiotics.

An MD, NP or RN may open a Temporary Condition.

8.4 Health Maintenance Conditions

Health Maintenance conditions are preventative medical or health maintenance issues that are not current problems and, if they require maintenance interventions, they are handled with a physician's order. Health maintenance conditions do NOT require treatment objectives or written interventions (i.e., no nursing care plans).

1. Health Maintenance Conditions include the following:
   a. Routine immunizations;
   b. Routine vitamin administration;
   c. Preferred diets, vegetarian, bran supplement;
   d. Motion sickness;
   e. Benign G.I. distress, e.g., antacid PRN requested;
   f. Preventative treatment of uncomplicated constipation;
   g. Chronic benign skin condition, Tinea infestations, chapped lips, dandruff, acne not requiring systemic antibiotics, skin sensitivity requiring sunscreen, dry skin;
   h. Birth control;
   i. Fluoride for prevention of tooth decay;
   j. Routine mild headache (which responds to acetaminophen or aspirin);
   k. Mild uncomplicated menstrual cramps (which responds to acetaminophen or aspirin), and
   l. Insomnia
2. Health Maintenance does not include the following:
   a. Special therapeutic diets prescribed for the treatment of significant medical/nursing problems;
   b. Minor aches and pains;
   c. Rehabilitation activities;
   d. Anything requiring a systemic antibiotic;
   e. Podiatry Clinic (except as noted in 2g above for chronic skin conditions);
   f. Movement disorders;
   g. Annual Physical Examinations, Laboratory tests, and X-rays, and
   h. Routine sedative, e.g., Dental Clinic

REVIEW QUESTIONS
• What medical conditions are included in Focus 6?
• What is the format for writing the objectives for medical conditions?
• What is the DMH WRP Attachment Form used for?
• Who enters the medical and health maintenance conditions on the Medical Conditions Form?
• Who enters the special nursing conditions on the Medical Conditions Form?
• What is included in the Temporary Conditions Form?
• Who may open a temporary condition?
• What is a health maintenance condition?
• Do health maintenance conditions require written treatment objectives and interventions?

9.0 INTERVENTIONS

WHAT YOU WILL LEARN
• The nature of Psychosocial Rehabilitation Malls
• How individuals make PSR Mall group and individual therapy choices
• How to request a new PSR Mall group
• The difference between PSR Mall and an individual's objectives
• The requirements for individual therapy
• The requirements for reporting an individual's progress in the PSR Mall
• The requirements for changing an individual's interventions
• When a WRP may need to be reviewed and revised out of regular WRPC schedule

9.1 Psychosocial Rehabilitation Malls

Each individual is provided psychosocial services four hours a day (i.e., two hours in the morning and two hours in the afternoon) 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 WRP. 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 human and 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/her increased wellness, enhanced quality of life and the ability to thrive in the world. 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 strengths-based.

9.2 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 the Focus of Hospitalization (i.e., goals) for the individual. Each focus has at least one Objective, which is written in terms of what the *individual* needs to do, and for each objective there are at least two interventions, (a) a PSR Mall group or individual therapy, and (b) reinforcement in the therapeutic milieu (hospital-wide) of what is taught in the PSR Mall. The individual makes a choice of PSR Mall group(s) based on a selection of the relevant groups or individual therapy identified by his or her WRPT. 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 WRPT 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 remaining groups. Describe to the individual the characteristics of the remaining groups;

4. Request that the individual choose one or more groups for this objective, and
5. Assign the individual to the group(s) 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 (and/or individual therapy) that the WRPT has identified would help the individual fulfill an assessed need for treatment, rehabilitation or enrichment. The number of groups and frequency of attending groups is linked to the individual's discharge criteria. For example, if the individual needs to control his or her physical aggression as a condition of discharge, it would help the individual to attend more (or more frequently) groups than those that are linked to enrichment (i.e., Focus 10). Thus, the individual may be encouraged to attend one or more anger management groups, two or three times a week, but one volleyball group a week, as an enrichment activity.

9.3 Requesting New Mall Groups

Most often, the WRPT will find that there is ample choice of mall groups for the individuals in their care. However, sometimes a WRPT will find that an individual needs to attend a group (or individual therapy) not currently offered in the PSR Mall. If a needed course is not listed in the PSR Mall catalog, the WRPT should complete the *Request for New Mall Group or Individual Therapy Form* (see DMH PSR Mall Manual) and submit it to the Mall Coordinator and Mall Director, with a copy to the Chair of the hospital's Mall Curriculum Committee. The Mall Coordinator will respond to the request directly to the WRPT within 24 hours. If a new group cannot be established in a timely manner, the WRPT 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 WRPT has appropriately identified in the individual's WRP.

9.4 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, 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., social skills, coping skills, anger management), but each individual's objectives are taught within the group. For example, in a social skills group, Sharon may have an objective to refine turn-taking skills in dyadic interactions while Swati may have an objective to increase her social conversations. In some cases, the group objective may be the same as the individuals' objectives. For example, for Focus 10, a group objective may be to teach individuals to play poker as a recreational activity and all individuals enrolled in the group may have an objective in their WRP to learn to play poker as a recreational activity. However, the group facilitator should report each individual's monthly progress towards meeting their WRP objective in terms of his or her participation and achievement on the *DMH PSR Mall Facilitator Monthly Progress Note* (see DMH PSR Mall Manual). This requirement does not apply to other enrichment activities provided outside of the PSR Mall requirements.

9.5 Individual Therapy

If an individual's WRPT has assessed an individual as requiring individual therapy, the individual will 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 individual's WRP 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 measured on a monthly basis prior to the individual's scheduled WRPC; and
5. The therapist completes the *DMH PSR Mall Facilitator Monthly Progress Note* and makes it available to the individual's WRPT prior to the scheduled monthly WRP 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 WRP will be counted as a part of the individual's active treatment regardless of when or where the therapy is provided. However, the individual will still need to complete 20 hours of active treatment during regular PSR Mall hours.

9.6 Non-Adherence to WRP

All individuals are mandated to attend 20 hours of therapy each week-day, as specified in their WRP. Thus, all individuals should go to the PSR Mall during the scheduled mall hours regardless of whether they attend their scheduled groups or individual therapy. Individuals do not have the option of unilaterally dropping out of scheduled group or individual therapy, but they often do. If an individual is non-adherent to WRP for more than 20% of the interventions in 7 consecutive days (excluding weekends and holidays), the WRPT should develop alternative strategies for encouraging the individual to re-engage in them. The team may refer the individual for 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 these services are offered in the PSR Mall. If an individual is non-adherent to WRP, but at a rate less than 20% of the interventions in 7 consecutive days (excluding weekends and holidays), the WRPT should endeavor to 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 WRP and actions taken by the individual's WRPT should be documented in the Present Status section of the WRP.

9.7 Reporting Progress

Facilitators of each group and individual therapy provider are required to complete a *DMH PSR Mall Facilitator Monthly Progress Note* on each individual served in the group or provided individual therapy. The completed note should be available to the individual's WRPT prior to the individual's scheduled WRPC. The progress note should provide evidence that the individual is making (a) good progress, (b) minimal progress, or (c) no progress. 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 unless there is some progress or documentation why progress may be slow.

9.8 Changing Interventions

An individual's intervention should be changed when the individual meets the criterion set in the corresponding objective (i.e., as evidenced by _____). Changes in group or individual therapy should occur as soon as the individual's WRPT has met at a regularly scheduled WRPC and ascertained from the *DMH PSR Mall Facilitator Monthly Progress Note* that the individual has met criterion on a specific objective. Only the individual and the individual's WRPT 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. Scheduling changes should be made in the weekends and new group facilitators or therapists informed prior to the individual's admission to a group or individual therapy.

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

9.9 Reviewing and Revising the WRP

An individual's WRP is reviewed and revised according to the WRPC schedule (see Section 4.3). However, an individual's WRPT is also required to review and revise the WRP, as needed, under other special circumstances. For example, if an individual is placed in seclusion or restraint more than three times in any four-week period, the individual's WRPT should review and revise, as necessary, that individual's WRP within three business days of the third restraint.

REVIEW QUESTIONS
• What is a PSR Mall?
• How many hours of active treatment are provided to an individual based on the interventions listed in his or her WRP?
• Who determines which groups an individual attends in the PSR Mall?
• How does a WRPT enroll an individual in a group that is currently not in the PSR Mall catalog?
• Does the mall group facilitator teach an individual the group objective or the individual's WRP objective in a PSR Mall group?
• Does an individual have access to individual therapy, if needed?
• How often is progress reported to an individual's WRPT?
• When can changes be made to an individual's group or individual therapy?
• Under what circumstances should an individual's WRPT review and revise, as necessary, an individual's WRP?

10. WELLNESS AND RECOVERY PLANNING CONFERENCE (WRPC) PROCESS

WHAT YOU WILL LEARN
• Scheduling requirements for WRPCs
• Attendance requirements for WRPCs
• Times for WRPCs
• Sequence of activities undertaken during different WRPCs
• Documentation in the individual's medical record

10.1 Scheduling

A designated staff member (e.g., unit clerk, unit supervisor) is responsible for the structural integrity of the WRPCs. This includes the following:

1. Scheduling of the WRP conferences;
2. Ensuring that
    a. conferences begin on time;
    b. all members are present;
    c. if a member is not present, his or her written report is made available to the WRPT at the beginning of the conference;
    d. the WRP computer and LCD projector system is operational and being used; and
    e. updated forms (e.g., DMH WRP Attachment Forms, WRP Task Tracking Form) are available;
3. A WRP recorder is specified; and
4. The individual has been invited to attend his or her WRP review;

All team members are responsible for collectively determining when WRPCs will be held. Each WRPT should designate days and times during which WRPCs will be held in their Unit and they should adhere to this schedule. If there is a change in the routine WRPC schedule, the designated staff should notify the individual, the WRPT members, the Unit Supervisor and Program Director, the program representative responsible for posting the schedule on the local hospital intranet, family members and significant others as appropriate), WRP observers, and outside agencies. It is the WRPTs responsibility to keep schedule changes to a minimum.

10.2 Attendance

The WRP conference should occur at the scheduled time, even if all team members are not present. The requirement is that *all* team members be present. The WRPT is composed of the individual, psychiatrist, psychologist, social worker, rehabilitation therapist, registered nurse (including psychiatric nurse practitioner and LVN), and psychiatric technician. In addition, others such as dietitian, pharmacist, teacher, county caseworkers, family members and significant others as appropriate) and CONREP representatives may also participate. The individual may choose to be his team's leader, or the WRPC may be led by a clinical professional who is involved in the care of the individual.

All WRPs are mandatory for all team members. It is the responsibility of the team to begin all WRPCs at the scheduled time regardless of an absent WRPT member. If the clinical professional designated as the team leader is not present, the team leader's discipline chief must be notified immediately and a replacement provided so that the WRPC can be held without postponement.

10.3 Timelines

Admission WRPTs should develop the initial WRP on the 7th day of admission based on the information available. This should include the A-WRP, Admission Assessments, Integrated assessments, suicide risk assessment, cognitive screening, and staff observation of the individual since admission. Revision and further elaboration of the WRP should take place as new information becomes available, but WRP must be fully developed by the 60th day of admission. If an internal transfer occurs within the first 60 days of admission, the receiving WRPT must also be an Admission Unit (i.e., the WRPT must have a 1:15 staffing ratio) so that assessments and development of the WRP can continue. Monthly WRPCs should review and revise the WRP, as necessary. If significant events take place between scheduled WRPCs, emergent medical, behavioral and psychiatric conditions and related interventions can be documented in the DMH WRP Attachment Form. A WRPT meeting may need to be scheduled between regular conferences if there is a required review because of the individual's behavior (e.g., see Section 9.8).

10.4 Sequence of Activities during WRPCs

There are many ways of undertaking WRPCs. WRPTs achieve the best outcomes in terms of the quality of WRPs and functional outcomes of the individuals served when they follow a specific sequence of activities.

Here is an example of one format:

10.4.1 General Conduct of the Meeting

1. Prior to the WRPC, the WRPT leader should have:
    a) synthesized the discipline-specific assessments and consultations, and
    b) communicated the results of the assessments and consultations to the WRPT members;
2. The WRPT should begin promptly at the scheduled date and time.
3. The WRPT leader should identify a recorder who is responsible for transcribing the conference as it occurs. If it is the 7-day WRP, the recorder should begin a new WRP template for that individual; if it is a subsequent WRP, the recorder can edit the most recent version of the individual's WRP. The recorder should use the computer and projector that are provided for this purpose. Handwritten WRPs are not acceptable in the DMH hospitals.
4. The WRPT should identify key questions or issues to address with the individual.
5. The WRPT reviews risk factors (findings of the Suicide Risk Assessment, elopement risk) and completes or updates the Identified Alerts Form, as necessary.
6. The WRPT should invite the individual to attend his or her WRPT 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 WRPT may facilitate this for the individual, and discuss in the individual's progress toward discharge.
7. During the WRPC, the WRPT leader should
    a) ensure that all team members present a concise and non-redundant summary of the results of their assessments prior to the discussion of objectives and interventions,
    b) review and update the individual's diagnosis,
    c) ensure that the Present Status section of the case formulation is updated during the WRPC and that other sections in the case formulation are updated as clinically indicated, including PBS, BY CHOICE, MOSES, AIMS, data from the DMH WRP Attachment Forms, medical issues, and current barriers to discharge that the individual is working on.
8. The WRPT should update the Life Goals and valued role functions based on discussion prior to the conference and, when appropriate, link to treatment, rehabilitation and enrichment goals.
9. The WRPT should review progress on all objectives and interventions, and make appropriate revision to the individual's WRP. The WRPT should follow the instructions provided in Section 7 of this manual when going through the appropriate sections of the WRP.
10. The WRPT should review with the individual progress on each discharge criterion, what the individual need to do to meet each criterion.

11. The WRPT should request additional evaluations, information or consultations.
12. The WRPT should answer any questions the individual may have, and thank him or her for attending the WRPC.
13. The individual should receive a completed and signed copy of his or her revised WRP.
14. The WRPT should discuss any outstanding issues that were not covered and complete all required documentation, and sign the revised WRP.

10.4.2 WRP Meeting Process for Specific WRPCs

There are different expectations for specific WRPCs.

1. WRPs during the first 60 days
    a. Complete a skeleton WRP on the 7th day following admission
    b. Update the WRP every 14 days as new information becomes available
    c. Complete the WRP by the 60th day following admission
    d. Begin monthly WRPs
2. Monthly WRPs
    a. Update any section where new information is available, especially the Present Status section of the case formulation, PBS, BY CHOICE, MOSES, AIMS, data from the DMH WRP Attachment Forms, risk assessments, medical issues, and current barriers to discharge that the individual is working on. Summarize for the preceding month.
    b. Update objectives and interventions based on data from the *DMH PSR Mall Facilitator Monthly Progress Note*.
    c. Inform the individual what he needs to work on next month and how this will help him or her to meet discharge criteria.
3. Quarterly WRPs
    a. Update all sections in terms of data from the preceding quarter.
    b. Update objectives and interventions based on data from the *DMH PSR Mall Facilitator Monthly Progress Note*.
    c. Inform the individual what he needs to work on next month and how this will help him or her to meet discharge criteria.
4. Annual WRPs
    a. Update all sections in terms of data from the preceding year.
    b. Update objectives and interventions based on data from the *DMH PSR Mall Facilitator Monthly Progress Note*.
    c. Inform the individual what he needs to work on next month and how this will help him or her to meet discharge criteria.

10.5 Documentation

The A-WRP must be in the individual's medical record within 24 hours of admission. The WRPs should be completed, printed and signed by all participants immediately following the WRPC. The completed WRP must be in the individual's medical record within 48 hours.

Handwritten A-WRPs and WRPs are *not* acceptable.

10.6 Appointment Cards

The WRPT should inform the individual about his or her next WRPC and issue a completed appointment card. One example of an appointment card is presented below.

Front	Back
Name: _____ ☐ 7-day ☐ 14-day ☐ Monthly ☐ Quarterly ☐ Annual ☐ Transfer Your next Wellness and Recovery Planning Conference is scheduled for: Date: _____ Day: _____ Time: _____	Things to think about before my next conference: ➢ My life goals ➢ What are my objectives? ➢ Am I meeting my objectives? ➢ Am I making progress on my discharge criteria?

REVIEW QUESTIONS
• What are the responsibilities of the designated staff member who is responsible for the structural integrity of WRPCs?
• Who should attend WRPCs?
• Can a WRPC be held if the individual's primary psychiatrist is not present?
• Can a WRPC be held if a member, other than a psychiatrist, is not present?
• What is the responsibility of a WRPT member if he or she is unable to attend a scheduled WRPC because he or she will be on vacation?
• What is the generic sequence of activities a WRPT may follow during a WRPC?
• What are the documentation requirements for WRPs?

11. MONITORING

WHAT YOU WILL LEARN
• Observations of WRPC process
• Chart audits of WRPs

Outcome measurement is an important component of a recovery-based system. The best outcome measurements are based on what the individuals served value and view as the desired result. These include outcomes that allow individuals to (a) better manage their own lives, to improve the quality of their life, to enhance independence, safety, privacy, empowerment, and satisfaction with services, and (b) to decrease negative consequences of their mental illness, undesirable side effects of treatment, and overcome stigma associated with mental illness. These are holistic goals that can be achieved through competent wellness and recovery planning.

We use four instruments to assess how well WRPTs are doing in terms of wellness and recovery planning. The data are used to provide feedback to the WRPTs as well as to provide targeted training to teams or team members.

11.1 Observations of WRPCs

Trained observers undertake *in vivo* observations of the WRPC process using the 11-item *DMH WRP Observation Monitoring Form* (see Appendix B). The observers visit each WRPT on a random basis and observe the WRPC process using the monitoring tool.

11.2 Chart Audits of WRP

Trained chart auditors review the medical records of a random sample of individuals each month using the 13-item *DMH WRP Chart Auditing Form* (see Appendix C) to assess specific requirements of the WRPC process.

11.3 Clinical Chart Audits of WRP

The clinical chart audits are to be completed by monitors from the discipline designated by each hospital as the team leader. The monitor reviews the medical records of a random sample of individuals using the 10-item *DMH WRP Clinical Chart Auditing Form* (see Appendix D) to assess specific requirements of the WRPC process.

11.4 Discharge Planning and Community Integration Audits of WRP

Designated members of the Social Work Department review the medical records of a random sample of individuals using the 12-item *DMH WRP Discharge Planning and Community Integration Auditing Form* (see Appendix E) to assess specific requirements of the WRPC process.

11.5 Feedback to Teams

Data from both direct observations of WRPCs and WRP chart audits are provided to the WRPTs in a timely manner. A WRP master-trainer explains the data and provides additional mentoring in specific areas, as needed.

REVIEW QUESTIONS

- Why is it important to undertake in vivo observations of the WRPC process?
- Why is it important to audit the WRPs?
- Who is responsible for the clinical chart audits?
- Who is responsible for the discharge planning and community integration audits?

12. References

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APPENDIX A

DMH Wellness Recovery Plan (WRP) Template
DMH WRP Attachment Form
DMH WRP Medical Conditions Form
DMH WRP Temporary Conditions Form

CALIFORNIA DEPARTMENT OF MENTAL HEALTH

DMH WELLNESS AND RECOVERY PLAN

INDIVIDUAL'S NAME:		**CASE NUMBER:**	
DATE:	☐ 7-DAY MASTER ☐ BI WEEKLY	☐ MONTHLY ☐ QUARTERLY	☐ ANNUAL ☐ TRANSFER

DIAGNOSIS:	*(Begin with principal diagnosis if the individual has multiple Axis I or Axis II diagnoses).*	
Axis I		Date of Diagnosis:
Axis II		Date of Diagnosis:
Axis III		
Axis IV		
Axis V	*Current GAF:*	*Last Quarterly GAF:*

Legal Status: *(Begin with primary legal status if the Individual has multiple legal status).*

CASE FORMULATION: *(Succinct analysis and integration of interdisciplinary assessments, including strengths and risk evaluation, which provides an understanding of the individual's situation, treatment and recovery needs)*

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

LIFE GOALS: *(In the individual's own words, include statements of dreams, hopes, aspirations, role functions and vision of life).*

DISCHARGE CRITERIA FOR ANTICIPATED PLACEMENT:

WELLNESS AND RECOVERY PLAN	ADDRESSOGRAPH
Confidential Patient Information See W&I Code Section 5328 Filing Guidelines Assessment Name of Facility MH Form # Pending	

FOCUS OF HOSPITALIZATION: *(Check the items which are barriers to discharge)*

1. Psychiatric and Psychological	
☐ 1.1	
☐ 1.2	
2. Social Skills and Self Care	
☐ 2.1	
☐ 2.2	
3. Dangerousness and Impulsivity	
☐ 3.1	
☐ 3.2	
4. Hope and Spirituality	
☐ 4.1	
☐ 4.2	
5. Substance Abuse	
☐ 5.1	
☐ 5.2	
6. Medical	
☐ 6.1	
☐ 6.2	
7. Legal	
☐ 7.1	
☐ 7.2	
8. School / Education	
☐ 8.1	
☐ 8.2	
9. Occupational Skills	
☐ 9.1	
☐ 9.2	
10. Leisure and Recreation	
☐ 10.1	
☐ 10.2	
11. Community Integration	
☐ 11.1	
☐ 11.2	

WELLNESS AND RECOVERY PLAN	ADDRESSOGRAPH
Confidential Patient Information See W&I Code Section 5328 Filing Guidelines Assessment Name of Facility MH Form # Pending	

FOCUS #		DATE INITIATED:

OBJECTIVES: *(Describe the specific changes expected, in terms of the individual's behavior, in measurable and behavioral terms. Include the target date for completion for each objective and the method used to measure progress).*

OBJ. #	OBJECTIVE DESCRIPTION	STAGE*	OBJ. STATUS**	REVIEW DATE

*STAGE OF CHANGE: 1-PreContemplation 2-Contemplation 3-Preparation 4-Action 5- Maintenance

**OBJECTIVE STATUS: M – Met N – Not Met P – Partially Met I - Inactive

INTERVENTIONS: *(Describe the clinical activity/treatment modality/therapeutic milieu activity, the provider of the care and where and when the intervention will take place. For each intervention, state at least 1 (one) strength the individual has that will be used by the service provider to help the individual achieve the specific objective.*

INT. #	INTERVENTION DESCRIPTION	ACTIVE TX

WELLNESS AND RECOVERY PLAN	ADDRESSOGRAPH
Confidential Patient Information See W&I Code Section 5328 Filing Guidelines Assessment Name of Facility MH Form # Pending	

FOCUS #		DATE INITIATED:

OBJECTIVES: *(Describe the specific changes expected, in terms of the individual's behavior, in measurable and behavioral terms. Include the target date for completion for each objective and the method used to measure progress)*

OBJ. #	OBJECTIVE DESCRIPTION	OBJ. STATUS**	REVIEW DATE

**OBJECTIVE STATUS: M – Met N – Not Met P – Partially Met I - Inactive

INTERVENTIONS: *(Describe the clinical activity/treatment modality/therapeutic milieu activity, the provider of the care and where and when the intervention will take place. For each intervention, state at least 1 (one) strength the individual has that will be used by the service provider to help the individual achieve the specific objective.*

INT. #	INTERVENTION DESCRIPTION	ACTIVE TX

WELLNESS AND RECOVERY PLAN	ADDRESSOGRAPH
Confidential Patient Information See W&I Code Section 5328 Filing Guidelines Assessment Name of Facility MH Form # Pending	

WELLNESS AND RECOVERY PLAN SIGNATURE PAGE

NAME	P-Code	DISCIPLINE		SIGNATURES	DATE
		Individual			
		Psychiatry			
		Psychology			
		Social Work			
		Rehab Therapy			
		R.N.			
		P.T.			
		LVN			
		Dietary			
		Family Member			
		Advocate			
		Friend			
		Other			

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 WRPT has determined the individual met his discharge criteria on this date _____ (specify date).
☐ The individual was offered a signed copy of the WRP.
☐ The individual accepted a copy of his or her WRP.

WELLNESS AND RECOVERY PLAN	ADDRESSOGRAPH
Confidential Patient Information See W&I Code Section 5328 Filing Guidelines Assessment Name of Facility MH Form # Pending	

California Department of Mental Health
DMH WRP Attachment Form

INDIVIDUAL'S NAME:	CASE NUMBER:
CONDITION / DIAGNOSIS:	DATE INITIATED:
FOCUS:	

OBJECTIVES: *(Describe in behavioral, observable and/or measurable terms what the individual is expected to do).*

OBJ. #	OBJECTIVE DESCRIPTION

INTERVENTIONS: *(Describe what staff will do to assist the individual to achieve the objective[s] stated above).*

INT. #	INTERVENTION DESCRIPTION

SIGNATURES:

NAME	DISCIPLINE		SIGNATURES	DATE
	Individual			

Reviewed at WRP Conference:
Date: _____ Type of WRP: _____ Initials: _____

DMH WRP Attachment Form

Confidential Patient Information
See W&I Code Section 5328
Filing Guidelines Assessment

Name of Facility

MH Form # Pending

ADDRESSOGRAPH

California Department of Mental Health
DMH WRP MEDICAL CONDITIONS FORM

Deferred Codes: H- History of; R- Remission; N- No Current Treatment

Focus 6	Condition /Diagnosis	Date Opened Date Close	Init	Date Opened Date Closed	Init	Date Opened Date Closed	Init	Deferred Code Date Deferred	Init

Conditions identified in Focus 6, should correspond to Focus 6 of the WRP

MD Signature	Init	MD signature	Init	MD Signature	Init	MD Signature	Init

DMH WRP MEDICAL CONDITIONS FORM

Confidential Patient Information
See W&I Code Section 5328
Filing Guidelines - Current WRP

Name of Hospital

MH Form # Pending

ADDRESSOGRAPH

California Department of Mental Health
DMH WRP TEMPORARY CONDITIONS FORM

THE FOLLOWING ARE NOT TEMPORARY CONDITIONS AND SHOULD BE ENTERED IN THE MEDICAL CONDITION FORM:
(1) Conditions requiring oral or parenteral antibiotics; (2) Chronic recurring conditions (i.e., any condition recurring more than once per quarter); and (3) Conditions that recur and have previously been entered in the individual's WRP.

Temporary Conditions	Date Opened Date Closed	Init	Date Opened Date Closed	Init	Date Opened Date Closed	Init	Date Opened Date Closed	Init

Signature / Title	Init	Signature / Title	Init	Signature / Title	Init	Signature / Title	Init

DMH WRP TEMPORARY CONDITIONS FORM

Confidential Patient Information
See W&I Code Section 5328
Filing Guidelines - Current WRP

Name of Hospital

MH Form # Pending

ADDRESSOGRAPH

APPENDIX B

DMH WRP Observation Monitoring Form

DMH WRP OBSERVATION MONITORING FORM

Rater: Review Date:

Individual's Initials and ID#: Program: Unit:

Specify WRP: ☐ A-WRP ☐ 7-Day WRP ☐ 14-Day WRP ☐ Monthly ☐ Quarterly ☐ Annual

Who attended the current WRP? Individual ☐ Psychiatrist ☐ Psychologist ☐
SW ☐ RT ☐ RN ☐ PT ☐ Other ☐

Section	#	Enhancement Plan Requirement	YES	NO	N/A
C.1. b	1	Each team is led by a clinical professional who is involved in the care of the individual.			
C.1. c	2	Each team functions in an interdisciplinary fashion.			
C.1.e	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 therapeutic and rehabilitation services.			
C.1.f	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 review.			
C.1.g	5	The team identified someone to be 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.			
C.2.a	6	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.			
C.2.f.i	7	The treatment plan includes the individual's strengths related to each enrichment, treatment or rehabilitation objective			
C.2.g.i	8	The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives..			
C.2.g.ii	9	The team reviewed the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors).			
C.2.g.iii	10	The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.			
C.2.g.iv	11	Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.			
E.2	12	Each State hospital shall ensure that, beginning at			

		the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.			

APPENDIX C

DMH WRP Chart Auditing Form

DMH WRP CHART AUDITING FORM

Rater: Review Date: WRP Date:

Individual's Initials and ID#: Admission Date: Program: Unit:

Specify WRP: ☐ A-WRP ☐ 7-Day WRP ☐ 14-Day WRP ☐ Monthly ☐ Quarterly ☐ Annual

Who signed the current WRP? Individual ☐ Psychiatrist ☐ Psychologist ☐
SW ☐ RT ☐ RN ☐ PT ☐ Other ☐

Section	#	Enhancement Plan Requirement	WRP	YES	NO	N/A
C.2.b.i	1	The initial therapeutic and rehabilitation service plans (Admission Wellness and Recovery Plan (A-WRP) was developed within 24 hours of admission.	A-WRP only			
C.2.b.ii	2	The master therapeutic and rehabilitation service plan (WRP) was developed on or before the 7th day after admission.	7th day WRP only			
C.2.b.iii	3	The WRP was reviewed and revised as per WRP schedule (therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	Current conference only			
C.2.e	4	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions).				
C.2.f.i	5	The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individuals strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.				
C.2.f.ii	6	The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.				
C.2.f.iii	7	The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.				
C.2.f.iv	8	The WRP includes all objectives from the individual's current stage of change (SOC) or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate.				
C.2.f.v	9	The WRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective.				
C.2.f.vii	10	The WRP maximizes, consistent with the individual's treatment needs and legal status,				

		opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.				
C.2.g.ii	11	The team reviewed the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors).				
C.2.i.xii	12	Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.				
C.2.o	13	When substance abuse is diagnosed on Axis I it is documented in Focus 5 and there is at least one objective and intervention.				

APPENDIX D

DMH WRP Clinical Chart Auditing Form

DMH WRP CLINICAL CHART AUDITING FORM

Rater: Review Date: WRP Date:

Individual's Initials and ID#: Admission Date: Program: Unit:

Specify WRP: ☐ Monthly ☐ Quarterly ☐ Annual

Section	#	Enhancement Plan Requirement	YES	NO	N/A
C.1.d	1	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.			
C.2.c	2	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;			
C.2.d.i	3	The case formulation be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;			
C.2.d.i.i	4	The case formulation include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status			
C.2.d.i.i.i	5	The case formulation consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each of the 6Ps: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status			
C.2.d.iv	6	The case formulation consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions.			
C.2.d.v	7	The case formulation support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and			
C.2.d.vi	8	The case formulation enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, 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.			
C.2.s	9	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are			

		appropriately addressed, consistent with generally accepted professional standards of care.			
C.2.t	10	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof.			

APPENDIX E

DMH WRP Discharge Planning and Community Integration Auditing Form

DMH WRP DISCHARGE PLANNING AND COMMUNITY INTEGRATION AUDITING FORM

Rater:	Review Date:	WRP Date:	
Individual's Initials and ID#:	Admission Date:	Program:	Unit:

Section	#	Enhancement Plan Requirement	YES	NO	N/A
		Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.			
E.1		Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:			
E.1.a	1	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;			
E.1.b	2	the individual's level of psychosocial functioning;			
E.1.c	3	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and			
E.1.d	4	the skills and supports necessary to live in the setting in which the individual will be placed.			
E.2	5	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.			
E.3		Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:			
E.3.a	6	measurable interventions regarding these discharge considerations;			
E.3.b	7	the staff responsible for implement the interventions; and			
E.3.c	8	the time frames for completion of the interventions.			
E.4		Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:			
E.4.a	9	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and			
E.4.b	10	individuals receive adequate assistance in transitioning to the			

		new setting.			
E.5(MSH only)		For all children and adolescents it serves, each State hospital shall:			
E.5.a	11	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and			
E.5.b	12	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.			

NOTES