

Santa Clara County's

Transformational Care Planning

Advancing Recovery, Resiliency & Wellness



Training Curriculum

Fall 2012/Winter 2013



A Collaborative Publication
between Santa Clara County
Mental Health Department
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for Mental Health



Transformational Care Planning in Santa Clara County

Training Curriculum

This training curriculum was produced by Santa Clara County in partnership with CiMH, largely constructed from source materials provided by CiMH, based on the book “Treatment Planning for Person-Centered Care” by Diane M. Grieder and Neal Adams

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Table of Contents

Special Acknowledgements	4
Overview	5
Module One: Conceptual Overview	8
Module Two: Assessment	15
Module Three: Understanding the Client’s Story & Creating a Narrative Summary	31
Module Four: Developing the Transformational Care Plan	48
Appendix A: Additional Case Examples	78
Appendix B: SAMHSA’s Working Definition of “Recovery”	92
Appendix C: Stages of Recovery and Treatment	95
Appendix D: Selected References	96

Transformational Care Planning

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Transformational Care Planning

Advancing Recovery, Resiliency & Wellness



Overview



Transformational Care Planning

Overview

This is a curriculum intended to present mental health service providers, from peer support personnel to psychiatrists, with the knowledge and skills necessary to prepare person-centered treatment plans in collaboration with clients. These plans are created in a relational environment that supports shared decision-making and creates a framework for person-centered, culturally inclusive, accountable care that contributes to the well-being of children, adults, and families. The training is an adaptation, in part, of California Institute for Mental Health's (CiMH) Transformation Care Planning (TCP) curriculum, for specific use in the public mental health system of Santa Clara County, California, in both the Adult and Family & Children's Service Divisions. Much of the core information for the curriculum was developed from the book Treatment Planning for Person-Centered Care, The Road to Mental Health and Addiction Recovery, by Neal Adams and Diane Grieder¹.

The immediate practical goal of the "Transformational Care Planning" curriculum is to train providers how to document their work in a way that demonstrates person-centered, culturally inclusive care, under the assumption that skillful treatment planning documentation will reflect and support medical necessity as a matter of course. This training will serve as a stepping stone for the larger goal, promoting the well-being of children, adults, and their natural, support systems by providing them with effective services that the client system itself values and finds appropriate to its unique culture. It should also be noted that the training is meant only to be the *first step* in preparing staff to collaborate with consumers and families in the construction and delivery of person-centered plans and services. Continual practice, supervisory and administrative support, and ongoing agency cultural change are also necessary elements in creating and sustaining a recovery-oriented system of care.

The curriculum is divided into four modules:

1. Conceptual Overview
2. Assessment
3. Understanding the Client's Story & Creating a Narrative Summary
4. Developing the Transformational Care Plan

Each of the four modules presents a range of information intended to facilitate participants' learning processes and skill building. Examples and group learning activities are provided when appropriate, along with references to current practice and documentation standards within the county mental health system. Modules are structured in the following manner:

¹ Adams N & Grieder D (2005) Treatment Planning for Person-Centered Care, The Road to Mental Health and Addiction Recovery. Burlington MA: Elsevier Academic Press.

- A. Introduction and Summary
- B. Content
- C. Activities
- D. Handouts

Transformational Care Planning

Advancing Recovery, Resiliency & Wellness



Module One:

Conceptual Overview



Conceptual Overview

A. Introduction and Summary

This module focuses on understanding the definition and components of person-centered, culturally sensitive care that results in positive quality of life outcomes for the individuals being served in the public mental health system in Santa Clara County. For adults who are involved in services, this means that they are active participants in their own care and are able to rely increasingly on peers as well as natural and community supports to achieve positive outcomes in their lives. For children and families involved in services, this means that care is family-driven and holds the developmental needs of each child and his or her family system at the center of the process. This module lays out a framework for person-centered care, and discusses how to keep the self-identified needs of individuals being served as the core of treatment. Key issues related to accountability and cultural humility are also reviewed. The module emphasizes knowledge and skills acquisition to support the development of strong relationships among individuals, families, and service providers, as these relationships are critical to promoting cultural humility and person-centered care

B. Content

What is Transformational Care Planning?

Transformational Care Planning (TCP) creates space for the client's voice to be heard clearly. It places an increased significance on the client's own desired results, and emphasizes shared decision-making between clients and mental health professionals as the primary method for reaching those results. TCP blends both voices into a constructive dialogue to support the creation and documentation of a shared vision for the client and family's ongoing wellness, and ultimately leads to improved outcomes for those participating in treatment.

How is this different from current practice?

The implementation of Transformational Care Planning will, by necessity, stimulate changes at a conceptual/theoretical level, as well as changes in daily practice with clients. These changes, in turn, will result in revisions to some of the documents, forms, and processes used to record and monitor practice.

Current practice emphasizes the translation of client's stated goals into a series of problems, symptoms, and professional interventions that are then documented in a way that focuses on quality assurance and standardization of treatment. In current practice, documentation is often written as an exercise in regulatory compliance. Practitioners throughout California often comment on the stress and difficulty of having to write progress notes in a way that connects with a formal treatment

plan, filled with professional jargon, while at the same time describing at least some of what really did happen in a session.

Transformational Care Planning (TCP) encourages documentation that clearly articulates the desired results of each client and his or her natural support system. TCP is also focused on helping clients construct meaningful short-term goals and take action towards overcoming the barriers or functional impairments they face as they seek to live happy, healthy lives. This planning process is not at odds in any way with the regulatory prescription for constructing treatment plans as outlined in Title Nine of the California Code of Regulations. In TCP, there is a single “golden thread” linking administrative requirements with clients’ own aspirations. The needs of the client and his or her natural support system drive the construction of the treatment plan, and regulatory requirements are met as a matter of course. Furthermore, when the person-centered treatment plan is written in plain language and is created in the context of shared decision-making with clients and families, it can truly be used as a practical tool that guides service delivery from day to day.

What is Family-Driven Care?

Along with the transition to person-centered care, Santa Clara County has adopted the standard that mental health services to children will be “family-driven.” In recent years, there has been an increased recognition of the critical role played by family members of individuals with serious mental health conditions. Others in the service system have come to an understanding of what family members have always known about themselves: they are the primary experts on their loved ones and the best source of information about them. Indeed, since the 1960s, families have redefined their own position within the mental health service system and have increasingly taken on new roles within it.

Of course, the creation of a family-driven system of care must begin with some definition of what a family is. A family can be seen as the group of individuals who support each other emotionally, physically, and financially. A family can include individuals of various ages who are biologically related, related by marriage, or not related at all. In this curriculum, the term “family” is often used in connection with the term “natural support system” to emphasize that while some clients primarily receive support from their biological families, others do not, and instead look to their broader community for support.

What role does culture play in TCP?

For person-centered and family-driven care to occur, services must be provided in a culturally sensitive way, and that is a central theme in this curriculum. The terms *cultural sensitivity* and *cultural humility* are used here in contrast with the idea of cultural competence. While *cultural competence* generally emphasizes the acquisition of cultural knowledge, and the proper application of that knowledge when working with individuals from a variety of cultures, *cultural humility* emphasizes adopting the proper posture or perspective in one’s work. The term *cultural competence* seems to suggest that one can reach a state of total competence in dealing with a variety of cultures, and understand exactly how to frame the provision of care to all people of those distinct cultures in order to achieve the best outcomes.

In reality, two factors must be considered relative to the delivery of culturally competent care. First, clients and families create their own cultural identities out of a complex and rich fabric that encompasses factors such as race, ethnicity, religion, gender identity, sexuality, socioeconomic status,

and political views (just to mention a few). Second, mental health professionals experience an incredibly broad range of diversity in the clients they serve. Nowhere is this truer than in Santa Clara County. When these two factors are considered together, it becomes clear that providers can never know everything there is to know about their clients' cultural identities, or know in advance the best way to care for those clients in a culturally relevant way.

While the level of detailed *cultural knowledge* may vary significantly from one provider to another, all providers are capable of adopting the proper *perspective*. All providers can be open to learning what they do not know, and can begin their work with the assumption that individuals and families are the best source of information concerning cultural issues. They can approach each client encounter with an attitude of cultural humility, maintaining a position of inquiry, and applying themselves to understanding as much as possible about the cultural lens through which each client and family views and experiences the outside world. This attitude and this sensitivity to the complexity of delivering culturally appropriate care is of primary importance.

Involving the Family and Natural Support System

In 1991, the Individuals with Disabilities in Education Act (IDEA) attempted to improve the service system through the training of professionals to implement family-centered standards of practice and transform a process driven by professionals to one driven by the family. As awareness grew concerning the ways in which family member/provider relationships may support or interfere with effective service delivery, greater attention was paid in fostering sensitivity to families, taking more relational approaches to care, and including a greater emphasis on individuated care for each family.

In order to be strong partners, and ultimately to drive their own services, families familiar with the old model must go through a process of transition, from passively receiving services to understanding what takes place in the professional domain and participating actively as drivers of their own care plans. They must embrace a new role in setting their own goals and be willing to collaborate with providers in making decisions. This final role stresses interdependence, shared responsibility among collaborating partners (clients, family members, and providers), and a holistic focus that includes the client and family's strengths.

Today, many family members have made this transition, or are newer to treatment, and come expecting to be treated as full partners who drive decision-making alongside providers. Research has demonstrated this emergence of family members as full partners in service planning and delivery. Families now engage with the mental health system in four different ways: as collaborators in treatment; as advisors and advocates on issues of policy development; as support for one another; and as providers of community based services. This shift toward families becoming engaged as partners in care proves critically important to the improvement of services and systems, and results in improved outcomes for clients.

Integration of Family-Driven and Medical Models

Mental health system transformation for clients and families must begin by first viewing, then operationalizing the provision of care in a more holistic manner. In essence, this is because families know what works for them and what their limitations are. They can keep track of the services they receive and the effects those services have on their lives. Unlike the experience of receiving various services, the family's experience is holistic.

A “holistic” system of care can be defined as “an alternative treatment system that focuses on the whole person rather than on specific diseases or disorders, and considers physical, emotional, social, environmental and spiritual factors.”²

The challenges that clients and families face all day, every day, are intimately familiar to them in a way they can never be to others. Naturally, families are absolutely committed to their loved ones’ mental health and engaged in processes intended to support their well-being. For these reasons families have a unique credibility and level of engagement that cannot be replicated by any aspect of the service system. They must be regarded as the primary experts on their own lives, and on the appropriateness of any services designed to improve their lives.

Understanding the family-driven model of care requires several processes:

- Understanding the values and principles involved in family-driven care
- Conceptualizing a clear definition of the term “family-driven”
- Identifying the steps involved in developing the family-driven model

Most mental health providers have been educated and trained in accordance with the medical model of care. A simple definition of the medical model, as it relates to mental health services, is the assumption that behavioral or emotional problems are analogous to physical illnesses and should be approached in the same way. According to Serendip, an online medical resource, the medical model has several strengths and limitations. The major strength of the medical model is in its application to diagnoses with clear biochemical causes. However, in relation to more complex problems, including those affecting many clients in the public mental health system, the medical model has limitations. They include the following: “an overreliance on ‘categories,’ ‘ideals,’ and ‘objectivity’; a failure to appreciate the significance of internal experiences; a lack of appreciation for diversity and for the essential role played by individuals in their own evolution; and a lack of appreciation for the role of culture in mental health.”

The following chart contrasts elements of “traditional care” with those of “family-driven care”³

Traditional Care	Family-Driven Care
Practitioner Directed	Family Directed
Problem Based	Strength Based
Professional Dominance	Family Empowerment / Skill Acquisition
Cure and/or Amelioration	Quality of Life and Adaptation
Facility Based	Community Based
Regimented	Individualized and Creative
Reactive	Proactive and Preventative
Professional Supports	Natural Supports

Family-driven care has been formally defined at the state and federal levels through inclusive processes that included a broad base of stakeholders. This included clients, family members, mental health advocates, the provider community, mental health administrators, and representatives from

² AIDS/HIV Prevention. Website. Accessed 7/5/2012 at <http://aids.hallym.ac.kr/dict/h.html>

³ Adapted from Adams N & Grieder D (2005) Treatment planning for person-centered care, The Road to Mental Health and Addiction Recovery, Burlington MA: Elsevier Academic Press

organizations such as CiMH and SAMHSA. While the specific definitions at the state and federal levels differ, they have much in common. Each definition emphasizes that:

1. Clients and families feel respected and valued as partners in the delivery of care.
2. The voices of clients and families must help determine the direction of the mental health system at three different levels: individual service planning, program development, and policy development/funding.
3. Clients and families are responsible for making care plan decisions based on partnership with their provider(s).
4. Care plans are clearly connected to the client and family's strengths, culture, language, beliefs, opinions and preferences.
5. Clients and families are offered easily understood information necessary to be full and credible participants in service planning.
6. The adverse effects of mental health stigma including shame, guilt and blame are understood and mitigated.

Encouraging service providers at all levels to integrate the traditional model with the family-driven model is one of the major objectives of this training. Service providers who are committed to and engaged in the provision of effective services must fully understand the definition and characteristics of family-driven care.

Medical Model vs. Social Model

Transformational Care Planning is also reflective, to some degree, of social model thinking concerning planning and care. For hundreds of years, the medical model has been the standard for providing care to those in need. This model is based on a scientific understanding regarding the causes of impairment, and confidence in medical science's ability to cure, or at least rehabilitate, disabled people. Those disabled people who were deemed incurable (often for social or political reasons) often found themselves placed long-term in institutions and special schools. In the mental health field, these decisions were made based on professional assessments that focused on the diagnosis of an individual's problems or deficits. The assessments then measured the degree to which an individual was capable of living a "normal" life. The medical model at its core adopts the view that disabled people have problems that can only be solved by professionals, without any significant input from clients and members of their natural support system. The table on the following page points out some of the common differences in thinking between the medical model and the social model that is gradually replacing it.

The social model identifies the many benefits of beginning from a strengths-based perspective that is anchored within a social context. The model takes into account the physical and social barriers that keep individuals from succeeding, whether at school, home or work, and employs personal and social assets to overcome those barriers. It contrasts the notion of a *disability*, with the alternative idea of an *impairment*.

"Impairment is the loss or limitation of physical, mental or sensory function on a long-term or permanent basis. Disablement is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers." (Disabled People's International 1981)

Medical Model Thinking	Social Model Thinking
The client is disabled due to illness (exclusive of the social context).	The client is innately healthy and health-seeking within a social context.
Professionals diagnose what is wrong.	Clients, families and professionals identify what results are desired, and what personal and social strengths and assets are available to achieve results.
Problems (and clients) are labeled and efforts made to fix them.	Barriers to client wellness are identified. Strengths are identified or developed at the individual and social level to overcome barriers.
The focus of attention is on disabilities.	The focus of attention is on wellness and recovery.
Clients and families are the passive subjects of assessment, diagnosis, and therapeutic procedures.	Clients and families are active partners in defining desired results, as well as identifying and taking action steps to achieve them.
Family relationships and other social connections are not factors in decision-making.	Ordinary needs are actively addressed and leveraged to achieve results.
Re-entry to society is dependent on the severity of one's symptoms. Some clients are permanent excluded from community life.	Re-entry is rapid to leverage existing social supports. Inclusion and diversity are emphasized.

One may have an impairment, but this does not limit his or her right to live in the local community and actively participate in community life. An inordinate focus on finding medically-based cures distracts people from looking at the array of socially and personally adaptive strategies that will enable people with mental health challenges to leverage both personal and social strengths. In doing so, they can learn to thrive within the context of their own social environments and to be positive influences not only for themselves, but for those around them as well.

The social model emphasizes a way of thinking that is very different from the medical model. From the perspective of the social model, if some part or parts of your body or mind are limited in their functioning, this is simply an impairment. This impairment doesn't make you any less human; instead it is something that can be overcome, or that society as a whole can learn to accommodate. This is an achievable goal that benefits everyone. Fortunately, the mental health profession as a whole has begun to embrace the social model, removing socially-constructed barriers, and empowering individuals with impairments to fully participate in community life. Transformational Care Planning supports this movement by working to align the policies, practices, and required documentation of the mental health field with this perspective.

Transformational Care Planning

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Module Two:

Assessment



Assessment

A. Introduction and Summary

This module explores the process of assessment from the perspective of person-centered, family-driven care. Clients, when viewed in the context of their natural support system, cultural identity, and various life domains, have a complex symphony of characteristics, many or all of which must be assessed and understood at a basic level prior to developing a plan of care.

This module also looks at the various elements of an assessment, all of which are intended to incorporate the principles and characteristics of family-driven services. For example, assessments must create a focus on improving resiliency, building on strengths, making collaborative decisions, and working toward goals established by the client and family. Medical histories and other information about a client's psychosocial interactions are also critical elements of a comprehensive assessment. Assessment practices such as screening, establishment of medical necessity, diagnostic procedures (including psychological testing), and other assessment activities are also discussed.

B. Content

Assessment is a process of collecting data from the many realms of a client's life in order to make informed decisions about supports and services that will benefit a particular client and family. This process must be comprehensive enough to inform a wide range of treatment decisions, including those related to safety planning, intensity and frequency of services, types of interventions used, and even the timing of a client's transition away from formal services.

Assessment first occurs at the onset of services, resulting in the creation of a formal written document. It also occurs on an ongoing basis throughout the course of treatment, as the client and provider work together to evaluate progress and make the adjustments needed to arrive at the client's stated goals.

Assessment should be guided by the values and principles involved in family-driven, culturally sensitive care. Because each client's family and/or natural support system is critical to his or her well-being and can provide the best care for the client, members of these support systems should be actively involved in the assessment, as well as the development and execution of any resulting plan. While work schedules, transportation, and family dynamics, among other things, may influence each member's level of participation in the treatment process, an inclusive approach is warranted to the greatest degree possible. In cases where the client has no family involved in his or her care (as is often the case with adult clients), providers must take care to include any natural or professional support people who is available. Where families are involved, the family's culture, race, ethnicity, values, customs, and other areas of difference must be respected and thoughtfully considered. In addition, mental health providers should include workers from other relevant systems (e.g. child

welfare, criminal justice, etc.) to participate wherever indicated as the assessment process moves forward.

An assessment process such as the one described above must be collaborative in nature, with the provider, client, family, and natural support system engaged in a constructive dialogue. This may occur through phone calls, face-to-face conversations, a review of previous records, and a variety of other methods of communication. In this process, the provider defers to the wisdom, historical knowledge and experience of the client and his or her natural support system, as this is the key to developing a holistic understanding of the client's situation. Rather than being focused solely on finding a diagnosis, this process focuses simply on bringing together information from all areas of the client's life. The assessment focuses on identifying strengths as well as challenges. A strengths-based assessment identifies the client's best qualities, competencies, insights, past successes, motivation to change, community supports, positive relationships and much more. Identified strengths are then used to help create the client's treatment plan, particularly in the crafting of the short-term goals and interventions. It then looks for ways to build on those strengths and move toward any initial goals the client and others have already identified.

Cultural Sensitivity in Assessment

A culturally sensitive assessment takes into consideration all the important cultural variables that affect the daily life of the client, family, and natural support system. It also focuses on tackling the barriers to effective communication with clients and families from a variety of cultural backgrounds. Since Santa Clara County is one of the most ethnically diverse counties in the nation, this is a significant undertaking, but also a very important one. Gaining an understanding of the client and family's worldview is the key component to conducting a culturally sensitive assessment.

For example, people of color, including individuals of African or Hispanic origin, may in some cases be uncomfortable with ideals of autonomy and self-determination. Family and peer-centered processes are often more central to goal setting and decision-making in these cultures. In instances like this, the provider must modify treatment processes in a way that legitimizes a more collective decision-making approach. For example, when a client expresses a cultural preference for including a parent or a community elder, a concerted effort must be made to encourage that person's participation in the assessment process (as well as later stages of treatment), and to support him or her in taking an important and active role in the process. To ensure this active participation, in some cases it may be necessary to offer the identified elder or parent orientation/information regarding the range of his or her possible roles and contributions.

A variety of cultural factors should be carefully explored in the initial assessment. Some family systems include multiple generations. These families may weave traditional cultural values with those of the mainstream culture. In addition, generation gaps can create misunderstanding and conflict within the family. When acculturation issues are identified (immigration, multiple generations, residing in the same home, adjustment challenges, etc.), it is important to assess how these factors may play into the client's/family's reasons for seeking services. In addition, providers must quickly identify any language needs within the client/family or natural support system, and secure the resources to provide services in the appropriate language. While Santa Clara County is home to over 100 languages and dialects, the Mental Health Department works hard to maintain the broad range of supports required by clients in need of care. Service providers who do not speak the language of a client or family must either use a trained interpreter or transfer care to a provider who is fluent in that language. Providers should remember that it is against best practice

recommendations to use a member of the client’s natural support system as an interpreter. This practice can create tension within that system, put undue stress on the individual being used as an interpreter, and severely compromise the value and accuracy of the information gathered. Of course, ethnicity and language are just two of many cultural factors that impact the course of treatment. Age, gender, sexual identity, religious and political affiliation, and numerous other factors must be assessed carefully, and incorporated into the assessment.

Risk and Protective Factors

Assessments must also emphasize the identification of important risk and protective factors in the client’s life, as these can increase or decrease their risk of developing problems such as aggressive behavior, self-injury, or substance use. Risk factors include such things as teen parenthood, illegal gun ownership, history of abuse/trauma, drug use and family violence, just to name a few. Protective factors include such things as engagement in spiritual activities, having problem-solving skills, and having good relationships with family members. Risk and protective factors may also be present at the macro and mezzo levels (e.g. living in a high-crime area, etc.). Assessments are intended to reveal potential risk and protective factors and to indicate the impact these factors might have on a client. Once the factors are identified they can be specifically addressed by interventions set out in the client’s care plan.

Life Domains and Sources of Collateral Information

Based on the preferences of the client, clinical judgment, and various system mandates, assessments may involve gathering information from a number of collateral sources. These may mean interviewing a client’s spouse or life partner, primary care doctor, probation officer, social worker, conservator, extended relatives, neighbors, and a variety of other individuals with whom the client has contact. These individuals come from a variety of life domains, or areas of a client’s life. The list to the right provides examples of some of those domains.

Gathering information about the client’s life across multiple life domains is an important aspect of assessment because a client may exhibit different kinds of behavior in different circumstances. For example, a client may have difficulty at home, but function well at work or school.

Because clients’ lives are not static, they become involved with new people in various aspects of life on an ongoing basis. In addition, clients’ interactions with any given individual may change. As a result, an assessment process that takes place over time, and solicits information from a variety of collateral sources at different times, has the best chance to provide the solid groundwork on which the plan of care will be created.

Primary Life Domains

- Living situation
- Family
- Natural supports
- Cultural and spiritual life
- Emotional and/or psychological
- Health status and medical needs
- School and/or work
- Legal issues
- Financial well-being

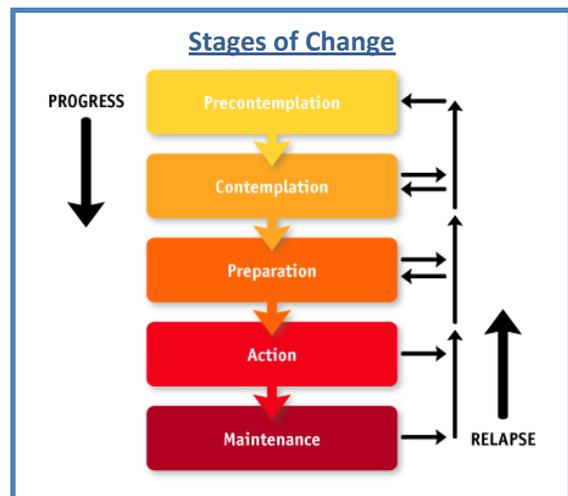
Stages of Development

Assessment and the entire planning and service delivery process must be informed by an understanding of the client’s stage of development. This is most important for children and youth, who rapidly grow and change, tackling a number of developmental tasks and learning age-appropriate skills along the way. We cannot think of these clients as merely “mini adults” but must

consider each one according to his or her developmental age. It can also be helpful to consider what stage of life an adult client is facing. While change may happen more slowly in adulthood, a young, single adult working his or her first job faces dramatically different challenges than an older adult whose children are grown. It is also important to remember that while often a client's stage of development often correlates to his or her chronological age, in many circumstances it does not. Substance use and cognitive disability are just two examples of factors that may delay an individual's development at any age. An assessment should take into account how a client's age and stage of development may relate to his or her reasons for seeking services, and the motivation of the family or natural support system in participating in the process.

Motivation and Stages of Change

A final component of any comprehensive assessment should include exploration of the readiness of a client and his or her natural support system to make needed changes. Since, many clients in the public mental health system are referred by someone else (a probation officer, social worker, homeless outreach worker, teacher, etc), it is critical that providers recognize this and assess its impact on the treatment process. The diagram to the right shows one popular model for thinking about the change process. There are a number of other models that may be helpful as well. For clients who did not refer themselves for treatment, it is important to include the referring party in the assessment process as much as possible, in order to clarify external motivators to change. In addition, motivational interviewing is a best practice that has been implemented in Santa Clara County and can be used to help clients and/or families identify their own reasons for participating in treatment. For example, a probation officer may generate a referral to "address the impact of depression and family conflict on the client's drug use and gang-related activity." However, the client may decide to participate, along with his or her natural support system, in order to "get the probation department out of our lives." In the best cases, a client may also agree that he or she wants to "get along better with my family and not fight so much." Transformational Care Planning stresses the importance of having these conversations with the client and family, as well as relevant system partners, and assessing the roles and motivations of each party in the effort to create positive change.



For example, a probation officer may generate a referral to "address the impact of depression and family conflict on the client's drug use and gang-related activity." However, the client may decide to participate, along with his or her natural support system, in order to "get the probation department out of our lives." In the best cases, a client may also agree that he or she wants to "get along better with my family and not fight so much." Transformational Care Planning stresses the importance of having these conversations with the client and family, as well as relevant system partners, and assessing the roles and motivations of each party in the effort to create positive change.

Assessment Process and TCP

In Santa Clara County, service providers must complete a formal, written assessment at some point within the first 60 days of any treatment episode. This assessment includes a clear identification of the presenting mental health problem, any symptoms the person is experiencing, the impairment to life functioning that results from the problem, and a qualifying DSM-IV-TR diagnosis.

Documenting the medical necessity for services in this way is a critical task that must take place during the assessment process in order for providers to receive reimbursement for their services. While these tasks are necessary to justify receipt of payment for services, Transformational Care Planning places an even greater emphasis on creating understanding between the client / family and the provider. Without documentation of medical necessity, providers cannot receive payment for

services. However, without creating a deep understanding of the client's culture, motivation, aspirations, strengths, and concerns, those services will not be collaboratively structured and delivered in a manner that will help families or individuals reach their goals. Without understanding, providers are ill-equipped to assist clients in achieving the quality of life outcomes they want and deserve. High quality assessment and treatment cannot be achieved without a fundamental grounding in client-centered, family-driven values and principles. So, assessments must first arrive at a deep understanding of a client's desires and goals, *and* also establish medical necessity for mental health services at the same time.

Three Criteria Establish Medical Necessity

The provider determines that the client has the following:

1. A qualifying diagnosis
2. Functional impairments resulting from a qualifying diagnosis
3. A need for specialty mental healthcare to reduce or eliminate impairments.

An assessment captures all the relevant facts and details provided by the client and his or her natural support system about the circumstances that led him/her/them to seek services. To that end, assessment continues on as an informal process even after a formal, written assessment has been completed. This continuing assessment process then allows providers to gather information in a less structured, more conversational approach. A family-driven and/or person-centered assessment engages the client and natural support system in the process—they are highly invested in it. The assessment process may identify key relationships and patterns within the family, and may also indicate where a good place to start the client and family plan might be. Because the goal of the assessment is to gain a clear understanding of the client and family, the process should identify the client and family's strengths, the developmental stage of the client, the resiliency factors apparent in the client and family and the interrelationships between individuals in the client's life. The assessment will serve as a context for the plan and may indicate the order in which objectives might be addressed. Reviewing key points with the client and significant support people can be a helpful verification strategy.

Some Key Tasks in Assessment include:

- Clear identification of the presenting problem, the needs of the client and family, and the client and family's strengths.
- Identification of the following:
 - The developmental stage of the client
 - The client's readiness to change and motivation for seeking help
 - The strengths and resiliency apparent in the client and family / support system
 - The interrelationships in the client's life
- Collection of data to support a formal diagnosis, including a DSM-IV cultural formulation, as needed

Two Barriers of Effective Assessment (and Potential Solutions)

There are two common barriers to effective assessment. The first barrier involves time. Often those service providers who are responsible for conducting assessments have serious time constraints. Because assessment is not a crisis-oriented activity, it may take a back seat to more urgent activities. One solution may be to do the assessment over a series of interviews (within county-defined time limits), rather than during one marathon session. This also enhances engagement of the client to a particular agency and their staff.

A second barrier to effective assessment involves the forms that may be the standard of an agency. When these forms are deficit-based rather than strength-based it may be highly challenging to focus on a client and family's strengths. In Santa Clara County, both the assessment and treatment plan forms have been reviewed to insure that they facilitate the creation of client-centered and strengths-based documents. In addition, the Child and Adolescent Needs and Strengths (CANS) assessment will be used with youth and their families. The CANS is an assessment process in addition to a multi-purpose tool developed for children's services to: support decision making (e.g. level of care and service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that "optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build strengths."⁴

CiMH's Three Recommendations for Assessments:

The first recommendation for assessments is that they be collaborative. The service provider and the client and family should come together to formulate a description of the client and family that is accurate and useful. Treatment outcomes, as a general rule, are better when committed family members and natural supports are involved in the recovery plan.

The second recommendation is that assessments should be comprehensive. They should include strengths, health status, substance use history, education and work history, presenting problem (with specific information about that problem, such as where and how often it occurs), history of social and emotional development, and any other relevant information from the domains discussed earlier in the chapter.

The final recommendation is that the assessments include standardized tools (assessment measures) that are repeated periodically over the course of the client and family's involvement in services. This periodic repetition will inform the family and the provider about the progress being made and about the need for adjustments and changes in services. In Santa Clara County, this recommendation is met by use of the MORS (for adult clients) and CANS (for children and youths).

Establishing Medical Necessity

The Medi-Cal system uses the term "medical necessity" to indicate the amount, duration, and scope of services the public mental health system will supply. California's counties and other mental health entities rely on the criteria established for medical necessity to create a foundation for documentation. In other words, a service must meet medical necessity standards before Medi-Cal will pay for it, and if the documentation is inaccurate or there are audit exceptions, no payment will

⁴ Lyons, J.S (2009). *Communimetrics: A communication theory of measurement in human service settings*. New York: Springer.

be provided, which in turn will lead to fewer programs and reduced services overall. Medical necessity defines the problems that need to be addressed and helps define the condition to be targeted by mental health interventions.

The California Code of Regulations, Title IX, Chapter 11, Section 1830.205 (b) (1) (AR), identifies qualifying mental health diagnoses. The symptoms of these diagnoses ***must create a significant impairment in the client's life***, such as an inability to attend work or school, or isolation with few social supports (social impairment). In addition, the diagnosis must be likely to require mental health interventions for the client to avoid a worsening of symptoms. Under medical necessity, the provider must show that the interventions implemented with the client and family address the identified impairment.

The role of the service provider is to observe and document, within his or her scope of practice, evidence of medical necessity. Documentation of symptoms, functional impairments, and results of interventions are key to providing evidence of medical necessity. Medical necessity is identified and documented throughout the client and natural support system's involvement with the mental health system, from assessment to service plans to progress notes.

Conclusion

Assessment is all about listening to and recording the unique story of a client and family in a comprehensive, systematic way. Many factors play into a family-driven, culturally sensitive assessment, and each must be attended to: family-driven principles and values, cultural humility, strengths of the client, family and natural support system, risk and protective factors, stage of development and motivation to change, among other things. Assessment processes that take place within a medical model must be integrated with a family-driven model in order for clients and their families to receive the best possible services and achieve the best possible outcomes. At the same time, establishing medical necessity and complying with Medi-Cal requirements are critical elements of the process and can be complementary to family-driven, culturally sensitive service provision. The next module will discuss how to take data from all the various components of an assessment, pull out the most significant pieces of the story, and craft them into a narrative summary.

C. Activities

“Practices Aspects of Completing an Assessment (Padma, adult client)”

Materials

None

Objectives

Review the practice of conducting a comprehensive, person-centered, culturally inclusive assessment

Instructions

Divide into groups of four or five. In each group, select individuals to play the following roles:

Service Provider: Choose an individual who has experience conducting assessments.

Padma: Choose an individual who will represent Padma, the client described below.

Family Member (optional): Choose an individual who will represent one of Padma’s family members

Collateral Sources (optional): Choose one or more individual/s who will play a part in providing collateral information from various domains of Padma’s life.

Recorder: Choose an individual who takes notes and captures key ideas about the process.

Based on the information below, role play an interview with Padma (and others in her natural support system, if you choose) to better understand her worldview, culture, strengths, resources, and factors that maintain the identified concerns. Consider Padma’s MORS score and what stage of change she is in to help guide a vision towards her hopes and dreams.

After the above parts of the activity have been completed the small group should sit in a circle and discuss what they learned about assessment from the process.

As time permits, share your learning with larger group, then review the information that was gathered for Padma and consider how this may influence your hypotheses about this client and her supporters/family.

Notes

- Each person in the group should feel free to use the text of the module’s narrative, specifically the sections that describe the processes involved in their roles, to guide their parts of the activity.
- In addition, the description of Padma on the following page should guide the activity.

Adult Vignette – Basic Information

- Name: Padma
- Age: 43
- Identifying info: Divorced Iranian female who resides in a small apartment with her ex-husband (Max) and their 12 year old daughter (Sam). Padma identifies with the Christian religion to which she recently converted from Islam. She collects SSDI and her ex-husband is currently not employed. She speaks English primarily, but can also speak Farsi, Urdu, and is trying to teach herself Spanish.
- Family history: Padma was born in Iran, but came to the US as an infant when her parents died. She and her two sisters were adopted out upon their arrival. Padma's older sister committed suicide when Padma was 12 and the younger died from cancer when they were in their early 20s. Padma was rejected by her adopted family, but the reason for this disconnect is unclear right now. Due to a traumatic past, she is uncomfortable disclosing information at this time. She has no knowledge of her biological parents and was unable to gather any information from her sisters. Padma does not get along well with her ex-husband or his parents and they particularly disagree on the style of raising their daughter. Padma has been arrested for anger outbursts towards her ex-husband, but feels the police do not believe that her ex-husband also returns the anger. Padma does not wish to have her family involved in her treatment right now.
- Social history: Padma used to attend church regularly and felt very connected to the pastor's wife and would like to re-connect with her. She does not generally get out of the house because she lost her driver's license. Padma worked for many years until a fire at her home and a car accident prevented her from being physically able to work. Between physical trauma and a long history of domestic violence, she tends to isolate from others. She has a history of employment in the tourism sector, but has not worked since 2002.
- Symptoms: guarded, depression "tired of life, sick of the pain both physically and emotionally", isolates to herself, anger, easily overwhelmed, anxiety, nightmares as linked to her youth, but details are presently unclear, auditory hallucinations, very protective of her daughter, has somatic complaints (some due to a house fire & car accident, others are unclear what they stem from), falls often, blacks out, drinks alcohol 3-4 days of the week to help her "feel better"
- Diagnosis: PTSD, with history of schizophrenia diagnosis (type unknown), features of dependent personality d/o
- Milestones of Recovery Scale (MORS) score at time of assessment: 5 (Not coping successfully/engaged with mental health provider)

“Practicing Aspects of Completing an Assessment (Diana, Child/Family Client)”

Materials

None

Objective

Review the practice of conducting a comprehensive, person-centered, culturally sensitive assessment

Instructions

Divide into groups of four or five. In each group, select individuals to play the following roles:

Service Provider: Choose an individual who has experience conducting assessments.

Diana: Choose an individual who will represent Diana, the client described below.

Family Members: Choose individuals who will represent Diana’s mother and other family members

Collateral Sources (optional): Choose one or more individuals who will play a part in providing collateral information from various domains of Diana’s life.

Recorder: Choose an individual who takes notes and captures key ideas about the process.

Based on the information below, role play an interview with Diana and her mother to better understand their worldview, culture, strengths, resources, and factors that maintain the identified concerns. Also, consider what needs and strengths you might identify as part of implementing the CANS tool.

After the above parts of the activity have been completed the small group should sit in a circle and discuss what they learned about assessment from the process.

As time permits, share your learning with larger group, then review the information that was gathered for Diana and consider how this may influence your hypotheses about this client and family.

Notes

- Each person in the group should feel free to use the text of the module’s narrative, specifically the sections that describe the processes involved in their roles, to guide their parts of the activity.
- In addition, the description of Diana and her mother on the following page should guide the activity.

Family & Child Vignette - Basic Information

Name: Diana

Age: 9

Identifying Info: Diana is a Latina girl who speaks Spanish and English. She lives with her mother Teresa, father Jorge, grandmother, 2 older brothers and one younger brother (ages 12, 10 and 3.) She is in the 4th grade.

Presenting Problems: Teresa describes Diana as “hyper” and notes that she has trouble completing homework. Mostly she has done well at school, but teachers have complained recently about her being more disruptive in class. She has intense reactions to other girls, getting very preoccupied with gossip and the image she projects to others. She has frequent tantrums and is very demanding and argumentative with parents and siblings. She fights with her brothers but also seeks support and protection from the oldest brother, Jose.

She had a traumatic incident 2 years ago when she was stuck in a locked room with other children. She now feels anxious in rooms with closed doors. She has had bedwetting incidents since early childhood possibly related to a tendency to urinary tract infections, but these incidents have increased in the last year.

Family History: Parents immigrated to U.S. from Michoacán, Mexico 13 years ago. One of her brothers is in Special Ed due to developmental delays. Mother works full time, sometimes graveyard shifts at a fast food restaurant and father is not fully employed.

Teresa struggles to feel connected to her daughter and finds her hard to please (though Diana is attached to grandmother and has less conflict with father.) Due to Teresa having experienced trauma in the past, she has difficulty expressing physical affection especially to a daughter. Teresa does not feel they had an easy time bonding when Diana was an infant, as she had to go back to work quite soon after the birth and had a hard time soothing her baby when she was upset. Teresa and Diana hoped youngest child would be a sister for Diana and were both disappointed when another boy was born.

Interview to better understand worldview, culture, strengths, resources, and perpetuating factors

- Grandmother has strong leadership role in family and influences rules. Jorge grew up without a father and believes a father is very important to his children. Mother wonders why if this is the case, he spends so much time watching television and drinking beer. Mother has a lot of resentment about how much she has to be the one working to support family. This takes away from her time to have quality time with children or supervise homework and adds stress getting out of the house in the mornings.
- Diana is well liked by teachers and peers and is a star in her folklorico group. However the family has difficulty transporting her to and from the dance group on a regular basis. She is verbal, expressive and artistic. Diana during interview makes many bids for attention from her mother who is uneven in her responses. Teresa often feels physically intruded on by her daughter and Diana does become intrusive as her frustration increases. Teresa feels Diana is

old enough to understand that she cannot instantly have everything she wants. Diana states that her wish is for her mother to love her. Father and mother argue a lot and father thinks mother creates unnecessary conflicts with daughter. Father admits that he worries mother will leave him.

- Mother has a comadre who she calls for support when her frustration is high. This person will sometimes have Diana stay for a weekend as Diana and her daughter enjoy each other's company. The family used to attend church and liked the priest but they have not been attending in recent months.
- Diana would not allow further discussion of bedwetting and Teresa indicates that they have had a good week in this regard and hope for ongoing improvement in this area.
- Parents note that she almost always gets mad and sees things pessimistically. They would like to see more optimism.

CANS Items:

STRENGTHS:

Family – 1 (some good relationships between siblings)
Interpersonal - 1 (good interpersonal skills, ability to develop healthy friendships)
Identity- 0 (connected to others who share cultural identity)
Talent/Interests- 0 (folklorico dance skills source of pleasure and self-esteem)
Educational- 0 (does well academically, likes to read and learn)

NEEDS:

Family- 2/3 (frequent arguing)
Social Functioning- 1/2 (mild to moderate problems with social development)
School Behavior-1 (mild behavior problems in school)
Impulsivity/Hyperactivity -2 (clear evidence of impulsive, distractible or hyperactive behavior that interferes with functioning in at least one life domain)
Depression-1 (suspicion of depression due to moodiness and irritability)
Oppositional -1 (recent history of defiance in family)

D. Handouts

Checklist for Culturally Sensitive Assessment

1. Have you considered cross-cultural explanations for problem behaviors?
2. Have you been an active investigator as you collected data, seeking to uncover all the relevant pieces of data that can inform you about your client's worldview?
3. Have you maintained a person-centered, oppression sensitive stance in conducting your assessment, being careful to consider how your own worldview impacts the care you are providing?
4. Have you identified key cross-cultural variables to integrate into the planning and intervention process?

40 Developmental Assets⁵

Search Institute® has identified the following building blocks of healthy development, known as Developmental Assets®. While these were designed to identify assets that help children and teens grow into healthy, caring, and responsible adults, many of these indicate assets that apply to adults later in life, and can be used as strengths when creating a plan of care for a client of any age.

External Assets

Support

1. Family support – Family life provides high levels of love and support.
2. Positive family communication – Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships – Young person receives support from three or more nonparent adults.
4. Caring neighborhood – Young person experiences caring neighbors.
5. Caring school climate – School provides a caring, encouraging environment.
6. Parent involvement in schooling – Parent(s) are actively involved in helping young person succeed in school.

Empowerment

7. Community values youth – Young person perceives that adults in the community value youth.
8. Youth as resources – Young people are given useful roles in the community.
9. Service to others – Young person serves in the community one hour or more per week.
10. Safety – Young person feels safe at home, school, and in the neighborhood.

Boundaries and Expectations

11. Family boundaries – Family has clear rules and consequences and monitors the young person's whereabouts.
12. School boundaries – School provides clear rules and consequences.
13. Neighborhood boundaries – Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models – Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence – Young person's best friends model responsible behavior.
16. High expectations – Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

17. Creative activities – Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.

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18. Youth programs – Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community – Young person spends one or more hours per week in activities in a religious institution.
20. Time at home – Young person is out with friends “with nothing special to do” two or fewer nights per week.

Internal Assets

Commitment to Learning

21. Achievement Motivation – Young person is motivated to do well in school.
22. School Engagement – Young person is actively engaged in learning.
23. Homework – Young person reports doing at least one hour of homework every school day.
24. Bonding to school – Young person cares about her or his school.
25. Reading for Pleasure – Young person reads for pleasure three or more hours per week.

Positive Values

26. Caring – Young person places high value on helping other people.
27. Equality and social justice – Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity – Young person acts on convictions and stands up for her or his beliefs.
29. Honesty – Young person “tells the truth even when it is not easy.”
30. Responsibility – Young person accepts and takes personal responsibility.
31. Restraint – Young person believes it is important not to be sexually active or to use alcohol or other drugs.

Social Competencies

32. Planning and decision making – Young person knows how to plan ahead and make choices.
33. Interpersonal Inclusion – Young person has empathy, sensitivity, and friendship skills.
34. Cultural Inclusion – Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance skills – Young person can resist negative peer pressure and dangerous situations.
36. Peaceful conflict resolution – Young person seeks to resolve conflict nonviolently.

Positive Identity

37. Personal power – Young person feels he or she has control over “things that happen to me.”
38. Self-esteem – Young person reports having a high self-esteem.
39. Sense of purpose – Young person reports that “my life has a purpose.”
40. Positive view of personal future – Young person is optimistic about her or his personal future

Transformational Care Planning

Advancing Recovery, Resiliency & Wellness



Module Three:

Understanding the Client's Story and Creating a Narrative Summary



Understanding the Client's Story and Creating a Narrative Summary

A. Introduction and Summary

The narrative summary is a brief document containing what is known about the client and family's story, including their strengths and culture, challenges and symptoms, as well as the client's stage of life and motivation to change. A culturally relevant and client-centered narrative summary is shared with the client and his or her natural support system. By assisting in the writing of the narrative, the client and others insure the service provider's understanding of their story is accurate. A well-written narrative demonstrates that the service provider has heard the client and support system and worked with them to weave the pieces of the story together into a coherent summary. In the end, the narrative will facilitate further shared decision-making to create a plan for achieving the goals they have articulated.

B. Content

Definition and Description

The word "formulation" can be used to refer to the *process* a service provider goes through in constructing the client's story. The narrative summary is sometimes referred to as a "clinical formulation" because it involves taking all the disconnected bits of data collected during the assessment process, identifying the items that are most relevant to the client's stated purpose for seeking help, and weaving them into a coherent summary of the client and family's past experiences (not merely repeating data points), while pointing toward likely interventions.

The formulation process supports the client and family's path to wellness by ensuring that they have a shared understanding with the provider. It is the process of creating a collaborative dialogue between the client, his or her natural support system, and the provider(s) who will be working with them to create positive change. *This is not an easy task.* It takes repeated practice for a provider to navigate skillfully through the formulation process to reach a point of shared understanding, and have the ability to document that journey in a narrative summary that is clear and concise. As difficult as this may seem, however, a provider can speed up his or her learning and begin to feel comfortable with the process by making use of clinical consultation with peers and supervisors, intentionally building on the experience of others, and by not shying away from opportunities to practice these skills with individuals and families receiving care.

The narrative summary, composed with the client and family, becomes the basis of a healing partnership that supports the client's resiliency and shows the family respect. It is an opportunity for genuine communication and collaboration, and for developing a positive relationship between the family and the provider. By achieving understanding of the family, a provider can assist them to reduce the impact of barriers to their goals.

Elements of the formulation should include:

- The strengths, hopes, motivation, and cultural grounding of both the client and natural support system.
- A description of the client (in the context of his or her family and natural support system, where applicable).
- Barriers to wellness and recovery, along with a clinical hypothesis about how to overcome the most significant barriers (potential action steps and/or interventions).

Challenges in Writing Narrative Summaries for Person-Centered Care

Perhaps the single greatest barrier to preparing narrative summaries is the lack of a single, structured format to follow, which results in some providers lacking the skill and comfort necessary to complete the task as part of their daily routine. Providers must be aware that contents of a narrative summary must be adapted to age and developmental maturity of each client, as well as the unique and distinct characteristics of the client and natural support system at the specific point in time that the process occurs.

Children, for example, may have the capacity to cite their immediate needs, but lack the ability and insight needed to delve into larger issues that impact their overall life functioning. In addition, due to their rapid, ongoing development it may be necessary to review the assessment and narrative summary more than once in a single year, and update the treatment plan accordingly. Parents and other family members often contribute significantly to the contents of the narrative summary. Adult clients may present some of the same scenarios, but bring different developmental, environmental, and motivational factors to the table. Parent-child relationship dynamics may be at the center of a narrative summary for a young client, but would be completely irrelevant when working with a number of adults. Likewise, interventions proposed in the narrative summary to help a client reach his or her goals will differ dramatically based on age, culture, and countless other factors. While this variation in client needs makes it difficult to create a single formula for describing a well-written narrative summary, a number of helpful guidelines are included in the remaining pages of this module.

The emerging assessment process has also challenged the formulation process. Because mental health agencies must be very sensitive to Medi-Cal practices so that they can establish medical necessity and bill for the services they provide, assessments have begun to address more life domains, and include collateral data from additional sources. They have grown in size and scope. To accommodate the increase in inclusiveness, assessments have moved toward a brief identification of various factors impacting treatment. They cover many more areas of data collection and do not always allow detailed discussion within each area. Rather than composing a document that accurately conveys a client's story, one that connects and brings together various details about the client's life, providers tend to focus on simple data identification. The resulting assessment may be a vast canvas of unconnected bits of information that are not useful for planning care until they are drawn together into a coherent narrative. *Thus, the formulation process has become most critical at a point when there may be less time to accommodate it.* However, when working conditions do not prioritize time needed to write a comprehensive summary, providers may make less informed decisions in creating a care plan. Providers may produce written narratives that cite clients' immediate needs but do not respond to larger issues. In response, Santa Clara County has committed to incorporating narrative summaries into the treatment process and improving client outcomes in the process.

The Writing Process

What, then, is the most efficient method providers can use to write narrative summaries that capture the most significant items relevant to a client's care? First, providers must recognize that formulation is a process that consists of both analysis and synthesis. It is a determination and distillation of assessment information for the purpose of care planning. Formulation involves analyzing the vast amount of assessment data and isolating those details that are important to consider. Then the salient details are synthesized, or put together, in a written narrative. The narrative summary must demonstrate understanding of those elements, situations, or presenting problems in the client and family's life that bring them to seek services, as well as the strengths and cultural factors that will contribute to an effective care plan.

More specifically, the formulation process involves drawing logical connections between sources of information, whether the information comes from people or from written material. Key elements of the narrative summary, such as data about an adult client's stage of change may be affected by the relationship with his or her spouse and closest friend. When working with children and families, a child's individual level of development and the uniqueness of his or her maturation process may be affected by familial relationships, especially caregiver relationships. In each of these cases, significant relationships will likely need to be discussed. Logical connections are mapped out between recent events and events that happened in the more distant past. These connections may explain how a particular problem originated. Certain elements in the life of a client, or the lives of people in his or her natural support system, might be sustaining the problem. These elements should be documented in the narrative summary.

The writing process then suggests possible decisions about the most productive way of dealing with problems. Because the story told in the narrative summary also includes the family's strengths, protective factors, and cultural identity, it can indicate potential methods or interventions that might be used in the process of accomplishing the client's goals. Methods that are strength and culture-based are not only likely to be more successful, but they are also more likely to be welcomed by the client and natural support system. A helpful way to crystallize one's thinking and avoid simply rewriting the assessment is to remember that the narrative is an explanatory document that seeks to answer the following 4 questions:

1. How did we get here? (Explain likely reasons for both the concerns and the strengths)
2. What is keeping us here? (Maintaining factors)
3. Where do we want to go? (Client/ family's desires)
4. How might we get there? (Possible next steps)

In addition, Santa Clara County has adopted a standard that the narrative summary should include the following elements:

1. A clinical hypothesis/understanding/core theme re: what drives the individual's experience of illness and recovery.
2. Strengths, interests, and current and/or desired life roles and priorities
3. Cultural factors and any impact on treatment
4. Any interfering or perpetuating factors, e.g., trauma history (and current responses), co-occurring medical or substance use disorders, etc.
5. Individual's stage of change and/or developmental factors (developmental capacities)
6. Available natural supports or community resources (supportive relationships in a child's life)

This standard means that the clinician will incorporate the factors/categories above as he or she constructs the narrative summary. These elements are not intended to comprise the entire content of the narrative summary. Instead, at each step of the process the clinician, client, and members of the client's family / natural support system should carefully consider what content is most important to include in order to tell the client/family's story. For children and youth, the CANS may guide the clinician and family in constructing the narrative. When the clinician blends questions related to the CANS into a natural discussion with the family, this enables the family to consider strengths and needs that otherwise might not be revealed.

Leading with Strengths

Narrative summaries may include some discussion of a client's eligibility for services (i.e. medical necessity); this factor can be complementary to the person-centered care planning. The determination of eligibility is often based, to some degree, on information represented in the assessment form. The assessment may, as a result, focus significantly on a client's deficits and impairments, even if it contains some limited discussion of strengths. While some assessments might lead one to believe that the mental health system does not emphasize client strengths, the narrative summary provides an opportunity to present a different view entirely. Strengths identified at first in the assessment can get the spotlight during the creation of the narrative summary. The client and family's story then becomes a very different story from one based entirely on deficits. For example, an assessment (focused on documenting medical necessity) might include the following remark: "This 10-year-old child has been removed from his classroom on numerous occasions for disruptive behavior." A strength-based narrative might read, instead: "This is a bright child with marked artistic abilities who has been referred to services as a result of disruptive behavior." When a narrative summary leads with strengths, it presents a hopeful, resiliency/recovery-oriented vision of the client and family that will lead those who read it to build a care plan with the same vision.

The formulation process plays an important role in building a relationship between the client / family and the care provider. When narrative summaries include an emphasis on strengths and cultural factors, family members and service providers are more likely to develop the type of mutually pleasant and respectful relationships that are key to creating positive outcomes. In fact, we find that most of the complaints made by those receiving care relate to the perception that they are not being treated respectfully. Focusing on strengths, then, becomes a vital part of providing quality care.

Cultural Formulation and the DSM-IV-TR

Developing a narrative summary requires understanding the cultural background of the client and his or her natural support system. Culture grounds all our actions, so it is essential to introduce a discussion of culture into the formulation process from the start.

This discussion should be respectful, humble, open, and accessible. Unfamiliar vocabulary should be explained in understandable terms and without condescension. Listening well to what is stated and attending to body language are essential skills for providers engaged in the development of narrative summaries. Body language, such as facial expressions, may indicate the client and family's yearning to be fully understood. Before the family's full story can be represented in the narrative summary it must have been heard.

The Diagnostic and Statistical Manual IV-TR (DSM IV-TR), in addition to naming and describing the various problems that might bring a client to seek services, discusses culture when it is appropriately considered within diagnostic categories. It also includes a section on “cultural formulation” that outlines how to take into consideration the various aspects of a client and family’s culture, the problem presentation, and some other aspects of the family’s story that will make up the narrative summary. Lastly, it presents a glossary of culture bound syndromes that must be considered when making diagnoses of all kinds. These additions to the DSM IV-TR, which were not present in previous versions, promote understanding and appreciation of the client and family’s full humanity, that is, the client and family in its whole and complete form. While providers are not required to use the DSM-IV-TR cultural formulation as part of TCP, it provides a helpful model for analyzing the impact of culture on treatment, and incorporating the results into a coherent summary of the client and/or family story.

Elements of the Cultural Formulation

Though many providers are in roles that do not require them to engage in the process of diagnosis, all should endeavor to understand the client with whom they are working from a cultural perspective. In addition, providers should have an understanding of their own cultural grounding and the cultural issues inherent in the helping relationship. It is important to note that providers should neither over-nor under-attribute symptoms to cultural factors. A provider may want to consult with family members, cultural consultants, or others to form a better understanding of various cultural norms.

The DSM IV-TR describes the cultural formulation as “designed to assist the clinician in systematically evaluating and reporting the impact of the individual’s cultural context.” It explicitly states that the clinician must take into account “the individual’s ethnic and cultural context in the evaluation of the multi-axial diagnoses.” The purpose of cultural formulation in relation to this curriculum is broader.

The questions in the cultural formulation are meant to be a guide, and they are intended to be used over time rather than during one meeting. In developing a cultural formulation providers may choose from among the questions above or may formulate questions of their own. The cultural formulation may also include questions that elicit information about cultural explanations regarding the client’s presenting problem. Some questions of this kind are listed below:

- What cultural words are used to describe your challenges, problems, or illness?
- What is the meaning of the symptoms you are experiencing in relation to your cultural group?
- How does your family or community explain your challenges?
- What other kinds of help, beyond public mental health services, are available in your community?

Five Elements Make Up the Cultural Formulation:

1. Cultural identity of the client and family
2. Cultural explanations of the client and family's presenting problem
3. Cultural factors related to the client's psychosocial environment and developmental stage
4. Cultural elements that impact the relationship between the client/family and the service provider
5. Overall cultural assessment for the diagnosis and care of the client, and for the development of a productive relationship between service providers and the client, along with his or her natural support system.

Cultural Contexts of Mental Health Conditions

Clients who have conditions that are labeled “disabilities” in the larger community may not be seen as disabling in some cultural communities—they are looked at as being special and valued. There is a story from a book called The Spirit Catches You and You Fall Down, by Anne Fadiman, that explains this point very well. A short synopsis of the story follows:

A young girl, opening the screen door and running from her house, falls to the ground after the screen door bangs loudly as it closes. The doctors identify the girl's problem as epilepsy. The family, however, explains the event as the girl's spirit being frightened by the sound of the door slamming. The girl's spirit leaves her body, and this is why she falls.

To work most effectively with this girl and her family, a provider would have to understand the family's point of view.

Along with understanding specific cultural elements that may contribute to mental health, service providers should be aware that “healers,” individuals who have expertise in treating health issues but who do not have medical degrees, may be very effective in treating others within their culture. At the University of California at Davis, Hmong shamans are now working side-by-side with medical doctors, with much higher success rates in treating Hmong clients. Following is an example:

A Hmong elder was in the hospital, very near death. The indicated medication had been given to him, and there was no improvement. The family requested that the Hmong healer be called in. Since the medical professionals thought there was little hope, they agreed. The shaman performed the rites of healing for this elder and within days he was able to return home to his family.

Another element of the cultural formulation involves racism and discrimination. Many individuals from diverse cultures have experienced racism or other kinds of discrimination on a few, several, or many occasions. Some have such experiences so often, they consider them routine. These individuals may not articulate discrimination as an important factor in their lives because they feel it is too obvious to mention. Drawing out family members about negative experiences involving discrimination, prejudice, stigma, blame, and shame can bring a critical element of understanding to the formulation.

In addition, the cultural formulation gives information about the client's natural support system. It identifies who the client considers “family” and who he or she looks to for assistance. It also identifies religious and spiritual sources of support. All of these aspects of the cultural formulation may have a direct bearing on the conception of a client and family's plan.

Completing the Process and Sharing with the Family

Once an initial draft of the narrative summary is complete, it is shared with the client and family and their feedback is sought in order to insure that the provider and family have a shared understanding of both the presenting problem and desired outcomes. Clinical judgment is required in determining who will provide feedback about the narrative, and the client / family can provide input here too. In some cases, the client is a child too young to participate meaningfully in the process, and the parent or guardian may provide feedback instead. In other cases, adult clients may choose to involve several members of their family or natural support system in the process of creating the narrative summary. In still other cases, a client may choose not to include *anyone* else in the process.

As the client and/or family works with the provider to craft the narrative summary, changes are made as needed and a final version is placed in the chart prior to moving on with the treatment planning process. This sharing between the client, family, and provider must always occur for client-centered, family-driven care to take place, because the narrative summary is the basis for the next phase of work. Educating the family / natural support system about the use of the narrative summary in the treatment planning process is important so that they too can make use of their written story. Since the narrative summary is used to inform and assist the client and family / natural support system in driving their own treatment, it may be beneficial to write or translate the written document in the client's preferred language when needed.

Identifying the social resources an individual brings to the table is also crucial. When the narrative summary is complete, it should indicate those individuals whom the client and family trust and rely on and those whom they may not. This information is helpful in developing short-term goals and action steps and in generating interventions for the client and family plan.

In sum, formulation requires judgment, skill, and experience, gained over time. It moves from looking at raw information, to determining what the information means, to writing about how it might be used. Formulation identifies the client and family's strengths; it points to the client's stage of life and motivation for change, while showing the interrelationships between various elements in the client and family's life. The narrative summary, when written and finalized, serves as the context for the plan and clarifies the order in which short-term goals and action steps may be addressed. It is the bridge between the assessment process and the creation of the plan.

Conclusion

In putting together information about a client and family, a provider should not overlook cultural and other factors that might affect their relationship. Following are several questions a provider might ask to promote understanding about the relationship he or she is developing with the child and family:

1. What are the differences between the cultural status of the client and family and my own?
2. How do power dynamics, characteristic of many intercultural relationships, influence treatment?
3. How can some of the differences between the family and me be bridged? (for example, by understanding cultural nuances of the symptoms or problems, or understanding behaviors in a cultural context)
4. In what ways might the differences be discussed so that I can successfully engage the family?

Power dynamics should be openly addressed. A central aspect of working from a family-driven, culturally competent point of view is the establishment of a collaborative, mutually respectful working relationship. Identifying and reducing barriers to this collaborative relationship are necessary processes.

The final element of the narrative summary is a restatement of the most significant information and insights gained through the assessment. The assessment and formulation processes can be a powerful means of creating relatedness, partnership, and shared understanding. The summing up should focus on a question such as the following: how will the client and family's story come into play during the process of developing their care plan?

C. Activities

Adult Activity: Practicing Analysis and Synthesis to Arrive at a Narrative Summary

Materials

Information from the Assessment module on our example of Padma, and the Progress note analyzing this assessment. Blank sheet for group to write a narrative summary.

Objectives

1. Helps differentiate the processes of analysis and synthesis in creating a summary
2. Provides an opportunity to practice creating a narrative summary (this can be an opportunity to review the 4 questions from page 34 that the narrative should address)
3. Reinforces the elements that should be included in a narrative summary

Padma – further information gathered during interview process (assists in developing narrative)

Padma has never had mental health treatment, but does note a “lifetime” of feeling sad, angry, confused and needing an outlet.

Relationships play an important role in Padma’s life, but she is unsure how to keep them around and healthy. Padma grew up without her biological parents and her cultural identity was shifted by moving from Iran to the US at a young age. Padma married in her 20s to an Italian-American man. She says she feels “lost” in her life without a role, particularly since she is talked down to by her ex-husband and his family about her parenting. She would love a better relationship with her daughter, but feels she is pulling away and stated she gets very protective as she does not wish for her daughter to live a life similar to hers. This triggers memories of losing her siblings and other family members, which she has been grieving since childhood. Presently there has been no DFCS involvement with this family. However, Padma did note she has been arrested for “protecting myself from my husband.” She began to cry and did not wish to continue speaking about this area. She is not currently on probation, but did complete a court-ordered 12 week anger management class after her arrest.

Padma used to work as a receptionist and “welcomer” at tourism companies in San Jose and Santa Clara because of her bright personality and her skills at speaking multiple languages. She was laid off following the decline of travel soon after 9/11, but expressed suspicion that it was because she was Iranian.

Padma was very guarded about her family disconnections and simply referenced she has “nightmares” and “sees things that used to happen but can’t understand them” when stressed. Her current tools to manage this include “sleeping a lot,” and drinking alcohol. She stated she has not drunk in 2 days, to which she was very proud.

Padma spoke very little about her change of religions and beliefs, but did recognize the importance of going back to church for support from her pastor and his wife.

Padma (adult client) – assessment progress note sample (analysis)

Below is an example of how one's progress notes can reflect emerging hypotheses and analysis as assessment information is gathered.

Review the note below and consider if you would add any other thoughts; then create your own narrative summary to present to the family.

Sample Assessment Progress Note

“Completed assessment with Padma at main office. Padma indicated she prefers to come to our office as it gives her a chance to be away from home and her strained familial relationship with her ex-husband, which she presently did not feel comfortable expanding upon in much detail.

In reviewing assessment data collected along with Padma's reactions and emotional states, the following is found to be significant in Padma's situation: Padma showed excitement in both her voice and overall demeanor when speaking about her work history and ability to socialize, but became discouraged when speaking about losing her job and role as the central figure at work and home. She did reference struggles with outward expressions of anger and frustration when her bosses did not listen to her concerns prior to losing her job, which may have contributed to her unemployment. More exploration in this area may help her better identify skills building areas.

It is apparent that Padma connects her role as an employee and mother to her confidence levels. Getting a better understanding of Padma's family structure will be a key to considering her trauma history and triggers. Exploration of the difference between church relationships and familial may also be a key to understanding Padma's motivations and viewpoint. MORS score = 5.”

Now it's your turn to practice. Complete the narrative summary below for Padma

NARRATIVE SUMMARY (Synthesis)

Padma (Sample Narrative Summary)

Padma is a 43 year old Iranian woman raised much of her life in the US. She has a solid work history as a receptionist and welcomer in the tourism industry, but it has been tough for her to focus on getting or keeping a job due to physical and mental health problems. She enjoyed her work and feels motivated to get back into the work-force. Padma is strong-willed and independent – wanting to go beyond cultural barriers and take on the challenge to understand and be part of American culture (converting to Christianity from Islam religion, working, learning other languages). She is passionate and tries to stand up for much of what she believes and feels, including parenting her daughter versus what her husband believes. Padma is able to communicate well with other cultures as she speaks various other languages (Farsi, Urdu, English, and some Spanish). Padma is a survivor – she was and continues to feel rejected by family and others, but continues to move on through her life. She greatly values family and relationships and wants to get her family back in-tact, if possible – particularly with her daughter.

She resides and socializes within the same cultural environment, living with her ex-husband and her daughter. Her husband is somewhat supportive of her physical needs, but they do not get along well (frustration, fighting, physical and verbal/emotional). Padma and her ex-husband are financially dependent on each other. She is also in contact with her ex in-laws who are not supportive or approving of her. Moving from such a tumultuous environment may help improve her over-all well-being, while still keeping her connected to her daughter in a healthy manner. She has done this before and did very well, but had a car accident which led to a backslide, including an increase of drinking alcohol. Padma drinks alcohol 3-4 days out of the week and has not stopped for more than a week to three weeks. Physical issues (fainting and falling over) have led to her not having her license, which is limiting her ability to get around, increasing her depression and reliance on others.

Loss & rejection are themes in Padma's life, including not having an opportunity to grieve. Loss of biological family (she was adopted out, her parents passed away, sister committed suicide, another sister died from cancer), loss of adoptive parents, loss of childhood, relationship with her husband and daughter, loss of status and independence (driver's license, jobs, car), self-worth and identity (being a strong woman), loss of cultural identity. She struggles with sleep, hopelessness, frustration & agitation, isolating, and self-medicating with alcohol. She is on over 10 medical medications and three psychiatric medications. She is contemplative about her drinking as she finds it prevents her from doing things she would like, but does not feel ready to make a change as it comforts her when she has increased stressors. Much of this is due to not having other activities in line to do. She is starting to show home-based improvements, like cleaning and cooking. Padma is trying to figure out who she is and where she fits in, while staying strong. Padma recognizes she has some of these struggles, but does not know where to start in getting better. Finding a meaningful role and purpose in life is important to her. Padma is also contemplative in her stage of change regarding choices in her social and familial relationships. She will need increased support and awareness building to encourage her to move into the preparation phase. Providing practical resources, emotional support as well as grief counseling, community linkage and coordination with outside providers (medical/health, alcohol reduction) will encourage Padma in taking better care of herself and taking pride in her improvements. Strengthening self-confidence through appropriate communication skills with others, including her ex-husband, may lead her towards improved relationships.

Review the narrative summary above and note which of the elements below are included. Discuss what works well in this summary and what could be improved

1. A clinical hypothesis/understanding re: what drives the individual's experience of illness and recovery?
2. Strengths, interests, and current and/or desired life roles and priorities
3. Cultural factors and any impact on treatment
4. Any interfering or perpetuating factors, e.g., trauma history (and current responses), co-occurring medical or substance use disorders, etc.
5. Individual's stage of change and/or developmental factors (developmental capacities)
6. Available natural supports or community resources (supportive relationships in a child's life).

Family and Children’s Activity: Practicing Analysis and Synthesis to arrive at a Narrative Summary

Materials

Information from the Assessment module on our example of Diana, and the Progress note analyzing this assessment. Blank sheet for group to write a narrative summary

Objectives

1. Helps differentiate the processes of analysis and synthesis in creating a summary
2. Provides an opportunity to practice creating a narrative summary (this can be an opportunity to review the 4 questions from page 34 that the narrative should address)
3. Reinforces the elements that should be included in a narrative summary

Instructions

Below is an example of how one’s progress notes can reflect emerging hypotheses and analysis as assessment information is gathered. Review the note below and consider if you would add any other thoughts. Then create your own narrative summary to present to the family.

Sample Assessment Progress Note

(Supported by reviewing the 6 recommended elements for a narrative summary)

“Completed second assessment meeting with Diana and family during which more strengths, resources and concerns were identified. (See CANS summary sheet and Initial Mental Health Assessment form.)

While Diana has grown up in California, she also enjoys her Mexican heritage and her folklorico dance activities appear to be a strong source of self-esteem. However her sense of worth appears very dependent on external input and this appears to relate to her anxiety in peer relationships which is greater than one would expect as typical at this developmental stage. The attachment history between her and mother appears to have made it hard for both of them to feel secure in their relationship or consistently connected to each other. Mother appears to be passing on tension from her own painful history. Gaps in early comfort and trust may contribute to current difficulties in emotional regulation. Current marital issues are also raising level of tension in family. We need to build on Diana’s positive history with teachers, older brother, grandmother

Need to explore role of a girl in a Latino family, what it looks like to grow up as a young girl in both cultures, and notice the different models she has observed in her mother and grandmother.

Causes of current problems are likely a combination of difficulty managing intense feelings, past and present situations (family dynamics) that evoke intense feelings and a habit of getting more attention for negative behavior than positive behaviors. Unclear how much the traumatic incident of feeling trapped in a locked room is a cause of anxiety or possibly more a crystallization of her own and other family members’ feelings of being stuck/ trapped.”

Now it's your turn to practice. Complete the narrative summary below for Diana.

NARRATIVE SUMMARY (Synthesis)

Diana (Sample Narrative Summary)

Diana is a bright and friendly 9 year old girl who has grown up in California but also enjoys her Mexican heritage. She is a strong folklorico dancer, makes friends easily and is verbally expressive. She wants her mother to love her and to be a leader with her friends. She would like to once more be seen by her teachers as a positive student in her class. She is at a stage where peers are becoming more important and where she is capable of observing and questioning the situations in her life. She will soon be a pre-teen at which time she will be dealing with her understanding of the role of a girl in a Latino family, and what it looks like to become an adult woman. She has different models in her mother and grandmother and madrina but she may need a lot of reassurance from others about her worth as a person.

At this time Diana appears to be struggling to manage intense feelings and often feels anxious, disappointed and frustrated. It is likely that some of her tantrums and arguments continue due to a pattern of her receiving more attention for negative behavior than positive behaviors.

There appear to be many sources of these difficult feelings including the early difficulties Diana and Teresa had in having a trusting and soothing relationship with each other. Daughters often also tune in to painful feelings in their mothers and Teresa has had painful experiences in her past and is frustrated by many demands on her at present. Diana is also likely to be affected by upsets between other members of her family. Her past experience of feeling trapped in a locked room clearly still has an effect on her difficulty feeling safe and protected. She needs help learning ways to calm and soothe herself when frustrated.

It would be helpful for Diana's parents to attend a class that gives parents strategies for supporting positive behavior and emotional coping skills in their children. In addition, some conjoint counseling with mother and daughter can help them to have happier experiences together and for mother to understand Diana's needs before negative interaction cycles begin. We should also consider some sessions with the full family to help everyone practice more satisfying ways of communicating. She will benefit from having regular experiences of mastery, confidence building and personal connection such as folklorico classes, church, and times with her madrina's family.

Review the narrative summary above and note which of the elements below are included. Discuss what works well in this summary and what could be improved

1. A clinical hypothesis/understanding/core theme re: what drives the individual's experience of illness and recovery?
2. Strengths, interests, and current and/or desired life roles and priorities
3. Cultural factors and any impact on treatment
4. Any interfering or perpetuating factors, e.g., trauma history (and current responses), co-occurring medical or substance use disorders, etc.
5. Individual's stage of change and/or developmental factors (developmental capacities)
6. Available natural supports or community resources (supportive relationships in a child's life)

Transformational Care Planning

Advancing Recovery, Resiliency & Wellness



Module Four:

Developing the Transformational Care Plan



Developing the Transformational Care Plan

A. Introduction and Summary

This module presents the basic principles at work in the development of a person-centered, culturally sensitive plan of care for each client. This plan is built on collaboration and partnership between the provider, the client, and his or her natural support system. This process includes the creation of a desired results statement, short-term goals, and interventions.

The core technical skills involved in developing the care plan are presented first: how to facilitate the development of a meaningful desired results statement, break it down into manageable steps (short-term goals), and identify who will engage in which specific intervention at each step along the way. Desired results statements are big-picture, quality of life changes for each client and family that are often tied to discharge or transition criteria. Short-term goals are the milestones, the signposts of accomplishment along the way to achieving the positive outcomes (desired results) identified by the client. Engaging with clients and their natural support systems to develop these markers of success is an essential element of culturally sensitive, person-centered care. Action steps and interventions are specific tactics for making change; they are concrete actions that are taken to reach short-term goals and eventually achieve the desired results identified by the client.

B. Content

The care plan should be a dynamic living document that changes over time and continuously guides the everyday work the provider and client do together. A well-developed care plan is a source of motivation and a yardstick with which to measure progress.

The plan is created by the service provider, the client, and his or her natural support system to outline the steps for achieving specific desired results or outcomes. In a sense, it is a contract between the client and the provider to guide the work they will do together. It is a key element that structures an ongoing partnership based on shared decision-making. The plan should be completed no more than 60 days from the time the client begins to receive services. This gives providers time to do a thorough assessment and narrative summary. After completion of the initial plan, it should be revised on a regular basis based on their achievement of short-term goals. Regular review and revision of the plan makes real the expectation of positive growth and change over time—it communicates an expectation of progress and hope. While frequent revision of the plan may seem highly work intensive and thus unrealistic, it *can* be done and *is* done in a number of counties within California.

One potential problem with developing a plan is that it may become too complex, incorporating too many desired results and/or short-term goals. Having a long-term focus on one or two large desired

results and a more short-term focus on one or two attainable short-term goals can be a strategy for making work more manageable.

Process of Writing the Plan

The first challenge in writing the care plan involves deciding how to begin. Clients and their family systems are complex; their lives may be somewhat chaotic; and they may be confronted by a host of concrete needs that must be addressed. At the same time, family members have a variety of hopes and desired results.

The first priority in developing a plan is to determine whether there are basic health and safety concerns that need to be addressed. These concerns are critical and primary, and they may involve legal obligations and mandates. In situations where the service provider is initially focused on health and safety concerns, the most successful approach is to negotiate and collaborate with client and family members to develop mutual agreement. When basic safety issues are addressed and fundamental needs are met, the plan can begin to focus on achieving the desired results articulated by the client and family.

Requirements, Regulations, and Medical Necessity

Strong plans are written in a practical way that responds to the narrative summary and spells out actions that will be taken. The rigorous assessment and narrative summary that have been completed prior to the drafting of the plan indicate necessary actions and may suggest the order in which actions should proceed. The plan is geared toward working through all the necessary small steps to reach larger desired results. As small steps are accomplished, the provider and client should take opportunities to acknowledge and celebrate their progress.

Requirements and Regulations

The plan requires a number of elements:

1. Client and family's (or support system's) statement of desired results
2. Obstacles to accomplishing those results
3. Discharge or transition criteria
4. Short-Term Goals—the smaller elements of a desired results statement that spells out steps that must be taken to achieve them
5. Strengths of the client, family and natural support system that will aid them in accomplishing each of their short-term goals, as they work toward achieving their desired results
6. Types of action steps and interventions, identifying who will take necessary actions and what those actions will encompass
7. Time frame for the accomplishment of interventions
8. Signatures of the client and those providing services

Note: Service providers must be qualified professionals, as identified by DMH contracts. Qualified professionals may include physicians, licensed or waived psychologists, licensed and registered (or waived) social workers or MFTs, and registered nurses.

Medical Necessity

In order for the agency to be reimbursed for services, the care plan must identify the medical necessity of the work provided. It must outline how the symptoms, behaviors, and functional impairments to achieving desired results will be reduced, improved or eliminated. Beyond Medical requirements, however, are the requirements for person-centered, culturally sensitive plans.

These include:

- Collaboration and partnership between members of the family or natural support system and service providers in all aspects of the development of the plan
- Articulation of results that are desired by the client and significant support people
- Focus on strengths, developmental assets, and protective factors of the client and his or her natural support system
- Utilization of the expertise of that family / system about the client, and the client's expertise about him or herself
- Incorporation of cultural elements that affect the plan
- Foundation on the values of the client in his or her natural environment / system

Risk and Protective Factors

Research about causes (and prevention) of serious mental health conditions has suggested that resilience primarily involves the client's ability to overcome adversity as a result of mitigating risk factors and promoting protective factors. These processes can be independent of one another.

A thorough assessment will reveal potential risk and protective factors, and the formulation process spelled out in Module Three generally describes the impact these factors have on a client. Once the factors are identified they can be addressed by specific actions set out in the care plan. This module defines and describes the desired results, short-term goals, action steps and interventions that are central to the care plan.

Resiliency

Resilience, when properly understood, refers to “the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work, and learn with a sense of mastery and competence” (California Family Partnership Association, March 2005). It may also be helpful to consider the definition used in the Child and Adolescent Needs and Strengths (CANS) outcome measure, which states that resilience is present when “an individual is able to both identify and use internal strengths to better themselves and successfully manage difficult challenges” ([CANS Comprehensive Manual](#), 1999). While early notions of “resilience” in children and adult mental health involved connotations of invulnerability to problems, the above definitions point to a more helpful definition that emphasizes an individual's ability to use their inner strengths and problem solving skills to handle life's challenges as they arise. It should be pointed out that one's level of resilience is neither static nor absolute, but depends on a process of changing thinking, behavior, and the environment in which the child, youth, or adult is active. Most individuals must understand how to change their thinking and behavior to achieve their own desired results, rather than being told by others about diminishing risk factors or building protective factors, in order for resiliency to develop. In the end, resiliency can and should be developed consciously as part of the work done between clients and

providers. It is therefore an important part of the care plan, and providers who understand how to build it will experience improved outcomes with their clients.

Cultural Humility and Alliance-Building

Providers who actively seek to understand the cultural grounding of families are better able to support clients as they build their resiliency. The strategy called “alliance-building” can be an integral skill in the process of developing a care plan that incorporates culture. Formalizing this step in the care plan process causes providers to deal directly with issues of similarity and difference between themselves and the clients with whom they work, which is an important part of cultural humility.

Different cultures have different means of developing collaborative connections among people. Understanding the rules of social interaction for the culture of a client and family (or natural support system) is necessary before a collaborative alliance can be built. Asking the client and family is the most direct means of getting information about their culture, but providers may also want to consult with others who have specialized understanding of a client and family’s specific cultural characteristics.

Alliance building depends on strong communication. Providers should avoid assuming that certain characteristics of their own families or communities are shared with any specific client or family. Avoiding making assumptions can be challenging, since some things that a provider might consider universal and fundamental may not be so. For instance, such qualities as warmth and such behaviors as self-disclosure are not preferred in some cultures. Many cultures value distance, formality, and ritual in establishing new relationships. In addition, many individuals from diverse cultures may not believe that individuals should speak for themselves - they may prefer to communicate through family members or others.

Moreover, even though individuals may have some characteristics of a culture with which they are identified, they may not have others. One way to look at this complicating factor is to refer to the concepts involved in the “acculturation continuum,” which divides individuals with a shared cultural background into three groups: traditional, atraditional, and dualistic. Traditional family members are generally characterized by the beliefs, values, and practices of a culture. Atraditional individuals have characteristics that might be called “Western,” that is, they identify more with cultures of Western Europe. Dualistic individuals fall somewhere in between. A provider may want to elicit information from the client or family to determine where they fit on the acculturation continuum, so as to communicate more effectively and provide more relevant services.

A provider should also think about where he or she fits on the continuum. Without a strong understanding and recognition of one’s own culture, a person is unable to make connections and distinctions between his or her own experiences and those of others. When the differences between a provider and a client’s worldview are extreme, the provider should recognize that he or she is likely to interpret the nature of collaboration differently and must work considerably harder to form a culturally sensitive working alliance.

Desired Results, Short-Term Goals, Action Steps, and Interventions

Desired results, short-term goals, action steps, and interventions form the substance of the care plan. Desired results reflect the client's big picture, his or her ambitions and hopes for the future. Short-term goals break the big picture into its smaller conceptual parts. Action steps and interventions are devised to realize short-term goals. Together, the four move from a higher level of abstraction to a level of practical application.

Desired Results

Desired results express the hopes and dreams of the client and natural support system. They identify the hoped-for destination that will be reached through the services provided. A desired result can be described as “a broad, general statement that expresses the [client's] and family's desires for change and improvement in their lives, ideally captured in their own words.”⁶ Desired results represent big changes. They are written in positive terms and inspire the client/family to move beyond specific, identified mental health impairments to a better quality of life. Desired results are the central focus of the care plan, and they must be client/family-driven and strength-based. They must also correspond to one or more identified obstacles that justify the use mental health services as medically necessary. A provider should see him or herself as a facilitator in the development of desired results. At the same time, the provider must work to understand the client's own statement of desired results, and come into agreement about the importance of achieving that vision. In this way the desired result is a shared picture of success.

Desired results are long-term, global, and broadly stated. While the short-term goals discussed later in the module must be measurable, desired results may not be. Excellent desired results build on the abilities, strengths, preferences, and needs of the client and family. They embody hope, and an alternative to current circumstances. It is important to remember that identifying a desired result such as this can be frightening to a client and family. To share one's deepest aspirations with another is to be vulnerable.

Too often desired results are written in overly general terms or are written from the perspective of someone outside the family. Following is an example of a desired result that is too general: “Stuart will receive the assistance he needs to be successful.” While the client and family's success and well-being are paramount, the desired results that will contribute to them must be focused on specific life domains.

An approach to writing desired results that focuses on the provider's point of view is not consistent with a person-centered and family-driven model of care. An example follows: “The client and family will comply with medication requirements and follow-up treatment, as needed.” No one likes to be told to “comply” with someone else's instruction, and a provider would be more successful if he or she is focused on the client's perspective. Moreover, a client is not likely to see an intervention, such as taking medication or engaging in therapy, as an end in itself. Rather, it is the intended result (an increase in positive behavior and/or functioning) that should be emphasized. Providers should recognize, however, that some clients and/or family members may not be inclined to adopt a family-driven approach, because their experience has been that pleasing others is the best

⁶ Adams N & Grieder D (2005) Treatment planning for person-centered care. Burlington MA: Elsevier Academic Press

way to get at least some of their needs met. Having navigated a traditional system for a considerable time, family members may have developed an indirect means of achieving their aims. They may have astutely identified indirect means of influencing those who can help them. In such cases, the provider should help the client and family understand that he or she wants to represent their genuine hopes and desires.

In addition, a provider should be aware that many clients and family members may be unable to articulate their desired results in the same way the provider would. By listening carefully and reflectively, the provider may be able to help them identify the desired results that are most important to them. Direct questions may not elicit useful information in the same way reflective listening can. For example, a question like “what is your desired result for this year?” may not elicit an expected response. Instead, desired result development unfolds through the process of conversing with and getting to know the client and natural support system. Providers reflect back the key ideas that clients and others express by responding with such remarks as those below:

- You really hope to have some friends in your new school.
- You want to get your driver’s permit and learn to drive.
- It’s important to you that everyone in the family feels safe.
- You want to keep your child out of trouble with the law.

Indirect questioning may also be effective in eliciting information about desired results. Here are a few examples:

- If you woke up tomorrow, and a miracle happened so that you no longer had the problem we’re discussing, what would be different? What would the first signs be that the miracle occurred?
- What is one thing you used to enjoy doing, but don’t do anymore because of these problems?
- If I met you on the street 6 months from now, and these problems had been resolved, what fun things would you be doing? What do you wish you would be able to tell me about your life?

The client’s cultural grounding will have an effect on the desired results he or she develops, so it is essential for providers to see their work in the context of the client’s worldview and to investigate cultural aspects of developing desired results. Cultural humility in plan development will be discussed in greater detail later in this module.

Short-Term Goals in the Care Plan

A short-term goal is a significant and meaningful change that the client and family can recognize, and that is directly tied to medical necessity. Experiencing the realization of short-term goals gives the client hope and motivation. Short-term goals can be seen as milestones or intermediate destinations. They are paired with action steps and interventions that can be viewed as vehicles for getting to the desired destination. By dividing large desired results into manageable, measurable, and observable parts, the provider and client set up a framework for assessing progress.

Unlike desired results, which are broad, short-term goals are specific and must be measurable. Short-term goals must support the medical necessity of services, including services provided to

clients in a clinic, at home, and in other community settings. Short-term goals describe changes in behavior or subjective experience (thoughts and feelings), that impact functioning in life domains. They identify the client and family's desired results related to a specific aspect of the client's mental health condition. Besides being culturally sensitive and person-centered, short-term goals should be linked to increasing skills and abilities, and the reduction or elimination of behaviors, symptoms, or functional impairments. Short-term goals should be geared to the client's stage of life and motivation for change as well.

SMART Short-Term Goals are:

- Specific / Simple
- Measurable
- Attainable
- Realistic
- Time-Framed

Limiting the number of short-term goals is desirable because it makes their achievement more manageable. A good rule of thumb is to limit the number of short-term goals to three per desired result, in order to reduce the chances that the client and family will feel overwhelmed, but ultimately the number needs to be individualized. Limiting and prioritizing short-term goals may be difficult for providers and families, as each may be tempted to tackle every issue of concern. Success breeds success, so as much as possible, the provider should maintain concentration on realizing one short-term goal at a time.

Sometimes it is difficult to translate your language as a professional in a specialized field into language the client and family can understand, but person-centered care requires you to do so to the best of your ability. There should be no mystery on the client's part about what the provider understands and intends. Neither should there be any mystery about what the client is being asked to do in the short-term goal. In order to make decisions about what short-term goals to develop, the provider and the client must share comprehensive information in both directions. Providers and clients develop short-term goals in a variety of ways, but the elements of those goals are similar. Some providers, especially those who are new, may want to use a formula, that is, a well-defined and consistent process, when writing short-term goals. The following formula provides one good model:



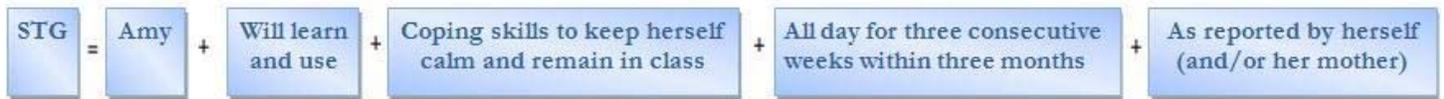
Two examples are presented below:

Example One

- Amy is a nineteen-year-old girl who lives at home with her mother.
- Amy seeks mental health services for her diagnosis of social phobia.*
- Amy has anxiety about doing well in her community college classes so she can attend a 4-year school.*
- Her symptoms include avoidant behavior, shortness of breath, rapid heartbeat, and sweating episodes.*
- She has low self-esteem and feels her peers do not think well of her.*
- She feigns illness* frequently as an excuse to avoid going to school.
- Sometimes she comes home from school early or skips altogether.

- Amy and her mother fear she will fail her classes because of absences.* Her mother has encouraged her to seek out support from a mental health professional

* behaviors, symptoms, and functional impairments that support medical necessity



This simple framework covers the basic parts of a short-term goal and can be easily replicated. By using this framework, providers get accustomed to remembering the necessary ingredients for a measurable goal. The larger challenge for a provider, however, is taking raw information from the client and family and, together with them, forming it into a clear goal statement.

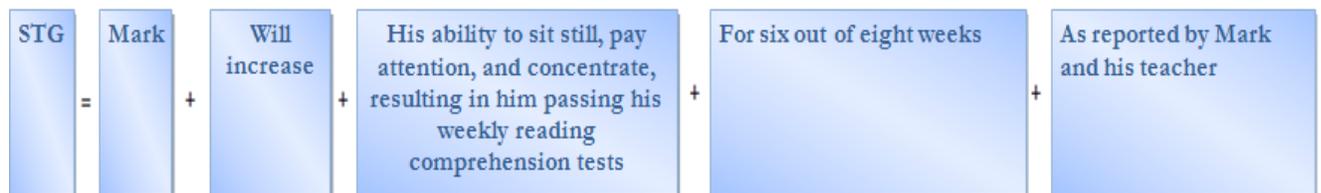
Example Two

- Mark, a ten-year-old boy, and his mother come to the mental health clinic.
- Mark, who has a diagnosis of Attention Deficit Hyperactivity Disorder,* is having difficulties at school.
- Mark’s mother ensures that he takes medication prescribed for ADHD every morning before school.
- Mark frequently gets distracted at school during the daily time allotted for silent reading and talks to other children.*
- He feels frustrated* when he is reprimanded and sad* when other children respond with annoyance.
- Mark is unable to pass tests* that measure his reading comprehension, since he has not completed the reading assignments.

* behaviors, symptoms, and functional impairments that support medical necessity



We can use the formula shown above to arrive at the following short-term goal:



Note how both of the examples above identify a specific goal aimed at mitigating diagnostically-related behavior, symptoms and functioning. This is the key to writing short-term goals that are person-centered and also document medical necessity.

Action Steps and Interventions

Action steps and interventions are specific actions or activities that are incorporated into short-term goals written with the client as part of his or her care plan. An action step is anything done by the client, family, peers, or others that supports a specific short-term goal designed to assist in moving toward the desired results. An intervention is simply an action step done by a mental health provider. In a care plan, action steps represent the activities that all members of the client's natural support system, including the client and family, are committed to doing. Since the care plan is a formal document and ultimately a work agreement between the client, his or her natural support system, and the provider, action steps have a specified format that clearly spells out the roles and responsibilities of each party. Cultural factors may impact the availability and accessibility of particular interventions. Below, "The Five W's of Action Steps" is a list of descriptors that apply to all action steps, and to interventions as well:

The Five W's of Action Steps:

1. Who: which member of the team or support system will provide the service
2. What: what specific service will be provided
3. When: how often will the service be provided and how much time will be involved
4. Where: the location of service delivery
5. Why: the purpose of doing the action step or intervention (link back to the desired outcome)

The process of writing action steps (and interventions) must be thorough and specific. It creates a clear link back to the short-term goals and forward to progress notes that will be written by the provider. In addition, the provider must keep in mind the cultural context for doing each activity. Availability and accessibility of appropriate services will affect the interventions chosen. It is important for providers to ensure that when they develop interventions, the proposed actions are focused and individualized to meet the needs of the client and family system and specifically address the functional impairments documented as medically necessary.

Examples: Using the Five W's

Example One

Short-Term Goal:

Short-term goal = Amy + will learn and use + coping skills to keep herself calm and remain in class + all day for three consecutive weeks within three months + as reported by herself (and/or her mother).

Staff Action Step/Intervention One:

Therapist will provide CBT in the home two times weekly for one month to help Amy develop the coping skills of deep breathing, journaling, and listening to music to decrease anxiety.

(Note: Some intervention strategies may involve non-billable services, but they can be included.)

Client/Family Action Step One:

Mother will provide Amy with verbal cues to remind her to practice learned coping techniques while in the home and community.

Client/Family Action Step Two:

Amy will request support from mother, teacher, or others when she is unable to calm herself.

Example Two

Short-Term Goal:

“Mark + will increase + his ability to sit still, pay attention, and concentrate, resulting in him passing his weekly reading comprehension tests + for six out of eight weeks + as reported by Mark and his teacher.”

Staff Action Step/Intervention One:

School-based therapist will provide behavioral therapy in the office one time weekly for one month to teach Mark how to use self-management/coping techniques for ADHD. Teaching will include use of worksheets, modeling, and role playing.

Client/Family Action Step One:

Mark will practice new self-management/coping skills with his mother three times per week for twenty minutes each time.

Client/Family Action Step Two:

Mark will be coached by his mother to use positive coping skills if/when he forgets.

Desired Transition and Obstacles Statements

Thus far, this module has focused on three components of the care plan that are likely familiar to many mental health providers: the client’s statement of desired results, short-term goals, and interventions. Santa Clara County’s care plan includes three additional sections:

1. Desired Transition
2. Obstacles
3. Individual, Family, & Supporters’ Strengths

The desired transition statement describes the point at which a client and/or family will be prepared either to step down to a lower level of care (e.g. from day treatment to outpatient services) or to transition out of the formal mental health system and into community-supported self-care. In other words, it describes discharge criteria for a client’s exit from professional mental health services.

Obstacles are simply the mental health or other co-occurring obstacles that keep a client from being able to transition away from formal services. These statements are critical to documenting medical

necessity. Well-written obstacle statements create clear connections between a client's desired results, their current mental health condition, and the interventions that will be provided throughout a client's time in treatment.

Below is an example of a desired transition and obstacles statement for Amy, the client discussed above.

Amy's Desired Transition:

Amy can identify two or more techniques that she regularly uses to self-manage her own anxiety, and reports no more than two school absences due to anxiety within the last month.

Amy's Obstacles:

Amy reports that she gets anxious about being in school nearly every day. She also reports that other students do not like her, and that she mostly keeps to herself because she is so worried about what they think. Amy's mom reports that Amy pretends to be sick at least once each week to avoid going to school, and also frequently comes home from school early or skips altogether because of her anxiety. Amy is at risk of failing her classes due to anxiety-related absences.

Individual, Family, & Supporters' Strengths

The strengths section describes past accomplishments, current aspirations, motivations, skills, etc. of the client, family, or other support people that can be used to help accomplish an identified short-term goal. This section cannot be completed simply by noting strengths listed by the client or others during the assessment phase. While the narrative summary may have included some comments about how client and family strengths could support the desired results, it is during care planning that this analysis *must* take place, if it hasn't already. Providers must consider the work to be done, engage with the client and his or her natural support system to identify the strengths and resources they *already* possess that will be helpful specifically in achieving the client's short-term goals, and document them here in the care plan.

Cultural Humility in Treatment Planning

There are a number of important cross-cultural and diversity elements to consider when establishing desired results, short-term goals, and interventions. For example, in many western cultures “family” tends to be understood as something a child grows up within and moves away from as an adult, forming a new family when he or she is grown. In this context, only unhealthy adults stay with their family of origin. However, there are many cultures in which “family” is a relational unit that a person continues to live within and never leaves. According to this cultural reference, only unhealthy adults *leave* their family of origin.

Cultural factors influence how the family sees responsibility and control, how the family interprets language, and how the family understands issues involving time, among many other things. Three different time orientations provide an example of how various cultures perceive a concept differently. Some cultures have an attitude that one should live in the present moment. Others insist that obligations to the past are of paramount importance in present actions. Still others assume that one should emphasize preparing for the future.

Attitudes toward time affect one’s actions. For example, in relation to the spending of money, those who live in the present may want to buy things now since the future is uncertain. Those who emphasize obligations to the past may want to use money to pay for debts they perceive themselves to owe from the past. Those who believe preparing for the future is most important may want to save or invest money. While all these attitudes have merit, the dominant culture may value one over another, and may convey the position that other attitudes are irresponsible or wasteful. Many western cultures whose populations are wealthy relative to the rest of the world, for example, tend to put an emphasis on investing money individuals have to spare. Other world cultures whose populations are relatively poor tend to spend money in the present to take care of immediate basic needs.

Cultural humility involves being willing to recognize that meaning is relative to one’s environment. The meaning of even simple actions changes from one place to another, and from one family to the next. For example, a school-aged client communicating his or her desired results to parents may be seen as very appropriate in some cultures and very inappropriate in others. There are many cultures in which parents set the desired results even for their grown children.

Cultural humility also involves being willing to recognize that there are rules of appropriate social interactions, accepted ways of maintaining wellness and treating illness, and degrees of focus on the self in isolation from others or the self in connection to others. Rules of social interaction are formal and informal patterns of behavior that exist within a culture and govern how all forms of relationships occur. For example, these rules control how one person greets another, which may be with a kiss, a bow, a handshake, or some other action. Key questions involving wellness and illness are answered differently according to different cultures. Some cultures may value certain kinds of practitioners and not others; they may put more or less emphasis on the parents’ role in a child’s wellness/illness; or they may incorporate elements of ritual, spirituality, and folk healing into their approaches. A provider must assume that his or her family’s conception of mental health is not universally accepted and understood by other families.

In creating a care plan, a provider should understand the client’s conception of an individual self that operates independently and a contextual self that is interdependent with others. The desired results, short-term goals, and interventions they include should be consistent with the orientation of the

individual client in relation to other people. Individualistic clients may focus on their rights and responsibilities independent of others, and as a result, their care plans may emphasize strategies that build independence. At the same time, interdependent clients and families may focus on how each person's actions affect others, and their care plans may emphasize strategies that build support among a group of individuals. Characteristics of independence and interdependence should be seen, not as absolute, but as relative positions on a continuum of possibilities.

Many cultures do not operate with a focus on the individual. Practitioners who come from cultures in which individualism is second nature must maintain a high degree of consciousness in working with diverse families. The origins of most communities' mental health practices in America are rooted in an individualistic bias. Providers who are educated in the dominant culture's institutions must make an effort to understand families that value interdependence. Person-centered care, although it may focus largely on the individual client, also includes an emphasis on learning about and validating the broader family and community connections vital to clients from diverse backgrounds. This is done by moving immediately to include family and community components in the care plan.

Conclusion

At the heart of the plan for a client and his or her natural support system are a handful of basic elements. The statement of desired results must be co-created between the provider and client, and include the client or family's own comments about their dreams and hopes for the future. Short-term goals break the desired results down into measurable targets the client and others can work to accomplish. Obstacles and interventions provide evidence of medical necessity and identify the benefits of a client receiving specialty mental health services. Action steps point to the unique roles of the client and natural support system, and the desired transition statement provides the entire team with a clear picture of what life will look like when the client no longer needs professional support for his or her mental health and wellness.

Creating plans like the ones described above requires a defined set of skills. Partnership and collaboration are fundamental to building a care plan. They will lead to the identification of strengths that can be incorporated into the plan to meet the family's changing needs, address their evolving challenges, and achieve their unfolding desired results. Providers must also have skills in communication, understanding, problem solving, and cultural inclusion to work effectively with clients to develop transformational care plans.

C. Activities

“Getting to Best Practice”

Materials

Easel and markers
Index cards

Objective

Participants will practice describing a care plan in terms of the values of culturally sensitive, person-centered care and use the language characteristic of these values

Instructions

Form small groups. Ask individuals to discuss the following questions:

1. What are the barriers in your system or agency to achieving a 60 day standard for completing assessments, narrative summaries, and care plans?
2. What are the factors that would need to be addressed?

Report back from the small groups. Have one facilitator put the barriers on a paper pad on an easel, while the other facilitator writes them on index cards. After each group has reported back, give each small group one or two barriers to work on. Each group must brainstorm possible solutions. Report the solutions back to the large group.

“Creating Desired Results Statements”

Materials

Handout on Desired Results (See Page 76)

Objectives

Participants will practice working with clients to create “desired results” statements that are consistent with the client and family’s values and cultural worldview. Participants will identify client and family strengths that assist them in accomplishing their desired results, and address barriers to effective and culturally sensitive care planning.

Instructions

Ask participants to review the “desired results” statements on the handout. Identify the ones that do not meet the standards we have discussed.

Discussion

What was missing in the statements you changed?

Role-play

Form groups of four. One person is the observer, one person is the counselor, one person is the client, and one person is the family member. Using the “desired results” statements that need to be reworked, have a dialogue between the client, family, and provider that reviews the desired results and reworks it to meet the standards set forth in this training. The observer’s role is to identify what the provider did to facilitate this process.

Discussion

First, how did it feel to be the client and family member in this process?
For the provider, what were the challenges? What went well? From the observer’s perspective, what were the key strategies used to co-create a meaningful statement of desired results?

“Strengths and Desired results”

Materials

The previously completed “Desired Results” handout (See Page 76)

Objectives

Participants will be able to:

- Identify strengths that assist in accomplishing desired results and address barriers to effective and culturally sensitive care planning
- Develop short-term goals that are family-driven and culturally sensitive

Instructions

Break into groups of four: Provider, client, family member, and observer. Using the desired results that have been created in the previous exercise, the client, family member, and provider will have a dialogue to elicit and identify strengths and resources. The observer will note what strategies were particularly successful in drawing out strengths and resources.

Discussion

What strategies were effective in eliciting strengths?
When looking for strengths did you utilize a culturally sensitive perspective? Did you find any strengths based on culture or diversity variables?

“Creating Measurable Short-Term Goals”

Materials

Creating Measurable Short-term Goals Worksheet

Objective

Participants will practice developing short-term goals that are family-driven and culturally sensitive.

Instructions

Ask individuals to complete the worksheet. Form small groups or dyads to share answers.

Discussion

Were short-term goals similar? If elements were missing, is there a pattern for you?

“Desired Results, Short-Term Goals, Interventions, and Medical Necessity”

Materials

Blank Santa Clara County TCP treatment plan form
Information from the Assessment and Narrative Summary examples for our clients, Padma, Diana and their families.

Objectives

Participants will be able to:

- Develop desired results statements that are consistent with the client and family’s values and cultural worldview
- Develop short-term goals that are family-driven and culturally sensitive
- Identify appropriate interventions that meet medical necessity and identify non-reimbursable services

Instructions

You may do this exercise as a large group or small group.

Give the participants the following scenario: You are developing a treatment plan for Diana and her family. (Optional: you may consider that they have a present time orientation and a contextual definition of self.)

- Ask the participants to brainstorm desired results, short-term goals, and interventions that might be appropriate for this client and family.
- Now change client and family characteristics and see what difference it makes in setting desired results, short-term goals, and interventions.
- Discuss the implications of these cultural differences in creating care plans.
- Next, describe how the desired results, short-term goals, and interventions meet (or fail to meet) elements of medical necessity.

At the end of the exercise,

1. Review and discuss the model plan that was developed by trainers.
2. Review and discuss the progress note that describes how a provider might work with a family to develop a new short-term goal as treatment progresses and circumstances change.

Santa Clara County Mental Health Department – Treatment Plan (TCP)

Desired Results:	
Desired Transition:	
Obstacles:	
1a. Short-Term Goal:	2a. Short-Term Goal:
1b. Individual / Family / Supporters Strengths:	2b. Individual / Family / Supporters Strengths:
1c. Action Steps By Individual / Family / Supporters:	2c. Action Steps By Individual / Family / Supporters:
1d. Action Steps By Staff (Intervention):	2d. Action Steps By Staff (Intervention):

Treatment Plan for Diana

<p>Desired Results: Diana: “I want my family to help me so I feel strong and proud” Parents Jorge and Teresa: “She will be a happy girl and see things in an optimistic way”</p>	
<p>Desired Transition: Diana will communicate her needs in more constructive ways and improve her communication with her parents. Diana will decrease yelling and control her anger. There will be an increase in positive interactions with her parents.</p>	
<p>Obstacles: Diana is struggling with anxiety related to a past traumatic experience. She struggles with expressing herself at home and communicating with her parents. She gets angry very quickly and engages in frustrating arguing with her family and friends. Teresa reacts in ways that often escalate their conflicts. Parents lack confidence in their parenting skills.</p>	
<p>1a. Short-Term Goal: 1-Within the next 4 months, Diana will have increased daily positive interactions from 0 to 3 times, with at least 2 family members as shown by playing a game, engaging in drawing, singing or reading together per family’s report. * Parents will be able to identify 2 creative alternatives to power struggles that they use at least twice a week.</p>	<p>2a. Short-Term Goal: 1- Diana and her mother will be able to more easily soothe themselves and each other as shown by increased comfort offering and accepting hugs once a day and by using calm voices to describe their understanding of each other’s hopes, feelings or worries at least 3 times a week within the next 4 months per client’s and family’s report.</p>
<p>1b. Individual / Family / Supporters Strengths: *Family is committed to working together and Diana is a kind and intelligent girl. Given the opportunity, she can find creative ways to express herself and have fun experiences with family members. Mother can draw on friendships in her life to vent her frustrations so she can slow down her reactions to her daughter.</p>	<p>2b. Individual / Family / Supporters Strengths: *Diana’s madrina and grandmother are reassuring and soothing to her and her madrina is also soothing to her mother, so they can build on those positive experiences. Teresa has identified personal challenges and specific resources which will be helpful in supporting her to resolve some issues.</p>
<p>1c. Action Steps By Individual / Family / Supporters: *Diana will practice verbalizing her needs and feelings to her parents. *The parents will apply new parenting strategies such as praise and rewards from Incredible Years Parenting class each week. *Parents will also use resources in their church community to help them transport Diana regularly to her dance class.</p>	<p>2c. Action Steps By Individual / Family / Supporters: *Diana will practice noticing when family or friends do or do not want to be touched. *Diana and Teresa will practice breathing and relaxation exercises twice a week outside of sessions. *Teresa (mom) will attend a support group for women who have experienced abuse as children where she can learn ways to protect and show kindness to herself which will also help her express affection to her daughter.</p>
<p>1d. Action Steps By Staff (Intervention): * Twice a month, Lupe will also coach & practice w/ Diana abdominal breathing and muscle relaxation techniques so she can manage increased anxiety and anger. This will take place in the office or home visits. * Therapist Lupe will offer 8 week Incredible Years parenting class to teach behavior management skills.</p>	<p>2d. Action Steps By Staff (Intervention): *Therapist Lupe will do dyadic therapy 2 to 4 times a month to support mother and daughter to become more aware of and responsive to each other’s cues. * Twice a month, Lupe will also coach & practice w/ Diana abdominal breathing and muscle relaxation techniques so she can manage increased anger.</p>

Progress Note addressing process of preparing for Interim Treatment Plan update (Developing a new Short-Term Goal):

As treatment has progressed, Diana and her mother have become closer to each other and mother has felt more confident about addressing her own needs in the family. Diana has been able to report more frequent happy interactions with siblings and parents. However after first 3 months of services, mother decided to move out of home and live separately from father. Diana is expressing feeling that “life is not worth living” when she is staying with her mother in a cramped apartment that they are sharing with another family. She has had multiple night -time bedwetting episodes in the last two weeks and is frequently irritable reminding parents of her behaviors before they began treatment.

Progress Note – Plan Development

Met with parents to review renewed concerns about Diana who has been signaling a lot of stress during this time of family upheaval. Parents are angry and blame each other for exacerbating Diana’s negative behaviors. They have had difficulty sustaining the teamwork for consistent parenting strategies that they had learned in Incredible Years class. They are also noting concerns about how Diana’s older brother has been becoming withdrawn and depressed during this time. Focused on ways all children in family need support from both parents through this transition and invited parents to think about ways to continue addressing desired result of Diana learning to have positive optimistic attitudes. After a lot of discussion, agreed that parents need to meet periodically with therapist to be sure that they are backing each other up as parents. Both parents want to support Diana to decrease bedwetting and note that she is distressed by this. Began to create an interim short-term goal of increasing number of dry nights and linking this to action steps both parents need to take to decrease stress for Diana as well as steps they can take to resume a calm, encouraging approach to her upsets. (See new goal sheet). Will work with Diana alone and with each parent in the next month and then see parents together again to review progress

Treatment Plan for Padma

Desired Results:

“I want to feel better about myself and get back to being around others like I used to do when I worked and could raise my daughter on my own.”

Desired Transition:

Padma will be spending more quality time with her daughter. She will have begun looking for outside activities, like volunteer work.

Obstacles:

Primary: isolation, irritability, anger/frustration with family members, loss of identity, low self-worth, mood swings, not sleeping well, drinks alcohol regularly, limited support system

Additional: physical limitations (uses a cane or wheelchair), doesn't have a driver's license/loss of independence.

1a. Short-Term Goal:

Within the next 3 months, Padma will have at least one daily positive conversational interaction (at least 2-5 minutes) with her daughter per journaling and self-report.

1b. Individual / Family / Supporters Strengths:

Likes to take on challenges, can persevere through difficulties, values relationships, passionate about what she can do, knows what she wants, long work history, speaks multiple languages

1c. Action Steps By Individual / Family / Supporters:

- Padma will leave her house for at least 5 minutes per day to work on relaxation and distance from stressors at home for the next 3-4 months.
- Padma will attend women's support groups, particularly AA, at least twice a week for the next 6 months which will improve her ability to engage in positive communication with others, develop healthy relationships, maintain her physical health, and hopefully reduce the need to drink alcohol as a coping tool.

1d. Action Steps By Staff (Intervention):

- Sally CaseManager, MHRS will provide rehab sessions at least 1x/mo for the next 3 months for Padma to role play communication and coping skills (addressing frustration & anger management) and review Padma's progress with family relationships.
- With Padma's approval, Sally will provide collateral MH education services to Padma's husband and daughter monthly so they understand how to support and motivate Padma, along with taking care of themselves.
- Jackie Therapist, LCSW will help Padma process her experiences as related to grief & loss once per week for six months to help Padma understand her difficulties with relationships.
- Sally CaseManager, MHRS will provide outreach, linkage & support to access community resources that can help Padma increase her confidence and reduce stress as she rebuilds her role as a mother- (transportation, medical, Independent skills programs) by October 1, 2012.
- Monthly (or more often, if needed), clinic staff (MD, nurse) will provide medication education, psychopharmacology, and connect with the medical doctors regarding coordination of care & medications as part of emotional support and mood stabilization through the next 6 months.

Module 4 - Progress Note addressing process of preparing for Interim Treatment Plan update (Developing a new Short-Term Goal):

After two and a half months of work with both MHRS and Therapist, as well as much work on her own part at home, Padma has noted improved relationships with her ex-husband and daughter. She has also begun using the bus to go to church more in order to connect with others, but still finds it difficult to socialize so she leaves and goes back home or isolates to a corner if she is too afraid to go home alone. Her physical limitations though also make it challenging to take the bus. Padma has expressed a desire to find a friend to talk to as she only has her 12 year old daughter and her ex-husband as resources, but feels guilt in depending on them since she wants to be independent and a good mother. I recognized how well Padma is doing in her recovery and that she has been able to identify herself as a mother, an important role to her, rather than her daughter's friend. We discussed impediments to her getting out of the home and making friends, which included that she continues to drink alcohol "every few days" and she does not know that other women would like her. I suggested involving the pastor's wife, who has been a peer of hers for some time and is involved at the church. I also noted Padma may be able to do some volunteer work there to not only socialize, but gain another role. She responded favorably to this and would like to update her current treatment goals.

Interim Changes to Goal(s) and updates to Action Steps

Short-Term Goals

1. Within the next 2 months, Padma will report that she has improved satisfying relationships with at least one new female friend.
2. Padma will cut down drinking alcohol as a coping tool from 4 times per week to less than two times per week over the next 3 months as reported by herself.

Action Steps by Client/Family/Supporters

- Padma will connect with a transportation service to get her from place to place (monthly bus pass rather than tokens, Ken's, Outreach, etc.) by October 15, 2012 and use it regularly so she feels more able to get out of the house to take breaks, and do things on her own which could include social activity and volunteer work. (Goal 1)
- Padma will connect with community support (Silicon Valley Independent Living Center, Occupational Therapy, etc.) to learn more independent skills and coping tools by the end of November 2012. (Goal 2)

Action Steps by Staff

- Sally CaseManager, MHRS will provide resources for vocational and group supports for social skill building at least 1-2x/month. (Goal 1)
- Dual Diagnosis group facilitators provide a safe place for client to explore and gain new coping skills to learn new methods (other than self-medicating with alcohol) of self-management weekly. (Goal 2)

D. Handouts

- Risk and Protective Factors
- Protective Factors for Fostering Resilience in Children and Youth
- Desired result Statements Worksheet
- Creating Measurable Short-term goals

Risk and Protective Factors

As individuals, we are all exposed to a number of factors which may either increase our risk for, or protect us from, problems such as abusing drugs or engaging in antisocial behavior.

“Risk factors” are any circumstances that may increase our likelihood of engaging in risky behaviors. Conversely, “protective factors” are any circumstances that promote healthy youth behaviors and decrease the chance that youth will engage in risky behaviors.

As mental health providers engage with clients and families, conducts assessments, and begin care planning efforts, clients frequently identify the risk and protective factors present in their lives. It is imperative that providers explore the impact of those risk and protective factors, and in turn focus their efforts on addressing those factors. That is to say that the provider plays an important role in helping clients increase protective factors and minimize risk factors wherever possible.

Risk Factors

Many risk factors are simply the opposite of protective factors. For example, one risk factor for young people is family management problems. If parents fail to set standards for their teen’s behavior, it increases the likelihood that the teen will engage in substance abuse or delinquent behavior. Conversely, a protective factor is effective parenting. If parents consistently provide both nurturing and structure, it increases the likelihood that a teen will not get involved with substance abuse or delinquent behavior and will instead become involved in positive activities. Exposure to risk factors in the relative absence of protective factors dramatically increases the likelihood that individuals will engage in problem behaviors.

Risk factors function in a cumulative fashion; that is, the greater the number of risk factors, the greater the likelihood that youth will engage in delinquent or other risky behavior. There is also evidence that problem behaviors associated with risk factors tend to cluster. For example, delinquency and violence cluster with other problems, such as drug abuse, teen pregnancy, and school misbehavior. The most effective approach for improving people’s lives is to reduce risk factors while increasing protective factors in all of the areas that touch their lives.

Risk Factors and Protective Factors are often organized into five categories:

1. Individual
2. Family
3. School
4. Peer Group

Examples of common risk factors are shown below.

Individual

- Antisocial thinking
- Gun possession / illegal gun ownership
- Teen parenthood
- Early onset of alcohol / drug use
- Victimization and exposure to violence
- Poor refusal skills
- Early sexual involvement

Family

- Family history of problem behavior / parent criminality
- Family management problems / poor parental supervision and/or monitoring
- History of child abuse or neglect
- High levels of family conflict and/or violence
- Having a young mother
- Divorce
- Family transitions
- Low parent education level/illiteracy

School

- Low academic achievement / learning disabilities
- Negative attitude toward school/low bonding/low school attachment/commitment to school
- Truancy/frequent absences
- Suspension
- Dropping out of school
- Unstructured or negative environment created by teachers

Peer

- Gang involvement/gang membership
- Peer use of alcohol, tobacco, or other drugs
- Association with delinquent/aggressive peers
- Peer rejection

Community

- Availability/use of alcohol, tobacco, and other drugs in neighborhood
- Availability of firearms
- High-crime neighborhood
- Residence in an economically deprived neighborhood

Protective Factors

Researchers know less about protective factors than they do about risk factors because fewer studies have been done in this area. However, they believe protective factors operate in three ways. First, they may serve to buffer risk factors, providing a cushion against negative effects. Second, they may interrupt the processes through which risk factors operate. For example, a community program that helps families learn conflict resolution may interrupt a chain of risk factors that lead youth from negative family environments to associate with delinquent peers. Third, protective factors may prevent the initial occurrence of a risk factor, such as child abuse. For example, infants and young children who are easygoing may be protected from abuse by eliciting positive, rather than frustrated, responses from their parents and caregivers.

Recent scientific studies have shown that community resources also can influence individual teenagers' positive traits. For example, young people are more likely to be a part of youth organizations and sports teams if their parents perceive that the community is safe and that it has good neighborhood and city services (such as police and fire protection or trash pickup). Similarly, youth are more apt to be exposed to good adult role models other than their parents when communities have informal sources of adult supervision, when there is a strong sense of community, when neighborhoods are perceived to be safe, and when neighborhood and city services are functioning.

Protective factors that protect youth against delinquency and substance abuse are shown below.

Individual

- Positive/resilient temperament
- Religiosity/valuing involvement in organized religious activities
- Social competencies and problem-solving skills
- Perception of social support from adults and peers
- Healthy sense of self-esteem / optimism for the future

Family

- Good relationships with parents/bonding or attachment to family
- Opportunities and reward for pro-social family involvement
- Having a stable family
- High family expectations

School

- School motivation/positive attitude toward school
- Student bonding and connectedness (attachment to teachers, belief, commitment)
- Opportunities and rewards for pro-social school involvement
- Clear standards and rules /
- High expectations of students
- Presence and involvement of caring, supportive adults

Peer

- Parental approval of friends
- Good relationship with peers
- Involvement with positive peer group activities and norms

Community

- Economically sustainable/stable communities
- Safe and health-promoting environment/supportive law enforcement presence
- Positive social norms
- Opportunities and rewards for pro-social community involvement/availability of neighborhood resources
- High community expectations

Protective Factors for Fostering Resilience in Children and Youth⁷

Within the Family

- A close sustained relationship with at least one caring, prosocial and supportive adult who is a positive role model
- Close affective relationship with at least one parent or caregiver – perception of availability and responsiveness of caregivers; strong support systems
- Authoritative parents who are high on warmth and support, but who also provide structure (set firm limits and state clear rules), monitor their child’s behavior and peer contacts, and convey high expectations in multiple domains
- Positive family climate with low family discord between parents and between parents and children
- Organized home environment (role of rituals, ceremonies, shared dinner times and mutual responsibilities, cohesive and supportive)
- A secure emotional base whereby the child feels a sense of belonging and security; access to consistent, warm care-giving
- Parents are involved in their child’s education. Both parents and teachers should convey high, but realistic expectations to their children.
- Socioeconomic advantages

Within Other Relationships: Extrafamilial Factors

- Close supportive relationship with prosocial and supportive adult models (role of mentors). Bond to prosocial adults outside family. (See www.teachsafeschools.org for information on how to establish an adult mentoring program.)
- Connections to prosocial and rule-abiding peers who have authoritative parents
- Support from “kith and kin,” access to wider supports such as extended family members and friends.

The best documented asset of resilience is a strong bond to an inclusive and caring adult, which need not be a parent. For children who do not have such an adult involved in their life, it is the first order of business... Children also need opportunities to experience success at all ages.

(Masten & Reed, 2002)

⁷ Meichenbaum, D. Understanding Resilience in Children and Adults: Implications for prevention and interventions. The Melissa Institute for Violence Prevention and Treatment. Miami, Florida. www.melissainstitute.org.

Protective Factors for Fostering Resilience in Children and Youth (continued)

Within the Schools and the Community

- Ties to prosocial organizations, including schools, clubs, participation in extracurricular activities.
- Neighborhoods with high “collective efficacy,” social cohesion and social capital resources.
- High levels of public safety.
- Good emergency social services (e.g., 911 or crisis services, nursery school services)
- Good public health and health care availability
- Opportunities to learn and develop talents
- Support derived from cultural and religious traditions
- Have extended families who nurture a sense of meaning and identity (connected to larger community by having religious, cultural, community ties)
- Civic engagement -- engage with others (classmates, family and community members) in empowering activities such as helping others.

“School Connectedness”

“School connectedness” is the belief by students that adults in the school care about them as students and their learning. School connectedness is related to academic, behavioral and social success in school. A protective factor is the attendance in effective schools and being “bonded” to school; for instance, ask students the following question to assess school-bondedness: “If you were absent from school, besides your friends, who else would notice that you were missing and would miss you?”

Desired Results Statement Worksheet

Rewrite the following desired results and improve them as needed. Find a positive statement, future direction and/or a visionary focus that would add to the power and intent of these desired results.

1. I want to have more friends at school.
2. I want to get along with my parents.
3. I want our family to be happy.
4. I want to quit getting mad all the time.
5. I want to graduate from high school.
6. I want to get off of probation.
7. I want to live with my Mom and Dad, not in a foster home.

Creating Measurable Short-Term Goals

For each statement of desired results, a barrier and short-term goal are listed. However, the short-term goal does not meet the SMART standard (Specific, Measurable, Achievable, Realistic and Time-framed). Rewrite the short-term goals below using the following format:



- Desired Results:** I want to have friends.
Barrier: Sharon is very isolated and rarely goes out of her house, except to work.
Short-Term Goal: She will reduce her isolation.

- Desired Results:** I want to graduate from high school.
Barrier: Jack has extreme anxiety that interferes with his ability to go to school.
Short-Term Goal: He will learn two skills to manage his anxiety.

- Desired Results:** I want to get along with my siblings.
Barrier: Anna is very irritable and easily provoked.
Short-Term Goal: She will fight less with her siblings.

APPENDIX A: Additional Case Examples

Additional Narrative Summary and Treatment Plan Example # 1

Leonard (Early Childhood Client)

Leonard is an articulate 4 year old African American male who is challenged in areas of social skills and anxiety. Leonard has difficulty managing sensory stimulation and can get so overwhelmed that he has trouble regulating himself. It is also difficult for Leonard's parents to help him regulate himself when he is in that state, and the intensity of their efforts agitates him further. This contributes to his behavioral challenges.

Leonard is intelligent, has a desire to engage with others, and strives to do his best. He has a great support system in his parents and enjoys interactions with his younger sister, when it is a preferred activity for him. Parents have found a good preschool placement for Leonard that has provided him with much support. School has been able to find ways to help manage Leonard's difficulties by allowing him more time and warnings around transitions, providing breaks and allowing him to move his position to manage the level of stimulation he is exposed to.

Leonard has difficulty interpreting certain social situations which can lead to frustration, avoidance or hesitation to participate, and aggressive behaviors. Parents' interactions with Leonard are different but both are supportive. Father's play is observed to be calm providing space for Leonard to explore and lead. Mother provides a lot of stimulation during her interaction with Leonard. However she is often frustrated with his responses. Due to Leonard's sensory challenges, anxiety, and difficulty with social cues, he may need more time and space to process and respond to suggestions.

Parents admit feeling frustrated with Leonard's behavior and their inability at times to contain him. Mother cares a lot about the importance of a successful social life and worries a great deal about Leonard's abilities for social engagement. Parents have also been raised to be very concerned about how one behaves and is perceived in public situations. Leonard's unusual responses are often embarrassing to his parents. This adds to the intensity of emotions in the family. Therefore Leonard and his parents would benefit from dyadic therapy to continue to foster a healthy parent and child relationship and increase parents' understanding of Leonard's thoughts and behaviors. In combination with dyadic therapy, teaching of social skills and coping skills would benefit Leonard's ability to engage with others and move through difficult situations without reverting to aggressive behaviors.

Treatment Plan for Leonard (Early Childhood Client)

Client's Desired Results:

Leonard: *I want to have fun playing.*

Parents would like Leonard to be able to control his anxiety and fears. They would also like to see Leonard make and keep friends and have a normal, happy life.

Desired Transition: Leonard and his parents will be managing and enjoying social situations in more satisfying ways.

Challenges/Obstacles:

Leonard has difficulty with social skills, anxiety and emotional regulation. He also has difficulty managing sensory stimulation. When faced with certain situations where Leonard is unsure of how to respond he tends to become frustrated leading to difficult tantrums, self-injurious behaviors and aggressive behaviors. Parents have found it difficult at times to manage Leonard when he is in these agitated states creating more frustration in the home for everyone.

Short-Term Goals:

- 1) In the next 3 months, Leonard will use a coping activity such as deep breaths, time in quiet area or use of a stress ball, two or more times per day to help regulate his emotions as measured by parent and teacher report.
- 2) In the next three months, the parents will help Leonard implement preferred coping strategies in public situations a minimum of 3 times a week to help prevent tantrums and aggressive behaviors. This will be monitored by verbal report and behavior tracking log.

Individual/Family Strengths:

Leonard is a bright young boy that wants to be social and do well at school and home. Leonard is articulate and responsive. Parents are involved and concerned about Leonard's social development and open to working with him to address those concerns. Leonard's parents want the best for him. They are supportive of each other and want to fully understand of Leonard's needs. School has been very supportive of Leonard and found strategies to help Leonard throughout his day (e.g. more time to transition and remove himself to reduce his stimulation).

Action Steps by Client/Parents/ Supporters:

- Leonard will practice coping activities, at a time when he is not upset, one or more times a day.
- Leonard will let his parents know what he likes and dislikes in his environment
- Parents will follow up on recommendations for Occupational Therapy services for Leonard.
- (Parents Helping Parents can support parents with school based advocacy as needed)
- Parents will work with clinician to define when they need to implement coping strategies versus sensory activities.
- Parents will continue to work with pre-school to ensure Leonard's needs are being supported.

Interventions:

- Clinician will provide weekly play based therapy services, in the office or home (and case management, on an as needed basis) to help Leonard learn to communicate with others and be aware of his own needs and wishes so that he can request for breaks or coping activities.
- Clinician will provide support for parents to understand Leonard's behavioral needs and internal experiences using dyadic relationship based strategies, to increase reflective capacity, monitor the

urge to over stimulate, and find a pacing that matches Leonard's individual differences and decreases stress. To occur in the office or home.

- In the office or community, Clinician will assist family and teachers in implementing Social Stories to help address and prepare for difficult situations that may arise so that unusual behaviors and emotional reactions can be anticipated and modulated. Clinician will continue to work with family as needed to communicate with their preschool or school district to ensure Leonard's needs at school are addressed.

Additional Narrative Summary and Treatment Plan Example # 2

Dan (Youth FSP Client)

Dan is an eleven year old Mexican American male who speaks English and Spanish. His current preferred language is English. His mother and father are monolingual, speaking Spanish. Dan lives with his mother, 15 year-old sister, grandmother, aunt, uncle, and two cousins. Dan's parents are Mexican immigrants who met and married here in the United States. Dan's parents have been separated for six years, but they are both committed to Dan's well-being and success in life. They have been cooperating fully in therapy. Mother is on disability and his father works two jobs.

Dan is under a lot of stress due to his mother's ailing health, the parent's separation, and his living environment. He is irritable, uses foul language, has poor hygiene, and pulls out his hair when stressed. He experiences excessive worrying, difficulty concentrating, and restlessness. He struggles to follow through on instructions, and completing assignments at school. He has met developmental expectations but needed speech therapy as a younger child.

Dan has made some improvements in school. He is friendly, caring, intelligent, and very resilient. He has found that music and singing are helpful ways to release tension. He is a talented artist who likes to draw mischievous cartoons when he is in a good mood. Dan wants to work on respecting others and finding balance with his behavior.

Dan's current need to develop a strong sense of his own interests and talents has been disrupted by his anxiety over family stresses. His history of speech challenges makes him more likely to express his feelings in disruptive behavior rather than verbalizing his concerns. His mother would like to support and help Dan to be respectful, manage the stress he is under, and improve how he relates to the family, especially with his siblings because she is fearful that if and when she passes they will not turn to each other for support.

The family would benefit from the FSP Youth Intensive Program. Through individual and family therapy, Dan can learn healthy coping skills, identify appropriate boundaries and learn to manage his emotions. The Family Partner can help the parent with parenting skills and ways to connect with the community for services needed. The Peer Partner can work with the Dan so he learns to express his emotions in positive ways in the community. Dan can also receive psychiatric services to maintain the medications that help him regulate his emotions.

TYPE OF SERVICE	<input checked="" type="checkbox"/> Outpatient	<input type="checkbox"/> DTI	<input type="checkbox"/> DR	<input type="checkbox"/> AR	<input type="checkbox"/> CR
<p>DAN'S DESIRED RESULTS (Dan and parent's personal expression of desired outcome and vision):</p> <p>Dan = "I want to improve my focus in school and treat others more equally."</p> <p>Dan's Mother = "I would like Dan to be more respectful of others and help with school. For my family I would like that their last remaining days together to be happy."</p>					
<p>Anticipated Discharge/Transition Setting and Criteria:</p> <p>When Dan can participate appropriately in the classroom 2 to 3 days a week (rather than 0-1 day a week) for 10 consecutive weeks, Dan will step down from three sessions a week to two a week and receive an incentive prize of movie tickets to attend the movies with his family. Appropriate participation would mean that he reduces his acting out behavior in school, like talking out of turn, arguing with teachers over assignments and moving about the room without permission.</p> <p>Goals will be reviewed in case conference with Dan and parents in 90 days or as needed to evaluate Dan's progress. As Dan is more able to deal with his own emotions, new goals will be developed to improve his relationships with his siblings. When Dan meets goals agreed upon by Dan and parents Dan will graduate from the FSP Youth program and transfer to traditional outpatient program if needed.</p>					
<p>Challenges/Obstacles (diagnostic symptoms/behaviors; life functioning): Include Barriers to Treatment</p> <p>Dan is restless or keyed up, has difficulty concentrating, irritable and has sleep disturbances where he has difficulty falling asleep. Barriers to treatment are the impact of Dan's mother's ailing health and the volatile environment in the home. When his mother's health declines, Dan acts out by getting into verbal altercations with others, talking out of turn in school, and not doing his homework due to the stress he is under. Dan's volatile home environment makes it difficult for his mother to implement healthy communication skills discussed during collateral and family sessions. Dan's home environment makes it difficult for him to focus on his school work, and control how he behaves around others. The small quarters makes the family feel both physically and emotionally crowded.</p>					
<p>Short-Term Goals (measurable, observable and/or quantifiable):</p> <ol style="list-style-type: none"> 1) Dan will develop skills to increase his ability to express his feelings in an age appropriate manner from 0-1 day per week to 2-3 days per week, consecutively for 30 days as reported by his parents. 2) Dan will develop skills to increase his focus and participation in school from 0-1 day per week to 2-3 days per week, consecutively for 30 days. Goals will be measured by parent, teacher, FSP Team and self-report. 					
<p>Individual / Family Strengths: (Talents/Skills, Personal Characteristics/Qualities, Environmental, Past Successes, Hopes/Aspirations, Cultural)</p> <p>Dan loves to draw and sing. His expressive abilities and resilience will be a foundation for accomplishing Goal 1. He is friendly, caring, intelligent, and very resilient. These strengths will be a foundation to accomplishing Goal 2. Dan's parents are concerned for Dan's well-being and are invested in his care being consistent, fully present and willing to address difficult feelings during individual, collaborative and family sessions. This support will be key to both goals.</p>					

Action Steps by Dan (steps Dan, parents, family and others will take to accomplish goal):

For Goal 1:

Dan will recognize and verbalize hurt or angry feelings in a constructive way.

Dan will identify and verbalize what is needed from his parents and others to help him decrease his anxiety.

Dan's mother will be supportive and talk openly about issues related to fears and worries related to her illness.

Parents will role model appropriate ways to interact with others.

For Goal 2:

Mother will develop and implement an organizational system to increase the Dan's on-task behaviors and completion of school assignments, and chores.

Parents and teachers will work on improving communication about Dan's academic, behavioral, emotional, and social progress.

Dan will follow agreed upon psychiatric recommendations and attend all scheduled appointments, or give appropriate notice to cancel.

Interventions (rehab, group, med support, case management, etc.: include specifics, frequency, duration, purpose, and intent):

For Goal 1:

Therapist will use artistic activities with Dan to learn healthy expression of his feelings to cope with mother's illness and his anxiety and will use CBT techniques to create coping statements. Therapy will be provided one to four times per week.

Collateral support will build mothers skills to help her son cope with his anxieties about her illness. Collateral will be provided one to three times per week.

Case management will provide the Dan and family the support needed to manage activities of daily life and connect with additional services needed that can reduce family's stress levels. Case management will provided 1-4 times per week.

Psychiatric services will be provided once a month or more as needed to monitor medication and symptoms of anxiety.

For Goal 2:

Therapist will work with the Dan to learn more effective test-taking, problem-solving skills, and self-control strategies. Therapy will be provided one to four times per week.

Rehabs will provide opportunities to provide socialization to develop friendships. Rehab will be provided one to four times per week.

TCP TREATMENT PLAN

Revised June 2011

Name: _____

Unicare #: _____

Program (Cost Center) _____

Additional Narrative Summary and Treatment Plan Example # 3

Tina (Teenage Client with History of Substance Use and Involvement with Probation)

Tina is a friendly and charming 16 year-old bisexual English-speaking female of Hispanic descent who lives with her mother and brothers (ages 18 and 14). Tina is creative and has written poetry for classes in school. She comes from a close knit family. Mother is committed to helping Tina graduate from high school. They moved to a new neighborhood to have a new start and Tina's mother tries to coordinate with teachers as needed to get feedback for Tina.

Mother related concerns that Tina might be involved in negative peer relationships based on Tina's history of being drawn to peers who are gang involved. Family financial concerns and extended family health issues (e.g. grandmother being sick) impact Tina's mood and functioning. Tina has been off probation since November 2011 for bringing a weapon to school. There is a history of substance abuse (e.g. marijuana and ecstasy pills). Mother expressed concerns that Tina might not graduate from high school. Tina reports that her depressed mood and irritability get her into "fights" with peers and family members and inhibits her from focusing on her academic work. Tina reported that she has informed her mother about being bisexual and this has caused some conflict in the past. Tina is behind credits in school. Tina is currently concerned about maintaining her improved behavior and being off probation.

Tina being in the adolescent stage is challenged with finding an identity for herself. She has gained some important interests and commitments that can offer new motivation for accomplishing her academic goals. Spending time with extended family members and attending church is a source of support for the family. Tina's mother is aware that coping with grandmother's illness needs to be shared with mother's siblings so she and Tina are less overwhelmed. Tina's bisexuality has led to times of confusion but also to times of hope and joy though her family is still learning to respect her need to explore her preferences. Tina has been getting better grades in the past year than in the previous school year and she and her mother agree that social relationships need to be ones that support her goals and be with people who keep her safe. Tina enjoys her drama and choir class. She was chosen as one of the delegates for her church at a conference held during the summer. Tina talks about doing missionary work in the future.

Tina and her mother have benefitted in the past from receiving additional support. Mother has participated in a program "parent project" in the past where she has learned ways on how to help Tina achieve academic goals. Tina has expressed her goal of graduating from high school and needing academic support. She and her mother have begun to discuss academic concerns with school counselor. Individual and family therapy can offer ways to deal with emotional struggles and challenging behaviors that have interfered with Tina's goals so that she can more freely express her creativity and her commitment to helping others in her community.

Treatment Plan for Tina

<p>Desired Results: Tina: “I want to be a singer and a model and to have a better relationship with my mom.” Mom: “That we can work on things together without fighting and that Tina is able to feel contented with her life.”</p>	
<p>Desired Transition: Mother will not be yelling at Tina all the time and Tina will have new tools that she regularly uses to meet her needs when she feels frustrated. She will have accomplished some of her academic goals and will be progressing with her creative interests.</p>	
<p>Obstacles: Tina and her mother have a pattern of arguing many times a week escalating to yelling. Tina loses her temper, hits siblings and throws objects when frustrated. She is often depressed and irritable and at those times struggles to make good decisions and has some history of gang involvement, probation and substance abuse</p>	
<p>1a. Short-Term Goal:</p> <p>Within the next 4 months, Tina will communicate calmly and effectively with her mother from a baseline of 0 per week to 3x per week as reported by Tina, mother or observed in session.</p>	<p>2a. Short-Term Goal:</p> <p>By the end of the semester, Tina will regularly identify triggers for her temper outbursts and be able to use at least 2 different coping skills such as breathing and asking for support, as observed by mother, therapist and Tina herself. Temper outbursts will decrease from current baseline of 2 to 3 times a week to 0 to 1 times a week.</p>
<p>1b. Individual / Family / Supporters Strengths:</p> <p>Tina’s interest in helping others, writing poetry and being a performer are all areas where she has begun to practice self-expression. She is likely to find role plays and perspective taking relevant to her other interests.</p>	<p>2b. Individual / Family / Supporters Strengths:</p> <p>Tina is attending school consistently and showing the ability to cope with more demands on her at school by including motivating activities.</p>
<p>1c. Action Steps By Individual / Family / Supporters:</p> <p>Tina and her mother will regularly attend individual, conjoint and collateral sessions to practice communication skills.</p> <p>They will practice using skills between sessions.</p> <p>Tina will also practice these skills with peers and teachers with whom she has less intense reactions.</p>	<p>2c. Action Steps By Individual / Family / Supporters:</p> <p>Mother will work with Tina to balance chores at home with enjoyable shared activities such as watching their favorite show, “Survivor” together.</p> <p>Tina will keep track of her stress level using a journaling system so she becomes more aware of when she needs support from others as well as self-soothing actions.</p>
<p>1d. Action Steps By Staff (Intervention):</p> <p>Therapist will provide weekly individual and family Therapy in the office with the following focus</p> <ol style="list-style-type: none"> 1. Engage client in role plays to help her learn empathic responses and perspective taking. 2. Facilitate games in family that give Tina and her family members the opportunity to better know each other so they can communicate more effectively 3. Collateral contacts with mother to coach her in ways to deescalate arguments with Tina 4. Support Tina to practice “I” statements to convey her needs to others 	<p>2d. Action Steps By Staff (Intervention):</p> <p>In individual weekly sessions, therapist will coach Tina to notice her internal signals of tension and practice self-soothing skills by using CBT and mindfulness techniques.</p>

Additional Narrative Summary and Treatment Plan Example # 4

Roberto (Adult Client in Contemplation for Changes Related to Trauma)

Roberto is an intelligent 24 year old man with strong family ties and support and proud of his Hispanic heritage. Until his recent military experience when he served in Iraq, all of his family looked up to him as someone to emulate and he was a role model for his younger siblings.

Roberto has had high expectations for himself and his future as evidenced by his success in high school, plans to attend college to become a chemical engineer, marry and have a family of his own. Now, however, Roberto finds his life spinning out of control and his future seriously in doubt. He is having difficulty adjusting to civilian life following discharge from the Army. He has had numerous problems that have led to his seeking help including fighting/ separation from wife, being over-vigilant with his children, inability to sleep having nightmares and difficulties in gaining employment. He misses being with his wife and children. He is used to being independent and “in charge” and instead of being able to benefit from his family’s supports; he finds that he is embarrassed to be around them and ashamed of his perceived failures. His core values, shaped by both his military experience and cultural heritage contribute to making his current life situation so difficult.

Roberto appears to be experiencing symptoms consistent with diagnosis of post-traumatic stress and depression which are perhaps aggravated by his back pain and drug use. He recognizes that he needs to take some action to get his life on track, but is fearful to admit the extent of his difficulties and the effort it may take.

Roberto is in the contemplative stage of change. He is motivated to do what it takes to make things better, but unsure about what to do and wonders if anything can really make his circumstances any better. It appears that feelings of survivor guilt and the trauma he experienced/ witnessed during his military service have exacerbated an underlying vulnerability to depression. His ideas about being “macho”, pride and self-sufficiency and providing for a family, strongly influenced by his cultural values and traditions are impacting his ability to seek help and aggravating his feelings of guilt and failure. He may be using alcohol and drugs in an effort to maintain social connection with peers as well as gaining some relief of his anxiety and sadness.

Roberto wants to get his family back, get rid of his nightmares and go back to school so that he can be a good provider. Group services focused on anger management, trauma-resolution and psychiatric medication may be helpful. These are likely to work best in combination with community support groups for Veterans and addicts along with spiritual support in his family’s church.

Treatment Plan for Roberto

Desired Results

“I want to get my life back by getting rid of these nightmares.”

Desired Transition

Roberto will be reunited with his family and feel hopeful about employment.

Obstacles

Nightmares wake him and his parents up nightly, lack of sleep has made it difficult to do daily activities. Difficulty adjusting to civilian life. Arguing with wife, angry outbursts, hyper-vigilant with kids, depressed mood causing cognitive interference & concentration struggles, drug use, doesn't understand the effects of trauma, cultural (gender-based, ethnic and military) factors prohibiting help-seeking.

Short-Term Goal

Roberto and his parents will report at least 4 nights per week of uninterrupted sleep (minimum 7 hours) for 3 consecutive weeks, where Roberto does not wake up from nightmares, within the next 4 months.

Strengths

Strong family connection, religious/spiritual connections, motivated to seek help

Action steps by individual/family/supporters

- Roberto will attend a Vet-to-Vet support group 1 time per week for 6 months to help him cope with his nightmares and increase his social support network
- Roberto will email peers from his military unit 2 times per week for 3 months to encourage discussion of post-war stressors and coping skills to help increase alternative supports for his nightmares
- Within one month, Roberto's parents will help him connect with Spiritual Director from the family's Catholic Church for the purpose of seeking absolution and resolving issues of guilt around death of orphan Iraqi civilians
- Roberto to attend a minimum of 3 local AA/NA/DRA groups within two weeks to explore if 12-step programs can be helpful source of support in learning positive ways to manage stressors and life symptoms.

Action steps by staff (interventions)

- LCSW will provide weekly 1:1 trauma-resolution therapy in the office for 4 months to educate Roberto on symptoms and treatment of PTSD to better understand his nightmares.
- M.D. to provide medication evaluation and monitoring in the office to Roberto bi-weekly for 30 minutes for 4 months for purpose of identifying possible medications to address Roberto's difficulty sleeping and managing his nightmares.
- MSW to provide case management in the office bi-weekly for purpose of locating and referring Roberto to support groups in the community to assist in developing a social support network.

Alternative Treatment Plan for Roberto

(This plan illustrates how a variation in desired results leads to a different focus in short-term goals and action steps)

Desired results

“I want my family back and go back to school so I can be a good provider.”

Desired Transition

Roberto will be reunited with his family and feel hopeful about employment.

Obstacles

Arguing with wife, angry outbursts, hyper-vigilant with kids, depressed mood causing cognitive interference & concentration struggles, drug use, doesn't understand the effects of trauma, cultural (gender-based, ethnic and military) factors prohibiting help-seeking. Nightmares wake him and his parents up nightly, lack of sleep has made it difficult to do daily activities. Difficulty adjusting to civilian life.

Short-Term Goals

- A. Roberto will have 3 consecutive positive encounters with his wife during their weekly meetings within 4 months as reported by Roberto and his wife.
- B. Roberto will complete one college course toward the completion of his Associates Degree during the upcoming fall semester.

Strengths

Strong family connection, religious/spiritual connections, motivated to seek help, strong work history despite possible presence of depressive symptoms dating back to teen years

Action steps by individual/family/supporters

- A) Roberto's wife to participate in NAMI-sponsored Family-to-Family program to receive education and support re: Roberto's issues with depression and post-traumatic stress.
- A) Roberto and his wife to meet with parish priest weekly for 4 months to bring about understanding, forgiveness and reconciliation.
- B) Roberto to meet with entrance counselor from Gateway Community College within 2 months to explore course offerings and select one class for fall semester.
- B) Juan Espinosa (childhood friend & veteran) to link Roberto to the veteran's benefits program to pay for college tuition

Action steps by staff (interventions)

- A/B) LCSW will provide weekly 1:1 trauma-resolution therapy in the office for 4 months to educate Roberto on symptoms & treatment of trauma-related hyper-vigilance & how this impacts his behavior, relationship with his wife, and parenting his children. LCSW will also provide cognitive-behavioral treatment to reduce depression symptoms and manage cognitive interference.
- A) LCSW will provide bi-weekly anger management group in the office for 4 months to teach Roberto anger management skills.
- A) LADC to provide education and weekly motivational enhancement therapy in the office for 2 months to help Roberto identify consequences of drug use on impulse control and relational problems with his wife and children.

- B) M.D. to provide medication evaluation and monitoring to Roberto in the office bi-weekly for 4 months for purpose of identifying possible medications to address Roberto's complaints of difficulty concentrating during periods of depression.
- B) MSW to provide case management in the office bi-weekly for purpose of assisting Roberto in enrolling in Gateway course and in negotiating any necessary accommodations which will increase his likelihood of success in the classroom. Elliot will also provide depression and trauma education support to Roberto's family monthly so they can better understand and support him.

Additional Narrative Summary and Treatment Plan Example # 5

Michael (Adult Client in Pre-Contemplation Regarding Mental Health and Substance Use)

Michael is a 35 y/o heterosexual, single, Caucasian, male who has never been married and has no children. Michael was born and raised in the US and speaks English. Michael has traveled to, lived and worked in many States and settings. He is intelligent, perseverant, independent, interesting, and has rich life experience. Michael values his independence and the right to make his own life decisions. He enjoys listening to music and used to play football and basketball in high school.

When calm, Michael exudes a good sense of humor and is able to clearly communicate his concerns and to engage with caring staff. Michael is vocal about his treatment and educates himself about agency policies, privacy and client rights. Michael has difficulty trusting others and, at times, lacks consistency and follow-through with the services and medications that are recommended and offered to him. When taking medications, Michael is able to navigate well in the community. When not taking medications, Michael becomes verbally and physically aggressive, has increased fears and paranoia which lead him to using marijuana. Michael can get so aggressive that he is often arrested and jailed or hospitalized for his behaviors. At these times, it is difficult for others to reach Michael to communicate with him as he expresses distrust in them, particularly if they had to put him on a psychiatric hold. Michael experiences fearfulness about being persecuted and sexually assaulted as a child as well as preoccupied with death (family and friends of whom he valued the relationships with have died over the last few years).

Michael is currently pre-contemplative around his behavior change needs as well as drug use. Michael's recent aggressive behaviors, which occurred after stopping his medications and possibly using street drugs, have led to his current placement at St. Helena Hospital, possibility of temporary conservatorship, and may result in placement at a long-term inpatient facility. He also has been withdrawing from others and their support. It is because of this that his recovery is at a MORS 1.

Abuse and loss are themes in Michael's life. Michael has a history of trauma and suffered ongoing sexual abuse in childhood by a trusted authority figure (his doctor). Michael experienced loss of innocence, loss of trust, loss (recent deaths) of his mother and a close friend, loss of hope. Michael is doubtful of things going well in his life and about happiness being possible for him. Michael is leery of medications being helpful for him. It is possible Michael would benefit from being listened to, respected, encouraged and engaged with consistently by someone he can learn to trust. With such engagement, Michael would likely be able to achieve increased autonomy and independence.

Treatment Plan for Michael

Desired results

“I want to get out of here [hospital].”

Desired Transition

Michael will be residing in the community and hanging out with others weekly without harming them.

Obstacles

Guarded, having challenges trusting people, expresses past trauma and losses by expressing his delusional thoughts (fear of others attacking him, particularly doctors) by acting out aggressively in the community.) There is a possibility he may be using street substances, though while in locked setting, this is not occurring. Pre-contemplative in his recovery.

Short-Term Goals

Over the next 3 months, Michael will communicate his wants and needs in a positive manner at least 3 times weekly, which will help him engage and understand what's going on with him and around him as noted by staff members.

Strengths

History of sports and employment where he appropriately engaged with others, ability to engage with caring staff, independent and intelligent, resourceful, resilient and adapts well to new environments, values close friendships and family relationships, is interested in music.

Action steps by Individual/Family/Supporters

- Michael will consider following through on recommendations by support staff (i.e. taking prescribed medications, attending groups, self-care, productive activities) daily.
- Michael will observe and evaluate his immediate peers and staff for comfort level to communicate with them, and will talk with at least one person weekly at first, then daily.
- Michael will consider resuming communication with his aunt and will decide whether to sign a new consent for case manager to speak with the aunt.
- Inpatient staff will provide medication education and evaluate the appropriateness of medications, provide groups, individual coaching and feedback on appropriate behavior, as well as apprise outpatient staff of any updates or discharge plans.

Action Steps by Staff

- At least once a month, Case Manager will visit Michael at the hospital and engage with him to find out about his interests as well as reflect upon Michael's improvements and set-backs in the hospital or IMD; this will encourage and teach Michael to socialize appropriately.
- At least once a month, Case Manager will contact Michael and/or inpatient staff to collect information and discuss it with Michael so that he can make informed decisions as to the level of treatment he needs.

APPENDIX B: SAMHSA’s Working Definition of Recovery”

Recovery from Mental Disorders and/or Substance Use Disorders s Working Definition of Recovery”

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

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways: Individuals have unique needs, strengths, preferences, goals, culture, and backgrounds, including trauma experiences, that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations, including values, traditions, and beliefs, are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important.⁸

⁸ Substance Abuse and Mental Health Services Administration. (2012). SAMHSA’s Working Definition of Recovery Updated. Online at <http://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated/>
Transformational Care Planning

APPENDIX C: Stages of Recovery and Treatment

Ohio	Milestones of Recovery Scale (MORS)	Prochaska & DiClemente	Stage of Treatment	Treatment Focus
Dependent Unaware	High Risk/ Unidentified or Unengaged (1,2,3,4)	Pre-Contemplation	Engagement	<ul style="list-style-type: none"> ➤ Outreach ➤ Practical help ➤ Crisis intervention ➤ Relationship building
Dependent Aware	Poorly coping/ Engaged/ Not Self-directed (5,6)	Contemplation/ Preparation	Persuasion	<ul style="list-style-type: none"> ➤ Psycho-education ➤ Set goals ➤ Build awareness
Independent Aware	Coping/Self-responsible (6,7)	Action	Active Treatment	<ul style="list-style-type: none"> ➤ Counseling ➤ Skills training ➤ Self-help groups
Inter-dependent Aware	Graduated or discharged (8)	Maintenance	Relapse Prevention	<ul style="list-style-type: none"> ➤ Prevention plan ➤ Skills training ➤ Expand recovery

The purpose of thinking about the various stages of change, no matter how they are labeled, is not to “label” people but, rather, to use the stages of change to have a richer understanding of the person and to help with goal narrative summary and developing the entire plan, especially what will be called the “interventions,” the services we provide, on the plan.

Oftentimes in the mental health field, we write plans like everyone is in the action stage, ready, willing and able to receive services and be an active participant in their own treatment. However, most of the time, the people who come through our front doors are more in the pre-contemplative /contemplative stages, especially those who are “externally motivated” for services (legal mandates). Developing a plan that has the person attending lots of groups, day treatment five days a week, going here/going there (active treatment) when the individual is overwhelmed by their illness does not match where they are in the stages of change. Being unaware is only a set up for failure for the individual and for the provider. When the person does not attend all the wonderful services we have provided (because they are not yet ready to receive such services) we typically then say they are “non-compliant” or “in denial.” Another way to reframe this is to recognize that the person was not yet ready for those services and that we did not develop the proper plan to match their stage of change.

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