# TIP SHEETS FOR PRACTITIONERS
# IN INTEGRATED CARE SETTINGS

## PRACTICE PRINCIPLES AND FUNCTIONS FOR USE IN
## CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS

### TO SUPPORT WELLNESS, YOUTH RESILIENCY, AND ADULT RECOVERY

## TECHNICAL REVIEW VERSION 1.3D: MARCH 2016

## LISTING OF TIP SHEETS BY TOPICS ADDRESSED

### Guiding Principles for Providing High Quality Practice

**GUIDING PRINCIPLES. High quality practice is:** • **Person-centered.** • **Strengths-based.** • **Solution-focused.** • **Wellness-, resiliency- and recovery-oriented** • **Trauma-informed.** • **Outcome-focused and results-driven.**

### Key Concepts

**Person-Centered**. Person-Centered Care is an approach designed to assist someone in planning and achieving life goals and supports. It was originally used as a life planning model to enable individuals with disabilities and requiring support to increase their personal self-determination and improve their own independence. It is accepted as evidence based practice. Person-centered care is currently becoming the standard in many areas of practice and is the guiding philosophy behind the integration of medical and behavioral health care. It is evident that individuals and families are more invested in any process where they feel they are an integral part. Self-Directed Care is built upon person-centered care principles and practices.

**Strengths-Based**. Strengths-based practice is person-centered, with a focus on future outcomes and strengths that the people bring to a problem or crisis. This approach enhances the capacities of individuals and families to deal with their own challenges. Key features of this approach include:

* Strengths-based practice assesses the inherent strengths of a person or family and then builds on those strengths when addressing life changes, recovery and empowerment.
* It avoids the use of stigmatizing language or terms that families use on themselves and eventually identify with, accept, and feel helpless to change.
* It fosters hope by focusing on what has been historically successful for the person and builds on these past successes to support positive future changes.
* It inventories the positive building blocks that already exist in his/her environment that can serve as the foundation for growth and change.

**Solution-Focused**. This approach is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. It targets the desired outcomes of intervention as a solution rather than focusing on the symptoms or issues identified at intake. This technique gives attention to the present and the future desires of the person, rather than focusing on the past experiences. The practitioner encourages the person to imagine their future as they want it to be and then the practitioner and person collaborate on a series of steps to achieve that goal. Solution-focused practice aims to bring about the person's or family's desired change in the least amount of time.

**Wellness-, Resiliency-, Recovery-Oriented**. To provide effective interventions, the practice used for a youth or an adult should support wellness, youth resiliency, and adult recovery: • Wellness is an active process in which a person becomes aware of and makes choices toward a more healthy and successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential which is multidimensional and holistic, encompassing lifestyle, physical, mental and spiritual well-being, and the environment. • Resiliency is the process of managing stress and functioning well when faced with adversity or trauma. Youth are resilient when they are able to use their inner strengths to positively meet challenges, manage adversities, heal from the effects of trauma, and thrive in life given their unique characteristics, goals, and circumstances. A youth's resilience (self-efficacy) is aided by a trusting relationship with a caring, encouraging, and competent adult who provides positive guidance and promotes high expectations. • Recovery is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Intervention and goals are developed in accordance with the guiding principles of recovery, which are: hope, person-driven, holistic, peer supported, relational, responsive to culture and to trauma, focused on strengths and responsibility, and respectful.

**Trauma-Informed.** To provide trauma-informed care to youth or adults receiving services, practitioners should understand the impact of trauma on child development and on adult behavior and learn how to effectively minimize its effects without causing additional trauma. A growing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, physical, emotional, and behavioral development (often called socio-emotional development). Early intervention by human service practitioners provides the opportunity to identify a youth's developmental concerns and help families receive the support they need to reduce any long-term effects. Practices for providing trauma- informed care should be used for adults who have experienced complex trauma and who have lingering adverse affects of trauma today.

**Outcome-Focused and Results-Driven**. Desired outcomes guide the intervention process and can best be stated as life-change outcomes (related to well-being, essential supports, daily functioning, and/or role fulfillment). Goals are used by the person and his/her team to select strategies, supports, and services for working toward goal attainment. Delivery of intervention strategies and supports is carefully tracked to determine: 1) whether the strategies and supports are being provided in an adequate manner; 2) whether the strategies are working or not working based on progress being made; and, 3) whether the outcome has been met. Case practice decisions are informed by the progress (or lack of progress) being made toward the attainment of planned goals, and when a strategy or provider of the strategy is not working effectively, the practitioner quickly recognizes the failure and promptly replaces the provider or strategy.

### CASE PRACTICE IS PERFORMED TO PRODUCE POSITIVE LIFE CHANGES FOR PERSONS SERVED

Public service systems exist to help citizens experiencing life-disrupting needs or threats of harm to get better, do better, and stay better in daily life. The collective set of actions used for interventions to alleviate the needs or threats is referred to as *practice*. The purpose of practice is helping a person in need or at risk of harm to achieve and maintain, where necessary, adequate and ongoing levels of:

- Well-being (e.g., safety, stability, physical and emotional health, sobriety, recovery)

- Essential supports for daily living (e.g., housing, food, income, health care, child care),

- Daily functioning (i.e., basic tasks involved in daily living, as appropriate to a person's life stage and ability)

- Fulfillment of key life roles (e.g., a youth being a successful student or an adult being a successful parent or employee).

Typical functions in a practice model include engagement, understanding, defining the results to be achieved, selection and use of life change strategies and supports, resourcing and delivery of planned strategies, and the tracking and adjusting strategies until desired outcomes are achieved.

### A CASE PRACTICE MODEL DEFINES FUNCTIONS USED BY PRACTITIONERS TO GET RESULTS

A public agency's Practice Model defines basic functions used by frontline practitioners to join with persons receiving services to bring about a positive life change process that helps them get better, do better, and stay better. It encompasses the core values of the agency (e.g., use of person-centered care principles) and defines the fundamental expectations concerning working relationships, integration of efforts among the practitioners serving a person in need, and essential action patterns or functions associated with effective case practice. An agency's Practice Model becomes a central organizer for training of frontline staff, supervision, performance measurement, and accountability.

The *practice wheel* shown shown below illustrates basic practice functions typically used by agencies serving adults for reasons of improving wellness, youth resiliency, adult recovery, and greater independence from public service systems.

## Practice Wheel: Functions in Integrated Care Practice
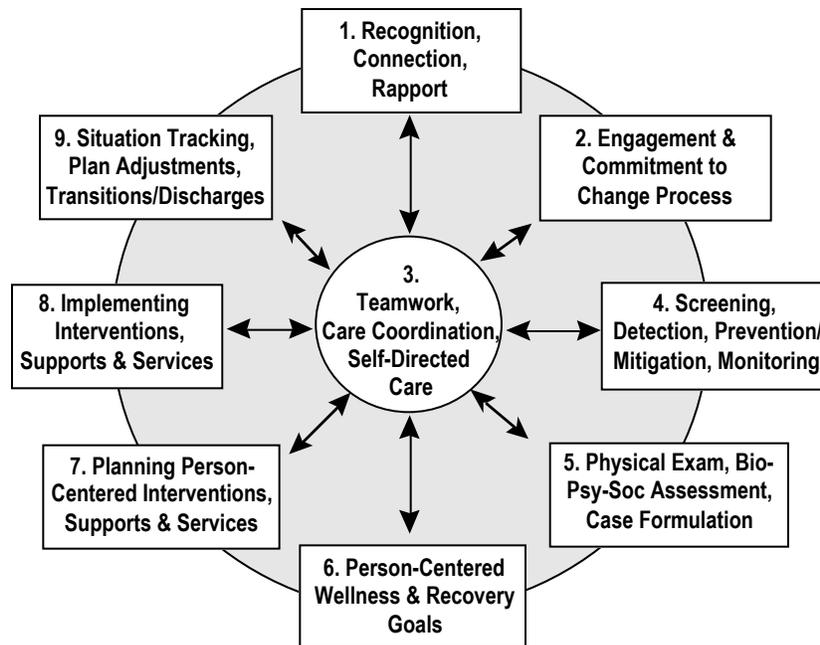


Practice Functions May Occur Interactively, Concurrently, and Progressively

## Desired Outcomes of Practice

**RECOGNITION, CONNECTION & RAPPORT: • The person's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.**

## Key Concepts

Building a relationship with a person entering services requires practitioners to recognize the nature of the person's situation and life story and to discover the circumstances that have brought the person into agency services. One of the most important first steps is recognition of any barriers that could thwart formation of positive connections with the person which could undermine acceptance and rapport building necessary for successful engagement.

Practitioners should take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships. Also key to successful engagement and connection is the recognition of the person's sense of identity, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services.

Persons coming into service require use of culturally relevant and responsive interactions and interventions in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services. A person's identity [e.g., race, tribe, ethnicity; social group; sexual orientation; religion; or disability, such as deafness] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

## Practice Tips

1. Learn the reason the person is seeking help. Consider whether the person's problem can be resolved in a single visit or brief intervention. Determine whether the person's problem is emergent/transient or serious/persistent. Determine whether the reported problem is a present threat to health or safety so that any need for crisis intervention or urgent response can be identified and provided.

2. If the person reports being in physical pain or emotional distress, ask about its nature, source, history, and impact on the person's life situation. Use the person's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now.

3. In early interactions, discover the person's sense of identity, language, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, deteriorating physical health, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help.

4. Recognize any barriers (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships.

5. In summary, take active steps in establishing positive conditions for connecting with the person and building mutual respect and rapport with the person. Remember: recognition, connection, respect, and rapport are the building blocks of a trust-based working relationship and are performed concurrently by the practitioner when a person is entering services.

### Desired Outcomes of Practice

**ENGAGEMENT & COMMITMENT. •** Service providers are building and maintaining a trust-based working relationships with the person and the person's informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. **•** Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's needs and preferences.

### Key Concepts

Effective wellness and recovery services depend on ongoing working relationships between a person in need and the service providers who help meet those needs. Service providers make concerted efforts to reach out to the person, engage him/her meaningfully in all aspects of the service process, establish and maintain a trust-based working relationship that is consistent with the person's language and culture, coordinate efforts with other providers and secure and sustain the person's commitment to a change process. Engagement strategies build a mutually beneficial partnership in decision-making and life change efforts. The person's direct, ongoing, active involvement is used in assessment, planning interventions, selecting providers, monitoring and modifying service plans, and evaluating results.

Practice approaches that support effective relationship building are:

- Person-centered (organizes around the person's goals)
- Strengths-based (builds on the person's positive assets)
- Solution-focused (moves from problems to solutions)
- Need-responsive (recognizes and responds to needs)
- Wellness-oriented and outcome-driven (starts with the end in mind)
- Builds readiness for change (uses motivational interviewing strategies)
- Fits the person's stages of change (starts where the person is ready)
- Respects the person's identity, culture, aspirations, and preferences

In the absence of a trust-based working relationship with the service provider, the person is unlikely to reveal the underlying issues that explain the dynamic circumstances causing the problem that must be solved in order to achieve desired wellness and recovery outcomes.

**Building Commitment to Positive Life Change.** A major contribution of effective engagement is building and sustaining the person's commitment to personally chosen wellness and recovery outcomes and to the change process used to achieve these outcomes. In the absence of the person's commitment to life change, wellness and recovery outcomes are not likely to be achieved.

### Practice Tips

1.  Remember that building a relationship with a person involves recognizing the nature of the person's life situation and reasons for requesting help. Listening is key to learning, empathy, respect, and trust building. Finding and overcoming any barriers to personal connections are essential. Recognition and rapport provide a foundation for building and sustaining a trust-based working relationship.

2.  Use a person-centered approach that puts the person's voice and choice at the center of the service process. Recognize and respond to the person's unmet needs related to wellness, well-being, and daily functioning. Use a solution-focused approach that is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. Solution-focused practice aims to bring about the person's desired change in the least amount of time. Strengths-based practice approach emphasizes a person's self-determination and identifies and builds upon the person's strengths and assets to create sustainable resources for solutions.

3.  Change-oriented approaches are especially useful in addressing lifestyle modification for risk reduction, disease prevention, long-term disease or disorder management, and addiction. Understanding a person's readiness to make change, appreciating barriers to change, and helping anticipate relapse can improve the person's satisfaction and lower practitioner frustration during the change process. A stengths-based, solution-focused change approach is useful in stimulating positive change and overcoming resistance.

4.  Remember that engagement is an ongoing process that builds and sustains: 1) a mutually beneficial trust-based working relationship between the person and 2) a person's commitment to personally selected wellness and recovery outcomes and to the life change process.

## Desired Outcomes of Practice

**SCREENING, DETECTION, PREVENTION/MITIGATION, MONITORING. • Screening detects imminent threats to the person's health, safety, supports, or behavioral well-being upon entry and ongoing thereafter. • Responsive actions are provided in a timely and appropriate manner to prevent or mitigate any foreseeable harm to the person or others around the person arising from the detected threats of harm, risks of near-term life disruptions, or risks of poor well-being outcomes. • Follow-along monitoring tracks the person's situation to detect and respond to any future threats to well-being.**

## Key Concepts

A timely and appropriate response is provided for a person who is detected via screening processes or self-report as has having a threatening life situation, behavioral condition, disorder, or disease for which intervention or treatment is indicated, possibly with urgency.

**Screening & Detection**. Screenings are performed to identify a person who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment, and to identify any imminent threat of harm from life partners/caregivers creating a major breakdown in essential supports. Screenings include labs to detect health problems as well as screening activities used to identify safety threats, behavioral concerns, and breakdowns in essential supports. Screenings may include metabolic syndrome factors, HIV, Hep-C, thyroid issues, depression, drug and alcohol use, suicide/homicide risks, trauma including domestic violence, and fall risk for the elderly. Detection involves identification of a specific health problem, safety threat, behavioral concern, or support breakdown that could cause harm:

- Safety / threats of harm at home, work, or school
- Adverse childhood experiences / complex trauma
- Emotional status / behavioral disorders
- Health status / physical well-being / illness
- A pattern of instability / trajectory of physical or emotional decline

- Self-endangerment / threats of harm to others
- Intellectual or developmental disability / TBI / learning problems
- Drug or alcohol use
- Unstable living situation or major break-down in key supports
- Diseases: diabetes, COPD, obesity, hypertension, seizures, thyroid issues, Hep-C, HIV, other

**Prevention or Mitigation and Follow-Along Monitoring** Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. The response must match the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions). Prevention strategies keep harmful things from happening. Mitigation strategies reduce risks or minimize adverse effects of something that is already happening. Follow-along monitoring is used to track risk factors and mitigation strategies used to manage health, safety, behavioral, or support problems in order to provide knowledge for planning next step actions.

## Practice Tips

1. Any problem requiring a crisis intervention or urgent response is addressed in a timely, appropriate, and sufficient manner so as to prevent unnecessary harm, pain, loss, or hardship for the person. Each response provided is commensurate with the urgency and severity of the presenting problem. Any response provided protects the person from preventable harm or mitigates the impact the problem would have likely had if not treated promptly and effectively.

2. Screenings of the person are performed upon admission and periodically thereafter. Practitioners continue to conduct screenings to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process. Based on results of screenings and self-reports by the person, any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected.

3. The nature, significance, and history of any detected problem are defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care.

4. Results of initial and ongoing screenings are incorporated into the ongoing Bio-Psycho-Social Assessment and Case Formulation involving the person's situation. Any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life.

## Desired Outcomes of Practice

**ASSESSMENT & CASE FORMULATION. • Ongoing formal and informal fact finding methods are used to develop and update a broad-based understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.**

## Key Concepts

Ongoing assessment and clinical case formulation guide the course of action designed and used over time by service providers in collaboration with the person being served to help her/him meet wellness and recovery goals that have been selected. Assessment provides answers to practical and clinical questions [see the Tip Sheet on Organizing Questions] that are used to develop a functional, working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge.

**Assessment & Understanding**. As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social based clinical case formulation used in developing a course of action with and for the person. Areas in which essential understandings are developed include:

- Earlier life traumas, losses, and disruptions
- Learning problems affecting school or work performance
- Subsistence challenges encountered in daily living
- Risks of harm, abuse, neglect, intimidation, or exploitation
- Traumatic brain injury and/or intellectual disabilities
- Court-ordered requirements/constraints/detention
- Recent life disruptions (e.g., eviction, bankruptcy)
- Dislocation due to natural disaster or changes in the local job market
- Co-occurring life challenges (cultural issues, mental illness, addiction, deafness, domestic violence)
- Significant physical health and/or behavioral health concerns
- Recent tragedy, trauma (including combat trauma), losses, victimization
- Problems of attachment, bonding, self-protective boundaries in relationships
- Recent life changes (e.g., new baby, job loss) requiring major adjustments
- Any significant screening and detection findings (health or safety risks)

**Case Formulation and Clinical Reasoning**. Understandings developed from ongoing assessments are used to create a clinical case formulation that guides service decisions and actions. Clinical reasoning is applied in moving from understanding to action: Any compelling urgency is addressed first. Practical solutions may precede clinical solutions in the course of action. Opportunities for early and repeated successes are identified and pursued. A pace of action that could confuse or overwhelm the person is avoided.

## Practice Tips

1. The outcome of assessment is a functional understanding of the person's situation used to build a clinical case formulation that guides goal setting and intervention planning. Assessment is a continuous learning process that includes gathering and assembly of facts, information, and knowledge to develop a broad-based understanding of the person's situation used to support decision making. Remember that screening data, detection of threats to the person's well-being, results of prevention or mitigation strategies, follow along monitoring findings, and evaluation of results are used in the ongoing assessment process.

2. A clinical case formulation includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present concern. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.

3. Practical reasoning and clinical judgment are used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment.

4. Functional understandings and a clinical case formulation are used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

## ORGANIZING QUESTIONS IN CLINICAL REASONING

Presented below is a set of basic practical and clinical reasoning questions offered for use by practitioners, clinicians, and supervisors to guide practical and clinical reasoning in case practice. Answers to these questions can help focus the organization of assessment information and clinical case formulation as well as guide outcome and intervention planning. It is not meant to be an all inclusive or exhaustive set of probes and thought organizers to cover every possibility. There may be other important matters in any case situation that are not addressed in this set of questions. Practitioners should remain alert to those situations.

1.  **People Involved:** • Who are the people involved in supporting and serving this person? • How well are they engaged, involved, and committed to helping the person?

2.  **Expectations and Voice & Choice:** • What outcomes of intervention are people expecting to be achieved? • The person? • The person's caregiver or key supporters? • The school or employer? • The medical provider? • The court? • Other service providers? • To what degree are the voices and choices of the person and the person's supporters influencing decisions are about the person's needs and preferences in the service process?

3.  **Causes & Contributors of Presenting Problems:** • What bio-psycho-social factors, life circumstances, and underlying issues explain the person's presenting problem(s), clinically significant distress, impairment in functioning, and currently unmet needs?

4.  **Risk Factors:** • Based on history and tendencies, what things could go wrong in this person's life? • What must be done to avoid or prevent future harm, life disruption, pain, loss, or undue hardship?

5.  **Functional Strengths & Assets:** • What are the person's functional strengths, aspirations for change, and life assets that can be built up to solve the problem(s) that brought the person into services?

6.  **Critical Unmet Needs:** • What critical unmet needs would have to be fulfilled in order for the person to get better, do better, and stay better?

7.  **Points of Consensus & Dispute:** • On what key matters do the people involved agree at this time? • What key matters, if any, may be in dispute by any of the persons involved? • What impact, if any, are unresolved disputes having on decision making about needs, risks, outcomes, interventions, or commitments to the change process?

8.  **Necessary Changes:** • What things in the person's life would have to change in order for the person to achieve and maintain adequate well-being, have essential supports for living, function adequately in daily activities, and fulfill key life roles - as appropriate to life stage, capacities, and preferences?

9.  **Essential Outcomes:** • What life conditions, when met, will show the person's problems are solved and critical needs are met (e.g., achieved adequate well-being, has essential supports for living, functions adequately in daily activities, and fulfills key life roles)?

10. **Key Opportunities for Rapid Successes:** • What near-term opportunities for getting early and repeated successes are available to strategically target intervention activities that could alter the case trajectory? • In what area is an early completion of a key outcome possible? • In what key areas is a readiness for change evident (based on the stages of change) in the person's present motivation? • How able is the person/family to make choices and self-direct? • How are such opportunities being used to advance efforts to achieve early, positive, and sustained changes for this person?

11. **Intervention Strategies:** • What combination and sequence of intervention strategies are likely to bring about desired life changes and meet the person's wellness or recovery goals? • How well does the pace and workload of interventions activities fit the person's tolerance for scheduling and acceptance of planned activities and ability to self-direct? • How well does the current rate of intervention activity avoid a pace and participation burden that would overwhelm or confuse the person and reduce motivation for ongoing participation and life change efforts?

12. **Intervention Requirements:** • Who will implement the planned intervention strategies and actions? • What will the persons implementing the intervention strategies have to know, believe, have, and do to be successful? • Who will train, support, and supervise the implementers to ensure that the required skills, knowledge, attitudes, coordination, resources, time availability, and commitment are present and used as planned?

13. **Results-Based Decisions:** • How will people know and decide: • Whether interventions are being delivered and are working as planned? • When interventions should be changed or stopped? • When life-change outcomes have been substantially achieved? • When the person's needs are met, key outcomes have been achieved, and intervention efforts can be safely and successfully reduced, transitioned, or concluded? • How thoroughly and consistently the understandings gained about implementation processes and results are being used to evaluate interventions and to adjust the assessment, case formulation, outcomes, and interventions used for this person?

### Desired Outcomes of Practice

**WELLNESS, RESILIENCY, RECOVERY GOALS. Planned life-change goals for the person: • Are based on under-standings developed from current assessments and a clinical case formulation. • Define agreed upon life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing resiliency or recovery. • Are stated as the person's vision for wellness, resiliency, and/or recovery in the person's treatment plan. • Are measurable for tracking progress and determining attainment of outcomes.**

### Key Concepts

WELLNESS, RESILIENCY, AND RECOVERY GOALS define how all involved in the service process will know that the person is getting better, doing better and staying better in life. Planned goals and life change outcomes specify states of well-being (e.g., safety, health, or substance free life-style), functioning (e.g., competency or capacity), or support (e.g., shelter or income) that was absent or insufficient at the time the person entered the service system and that will be necessary for the person to gain and maintain success in life without ongoing assistance from the service system, or when the person is ready to transition from one level of care or living arrangement to another. The creation of a person's well-ness and resiliency or recovery goals should be: 1) derived from current assessments and the clinical case formulation, 2) based on collaborative understandings of necessary life changes, and, where appropriate, 3) reflective of any court orders that require specific life changes.

Defining wellness and resiliency recovery goals creates a guiding view for services (working from outcomes to actions) that should precede the planning of intervention strategies and actions used to achieve outcomes. Having clear life outcomes enables the person and those helping the person to see both the next steps forward and the end-point on the horizon -- thus, providing a clear vision of the pathway to wellness and resil-iency or recovery.

### Practice Tips

1. Use person-centered, wellness/resiliency/recovery-oriented planning techniques to help the person identify and state what he/she expects to gain or achieve from services. Frame expectations as life-change goals using the person's own words. Make sure the goals created to guide service planning are based on the person's assessed needs, expressed aspirations for a better life, and socially-beneficial choices.

2. Consider the logical order in which life-change goals should be addressed. The practitioner should first plan to meet any compelling urgen-cies requiring immediate action to prevent harm (working from urgent to strategic). After any such urgencies are addressed, focus next on any life-change goals related to achieving well-being (e.g., safety, health, well-being) and goals related to supports for living (e.g., income, food, housing, health care). Once needs for well-being and supports for living are being met, the focus shifts to goals related to improving daily functioning and to fulfilling key life roles. This progression of meeting essential needs and strategic life changes should enable the person to achieve and maintain an adequate daily life situation and gain greater independence from the service system.

3. Discover opportunities available for making early and repeated progress. When selecting from among near-term goals and strategies, the practitioner should give priority to any ready opportunities for getting early and repeated successes and/or any important life outcome that could be easily and readily achieved. Early victories or rapid completions in life change efforts can increase satisfaction and motivation for the person and can have the effect of changing the trajectory of the case.

4. Construct goals that are *SMART*: **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound. Clear, relevant and achievable goals help in planning intervention strategies, in measuring of results, and in promoting the person's motivation and commitment to the change process. Avoid pitfalls in goal setting, such as: • Focusing on a narrow, immediate change rather than a long-term outcome; • Setting negative goals (focusing on stopping a bad behavior rather than focusing on the positive replacement behavior); • Focusing on too few things to solve the main problem being addressed; • Setting more goals than can be addressed at once; • Not setting an estimated completion time for the attainment of the goal; • Creating goals too vague to be measured or completed.

5. Use the person's life-change goals to guide the selection of intervention strategies used for their attainment. Identify goals for which the involvement of other practitioners or agencies will be involved, in or responsible for the helping the person achieve the desired outcomes. Use teamwork to develop consensus on goals (based on common purpose) and build unity of effort among providers in order to coordinate and integrate services for goal attainment.

### Desired Outcomes of Practice

**TEAMWORK/COMMON PURPOSE & UNITY OF EFFORT. • Using a person-centered decision making process, the person's service providers and supporters are building and sustaining: • Common purpose by planning wellness/ recovery goals and strategies with and for the person. • Unity of effort in service delivery by coordinating actions of the service providers and integrating services across providers, settings, time, and funding sources.**

### Key Concepts

Person-centered, resiliency- or recovery-oriented practices and self-directed care principles put the person's needs, aspirations, and choices at the center of the service provision efforts. A team-based, shared decision-making process helps the person create a vision for a better life based on aspirations for well- being, supports for living, and improved daily functioning and role fulfillment. Informal supporters and service providers join with the person to define wellness and recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success, and will create the "glue" that holds things together in practice for the benefit of the person receiving services.

**Common Purpose**. Common purpose is created when the person and service providers involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered/resiliency- or recovery-oriented, team-based, shared decision-making process may be used to achieve and maintain a CONSENSUS and COMMITMENT to a set of well-planned goals and related strategies which are essential for building common purpose.

**Unity of Effort**. Unity of effort is based on: (1) A common understanding of the person's situation; (2) A common vision for a better life; (3) Coordination of efforts to ensure coherency and continuity; (4) Common measures of progress and ability to change course, if necessary. Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among the person, providers and supporters, and integration of services across providers, settings, funding sources, and points in time.

### Practice Tips

1. Remember that effective TEAMWORK and SERVICE COORDINATION help build common purpose and unity of effort in frontline practice. Effective teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, the knowledge of the person, the authority to act on behalf of funding agencies and to commit resources, and the ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person.

2. The team assists in conducting person-centered planning activities and in providing assistance, support, and interventions after plans are made in order to meet important goals. Working together, team members support the person in identifying needs, setting goals, and planning strategies with related services that will enable the person and family to meet those goals. Effective, ongoing, collaborative problem solving is a key indicator of effective team functioning.

3. Leadership and coordination are necessary to: (1) form a person-centered team and facilitate teamwork; (2) plan, implement, monitor, modify, and evaluate services provided; (3) integrate strategies, activities, resources, and interventions agreed upon by the team; (4) measure and share results in order to change strategies that do not work and to determine progress; and (5) ensure a unified process involving a shared decision-making approach. While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated leader (e.g., a care coordinator) who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation skills, authority to act, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, negotiation may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient in order to increase self-direction of care.

3. Team functioning and decision-making processes should be consistent with principles of person-centered care, resiliency- or recovery-oriented practice and, where possible self-directed care. Evidence of effective team functioning over time is demonstrated by the quality of relationships built, the commitments fulfilled, results achieved, the unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, the dependability of service system performance, and the connectedness of the person to critical resources necessary for achieving important life goals.

## Desired Outcomes of Practice

**PLANNING. • Meaningful, measurable, and achieveable wellness/resiliency/recovery goals for the person are supported with well-reasoned, agreed-upon strategies, supports, and services planned for their attainment.**

## Key Concepts

Interventions consist of a combination and sequence of planned strategies, supports, and services which guide implementation toward life changes for a person leading to the attainment of wellness and recovery goals identified by the person and team. Intervention planning is an ongoing process throughout the life of the case, and planned interventions should be consistent with the person's aspirations for a better life.

## Practice Tips

Planned intervention strategies, supports, and services related to a person's wellness and recovery goals may be developed in one or more the following areas where co-occurring needs are identified.

1. **Physical Wellness** - focuses on planning for achieving and maintaining the person's best attainable health status by managing any health concerns. The person may need assistance to access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, hypertension, thyroid issues, Hep-C, HIV/ AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties.

2. **Mental Health Resiliency or Recovery** - focuses on reducing and managing psychiatric symptoms that impair daily functioning. Use of psychiatric medication in combination with counseling and supportive services are common intervention strategies used to reduce symptoms and build coping skills.

3. **Addiction Recovery** - addresses various aspects of substance use, relapse prevention and addiction recovery. Careful identification of co-occurring issues is essential for effective planning.

4. **Trauma Recovery** - addresses the lingering adverse effects of complex trauma. Trauma recovery may involve processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions via new coping skills, and rebuilding the ability to trust other people. Trauma recovery is a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication.

5. **Safety from Harm** - applies to planning strategies for keeping persons safe, including no contact orders, and safety plans, crisis responses, and/or safety supports. A behavioral crisis is one in which the person presents behaviors that put himself or others at risk of harm. A health crisis is one in which a chronic health condition suddenly becomes acute, putting the person's life at risk unless immediate medical care is provided. A safety crisis is a situation in which another person through intention and action or inaction puts the focus person at risk of harm, injury, or death.

6. **Income & Basic Necessities** - includes strategies for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, health care, medicine, or child care. Securing such supports, when they are lacking, may be necessary for the person's well-being, daily living, and for some adults, maintaining family functioning.

7. **Functional Life Skills Development** - involves skill-specific training and direct support to acquire, apply, and sustain functional life skills in daily living situations. Functional life skills include such elements as activities of daily living (ADLs), managing health issues and medication, and managing behavioral issues via effective coping skills. Functional skills are needed for successful everyday living and fulfilling important life roles, such as parenting dependent children or adults in the person's care.

8. **Education or Work** - includes education, career development, volunteering as a productive activity, and work, either competitive or supported.

9. **Community Integration** - or most adults, recovery includes regaining degrees of community integration, which involves making decisions about choice of social supports and life activities. Experiencing life activities in mainstream settings outside of an institution or provider agency that involve having interactions with non- disabled persons who are engaged in the same activities may be an important part of the plan (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election).

## Desired Outcomes of Practice

**IMPLEMENTING. Planned strategies, supports, and services are delivered in a manner sufficient to help the person make adequate progress toward meeting planned goals. • The combination of supports and services fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences.**

## Key Concepts

Implementation provides for the timely, competent, and consistent delivery of planned interventions (strategies, supports, services) in ways that are consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to bring about the life changes that lead to goal attainment. Implementation follows and flows from the strategies, supports, and services specified in person's treatment and support plans.

## Practice Tips

Implementation of intervention strategies, supports, and services may be occur in one or more the following areas.

1. **Physical Wellness** - focuses on achieving and maintaining the person's best attainable health status. This includes managing any health concerns by helping the person access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, thyroid issues, hypertension, Hep-C, HIV/AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties in the ongoing monitoring and coordination of multiple treatment modalities for the person. Strategies in this area involve not only the health care practitioners but also those supportive persons (e.g., the person, caregiver, health educator, care coordinator, and/or community support worker) having important roles in health education, transportation, medication administration, and meeting other daily health maintenance requirements.

2. **Mental Health Resiliency or Recovery** - focuses on reducing and managing psychiatric symptoms that impair daily functioning. Use of psychiatric medication in combination with counseling and supportive services may be interventions used to reduce symptoms and build coping skills.

3. **Addiction Recovery** - addresses various aspects of substance use dependence treatment, relapse prevention, and addiction recovery. An adult having a co-occurring disorder (depression and opiate addiction) could have several strategies used for achieving and maintaining sobriety and reduction in symptoms of depression. Use of psychiatric medications to treat depression and Suboxone to treat opiate addiction are common dual intervention strategies to achieve key outcomes for sobriety and mood stability.

4. **Trauma Recovery** - addresses the lingering adverse effects of complex trauma. Trauma recovery may involve processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions, and rebuilding the ability to trust other people. Trauma recovery is a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication.

5. **Safety from Harm** - applies to strategies for keeping persons safe, including no contact orders, and safety plans, crisis responses, and/or safety supports. A behavioral crisis is one in which the person presents behaviors that put himself or others at risk of harm. A health crisis is one in which a chronic health condition suddenly becomes acute, putting the person's life at risk unless immediate medical care is provided. A safety crisis is a situation in which another person through intention and action or inaction puts the focus person at risk of injury or death.

6. **Income & Basic Necessities** - includes strategies for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, health care, medicine, or child care. Securing such supports, when they are lacking, may be necessary for the person's well-being, daily living, and for some adults, maintaining family functioning.

7. **Functional Life Skills Development** - involves skill-specific training and direct support to acquire, apply, and sustain functional life skills in daily living situations. Functional life skills include activities of daily living (ADLs). Functional skills are needed for successful everyday living and fulfilling important life roles, such as parenting dependent children or adults in the person's care.

8. **Education or Work** - includes education, career development, volunteering as a productive activity, and work, either competitive or supported.

9. **Community Integration** - for some adults, recovery includes regaining degrees of community integration. Community integration involves making decisions about choice of life activities and experiencing life activities in mainstream settings as do other adults who do not have disabilities. Aspects of community integration include engaging in normal life activities outside of an institution or provider agency that involve having interactions with non-disabled persons who are engaged in the same activities (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election).

## Desired Outcomes of Practice

**SITUATION TRACKING, PLAN ADJUSTMENT, TRANSITIONING. • <u>Situational awareness</u> is sustained by tracking the person's life situation, changing circumstances, service process, progress, and goal attainment. • <u>Plans are kept relevant and effective</u> by identifying and resolving service problems, overcoming barriers, and replacing failed strategies. • <u>Seamless and successful transitions are achieved by ensuring continuity of care</u> across settings and providers as well as supporting the person's successful post-change life adjustments in a new setting or situation.**

## Key Concepts

**Sustaining Situational Awareness**. Ongoing situational tracking is used to: 1) monitor the person's status, service process, and progress; 2) identify emergent needs and problems; and 3) plan adjustments in services to keep strategies relevant and effective. Measuring progress toward wellness/recovery goals is an essential part of tracking and is accomplished by tracking the direction and pace of life changes made and proximity to the attainment of goals.

**Keeping Plans Relevant and Effective**. Effective tracking and adjustment build results-based accountability into case practice. Intervention strategies, supports, and/or services are tracked and are modified when goals are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. Working together, the care coordinator, team members, and the person play a central role in tracking and adjusting intervention strategies, services, and supports by applying knowledge gained through ongoing assessments, monitoring, and periodic evaluations.

**Achieving Successful Transitions & Continuity of Care**. The term *care transition* refers to movement of a person between care locations, providers, or different levels of care within the same location as the person's condition and care needs change and is a subpart of the broader concept of care coordination. Care coordination involves numerous providers who are dependent upon each other to carry out disparate activities in a person's care. In order to accomplish this in a coordinated way, each provider needs adequate knowledge about their own and others' roles and available resources, and relies on exchange of information in order to gain this knowledge. An effective discharge and care transition ensures the person and caregiver are able to understand and use essential health information they have been given and are able to move seamlessly from one service setting or provider to another. It requires the carefully planned transfer of clinical responsibility with the information needed to discharge that responsibility safely and effectively. The process requires: 1) essential clinical information at transition or discharge, 2) the opportunity to ask questions, 3) a seamless clinical envelope with a responsible clinician ("a seamless clinical envelope" means that the person is always enclosed in and surrounded by the care system, there are no lapses in care, and at all times in the transition there is an identifiable knowledgeable available clinician who is responsible for managing the person's clinical issues), 4) and logistical and management support for person and caregiver with the person's status and well-being being monitored across life adjustments throughout the transition process. Care and support are provided during the change process to ensure the person is managing the stress of the change, is stable and is functioning successfully in the new setting with adequate supports provided for ongoing success.

## Practice Tips

1.  <u>Sustaining Situational Awareness</u>. Maintaining adequate awareness and understanding of the person's status, service process, and progress are essential for effective care coordination. The identified care coordinator has a lead responsibility for sustaining situational awareness while working collaboratively with the person and others involved in the person's care. Tracking progress is accomplished by: • Monitoring the person's status, service process, and progress and by • Identifying emergent needs and problems.

2.  <u>Keeping Plans Relevant</u>. Building upon situational awareness, the care coordinator or case manager and clinician have lead responsibilities for working collaboratively with the person and his/her team to update assessments, advance the clinical case formulation, modify goals, and refine risk management and intervention plans for provision of supports and services. Keeping plans relevant is accomplished by: • Facilitating team decision-making about next step actions and by • Planning adjustments in strategies, supports, and services to keep plans relevant and effective.

3.  <u>Achieving Successful Transitions and Continuity of Care</u>. The person's care coordinator, clinician, and care team play a central role in planning and facilitating transition activities (including those involving discharge from one place of care and movement to another) to ensure continuity of care during a seamless transition to and successful life adjustment in a different care location. The lead clinician and care coordinator: • Provide essential clinical information at discharge and during the transition process; • Answer questions posed by the person or caregiver; • Provide wraparound care and support to prevent any lapses or breakdowns in care during and after the transition; • Provide logistical and management support for the person and caregiver during the transition; • Provide follow-along support after the transition to ensure that the person has continuity of care and achieves a successful life adjustment with sufficient ongoing supports to maintain well-being and achieve planned goals.

**Desired Outcomes of Practice**

**SOLUTION FOCUSED BRIEF THERAPY:** • **The person's concerns and reasons for requesting help are clarified.** • **The person's aspirations and vision for a preferred future are identified.** • **The person develops and demonstrates motivation and confidence in finding solutions.** • **The person's strengths and past successes are used to build solutions.** • **The person is taking small steps in the right direction toward a preferred future.**

**Key Concepts**

**Solution Focused Brief Therapy (SFBT)** is a recognized evidence-based practice that focuses on a person's strengths and previous successes rather than failings and problems and is provided via conversations that stimulate and support positive life change for a person receiving services. These conversations are centered on the person's concerns; who and what are important to the person; a vision of a preferred future; the person's exceptions, strengths, and resources related to the vision; scaling of the person's motivation level and confidence in finding solutions; and, ongoing scaling of the person's progress toward reaching the desired future. The goal is helping a person rapidly find a solution to a his/her identified and resolvable life problem.

Basic concepts of SFBT are:

* It is focused on the person's desired future, not the past.
* The person and provider create solutions based on what has worked in the past.
* It assumes that solution behaviors already exist and encourages the person to increase the frequency of these useful behaviors.
* It places responsibility for change on the person.
* It asserts that small steps in the right direction lead to larger changes.

**Solution-Focused Questions**

Solution-focused questions about the topics of conversation are used to connect to and build on the concerns and aspirations expressed by the person. Examples of solution-focused questions include:

* Given the issue or problems you are faced with, what are you hoping we can achieve together?
* How would you like your life to change in regard to the issues we have been discussing?
* Are there things you have tried already to solve this problem?
* What are some things you have already accomplished that you are pleased with?
* What types of support do you have from family/community/resources?
* What personal traits, skills, and talents have helped you in the past?
* What personal qualities are helping you get through these difficult times right now?
* How is it you found the strength and wisdom to come here for help?
* What do you suppose you do or have done so that the problem isn't any worse?
* What have you tried in the past when confronted with these types of problems?
* Would this type of solution help with your situation now?
* When you have achieved your goal, what are some things you will experience that will let you know that your goal has been accomplished?
* If your problem suddenly went away, what would be the first thing you would notice about yourself (how would be feeling, thinking, doing)?
* How would those around you know that this big change had occurred?

## Desired Outcomes of Practice

**MOTIVATIONAL INTERVIEWING: • The person is assisted to become increasingly aware of the potential problems caused, consequences experienced, and risks faced as a result of a particular behavior, is eventually able to envision a better future and becomes increasingly motivated to achieve it.**

## Key Concepts: Motivational Interviewing

Motivational interviewing is a practice that achieves success by facilitating and engaging intrinsic motivation within the person in order to change behavior. Motivational interviewing is a person-centered style of engagement for eliciting behavior change by helping a person to explore and resolve ambivalence about the desired change. It is non-judgmental, non-confrontational, non-adversarial and is based upon the concept of risk-reduction. Motivational interviewing recognizes and accepts the fact that persons who need to make behavior changes enter counseling at different levels of awareness and readiness to change.

In order for a practitioner to be successful at motivational interviewing, five basic skills will be necessary: 1) The ability to establish a therapeutic relationship through genuine empathy, warmth and respectful treatment. 2) The capacity for reflective listening. 3) The ability to ask open-ended questions. 4) The ability to provide affirmations. 5) The ability to periodically provide clarifying summary statements to the person.

The motivational practice attempts to increase the person's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question as well as helping the person to envision what might be gained through change.

The four general principles are:

1. **Express Empathy**. Empathy involves seeing the world through the person's eyes and sharing in the person's experiences. The practitioner's accurate understanding of the person's experience, which is demonstrated by reflective comments and summary understanding statements, can encourage change.

2. **Develop Discrepancy**. Practitioners help persons appreciate the value of change by exploring the discrepancy between how the person wants his or her life to be versus how it is currently (or between their deeply-held values and their day-to-day behavior). Practitioners assist the person to explore and resolve her/his ambivalence as well as grieving the need to change.

3. **Roll with Resistance**. The practitioner does not fight a person's resistance, but "rolls with it." Statements demonstrating resistance are not challenged because they are an indicator that the practitioner has "lost" the person. Instead the practitioner uses the person's "momentum" to refocus and further explore his or her views. The practitioner may need to apologize and repair the relationship if he/she has been "lecturing" the person. Using this approach, resistance tends to be decreased rather than increased, as persons are reassured that they are in charge of their own lives. Motivational interviewing encourages persons to develop their own solutions to the problems that they themselves have defined with the practitioner functioning as a partner in the process as both of them look toward the goal together.

4. **Support Self-Efficacy**. The practitioner explicitly embraces the person's autonomy (even when persons choose to not change) and helps the person move toward change successfully and with confidence. As persons are held responsible for choosing and carrying out actions to change, practitioners focus their efforts on helping people stay motivated, and supporting their sense of self-efficacy by celebrating small steps and any effort toward change.

**Key Points** on Motivational Interviewing are:

- Motivation to change is elicited from the person and is not imposed from outside forces.
- The practitioner's job is to help the person discover his/her own path.
- Direct persuasion is not an effective method for resolving ambivalence.
- The practitioner is generally quiet and elicits information from the person who does most of the talking.
- The practitioner helps the person to examine and resolve ambivalence and to grieve the need to change.
- The therapeutic relationship is viewed as a partnership.