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North Sound Mental Health Administration

Section 1500 – Clinical: Resiliency/Recovery Plans (Individual Service Plans)

Authorizing Source: WAC 388-865-0425, WAC 388-865-0405(5); U.S. Code Title 20, Chapter 33, Subchapter III, Section 1436
Cancels:
See Also:
Providers must comply with this policy and individualized implementation guidelines may be developed by CMHAs
Responsible Staff: Deputy Director
Approved by: Executive Director
Signature:
Date: 8/29/2014

POLICY# 1551.00

SUBJECT: RESILIENCY/RECOVERY PLANS (INDIVIDUAL SERVICE PLANS)

PURPOSE

To ensure development of the Resiliency/Recovery Plan (also referred to as an Individual Service Plan) is a collaborative effort between the individual, or individual's parent or legal representative if applicable, and Mental Health Care Provider (MHCP) that results in a person-centered, strength-based plan that meets the individual's unique mental health needs.

POLICY

The term Individual Service Plan (ISP) is terminology utilized in Washington Administrative Code (WAC). While it is acceptable to use this terminology, NSMHA strongly encourages providers to use the term Resiliency or Recovery Plan or similar terminology (e.g., Individual Recovery Plan or Wraparound Plan). These terms better reflect the region's focus on integrating the fundamentals of recovery as found in the National Consensus Statement on Mental Health Recovery. Further, plans shall reflect the principles and fundamentals found in the NSMHA *Guidelines to Person-Centered Recovery and Resiliency* (contained within the NSMHA Clinical guidelines http://www.nsmha.org/PDFs/Clinical_Guidelines/Clinical_Guidelines_Manual.pdf).

Individual recovery planning is an ongoing, dynamic process that begins at the intake assessment. A clearly articulated plan provides the following benefits to the individual and the treatment team:

1. Serves as a roadmap for the individual and the treatment team, providing direction and allowing the team and individual or family to evaluate progress toward the resiliency/recovery goals and desired outcomes (i.e., objectives that once met indicate discharge criteria) and the effectiveness of interventions;
2. Supports the individual as he/she works through his/her personal resiliency/recovery process;
3. Documents both individual and provider responsibilities towards resiliency/recovery.

Resiliency/Recovery Plans (RRPs) reflect:

1. Goals that address individual needs identified at intake and throughout the treatment episode. This may include, but is not limited to:
   a. Mental health needs (i.e., related to diagnosis) necessitating current treatment episode;
   b. Non-mental health needs requiring referral and support;
   c. Risk factors;
   d. Rationale for deferring treatment/referral of a need.
2. Individual's stated resiliency/recovery goals and desired outcomes (discharge criteria).
3. Interventions and services that are resiliency/recovery-oriented and can reasonably be expected to assist the individual in achieving his/her goals.

PROCEDURE

The Behavioral Health Agency (BHA) must have a person-centered, strengths-based RRP that meets the individual's unique mental health needs and promotes the individual's resiliency and recovery. The plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable and a copy provided to the individual. The plan must:

1. Be developed within thirty days from the first session following the intake evaluation.
2. Document that the MHCP collaborating on the plan is a Mental Health Professional (MHP) or that the plan has been reviewed by a MHP (i.e., signature of MHP on the plan).
3. Address the individual's unique needs including, but not limited to:
   a. Identified mental health needs including information and education about the individual's mental illness.
   b. Age, gender, cultural and/or disability strengths or issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.
   c. Identified needs beyond mental health needs such as physical health care, substance use, daily activity needs such as employment and education.
4. Identify and incorporate specific strengths and resources in a way that actively supports the individual in recovery/resiliency.
5. Include resiliency/recovery objectives that are measurable and that allow the MHCP and individual to evaluate progress.
6. Identify medically necessary service modalities, mutually agreed upon by the individual and MHCP, for this treatment episode.
7. Demonstrate the individual's participation in the development of the plan.*
   a. The plan includes at least one goal/objective identified by the individual or parent/legal representative if applicable.
   b. The plan includes the individual's signature and/or quotes documented in the plan.
   c. Be in language and terminology that is understandable to the individual and his/her family.
   d. Participation must include family or significant others as requested by the individual or as applicable for individuals under 13 or who have a legal representative.

      For individuals 13-17 for whom the parent/legal representative has consented to treatment when the individual has not (see statutes on Parent-Initiated Treatment), there is evidence that the RRP was developed collaboratively with the parent/other legal representative even if the individual has refused.
8. Include coordination goals/objectives with any other systems or organizations when required or that the individual identifies as being relevant to his or her treatment with the individual's consent or their parent or other legal representative, if applicable. This includes, but is not limited to:
   a. Coordination with any Individualized Family Service Plan (IFSP) when serving children less than three years of age.
   b. Education and/or employment system
   c. Children's Administration
   d. PCP and other health care providers
   e. Department of Corrections
   f. Substance use treatment provider

9. Contain crisis planning for all individuals Level 4 and up (as identified by Child and Adolescent/Level of Care Utilization System – CA/LOCUS) and all other individuals as clinically indicated including but not limited to individuals who:

    a. Experience an episode of decompensation,
    b. Use the emergency department frequently and/or inappropriately,
    c. Have multiple contacts with the crisis system (excluding the crisis line),
    d. Experience psychiatric hospitalization,
    e. Experience incarceration.

    The crisis plan may be a separate document from the RRP. Elements of a thorough crisis plan include:

    a. Individual and family voice.
    b. Focus on health and safety of individual, family and others (e.g., natural supports, professionals). May include, but not be limited to, information about:

        i. Self harm
        ii. Harm to others (e.g., assaultiveness, sexual aggression, criminal behavior)
        iii. Previous psychiatric hospitalizations
        iv. Emergency department usage
        v. Ability and willingness to take medication, list of current medications as applicable
        vi. Substance use - current and historical
        vii. Medical conditions
        viii. Developmental issues

    c. Roles, directives and responsibilities of individual and family and others.
    d. Early warning signs of decompensation.
    e. How to contact both formal and natural supports (contact phone number for MHCP and Crisis Line at minimum).
    f. Proactive and progressive measures, by the individual as well as informal and formal supports, to prevent a crisis.
    g. Proactive and progressive measures, by the individual as well as informal and formal supports, for intervening in a crisis.

10. Include documentation that the individual's plan was reviewed at least every 180 days and as necessary updated sooner to reflect any changes in the individual's treatment needs or as requested by the individual or their parent or other legal representative, if applicable.
11. Progress notes shall clearly reflect provision of treatment consistent with the RRP.
12. The treatment proposed and provided is consistent with NSMHA clinical guidelines. In the absence of a NSMHA clinical guideline, treatment follows generally accepted clinical practice for the individual's diagnosis.

<u>*Disagreement with Resiliency/Recovery Plan</u>

As the plan is developed collaboratively, disagreements over various aspects of the plan may arise. Some of these disagreements are considered expression of dissatisfaction with NSMHA-related services and would follow the grievance process when applicable. However, disagreements regarding service type and intensity that cannot be resolved result in an Action (Disagreement with the Treatment Plan) and require a Notice be sent. Issuance of Notices, resulting from Disagreement with the Treatment Plan actions, is delegated by NSMHA to BHAs.

A disagreement about the RRP occurs when the individual refuses to sign the plan *because* of disagreement with the plan or when the individual verbally states disagreement with the plan. Please note there are limitations of an individual on a Less Restrictive Court Order (LRO) or Conditional Release (CR) to disagree with aspects of the RRP that are directed in the court order (refer to the individual's court order to determine how this issue may apply to a specific individual). When disagreements regarding service type and intensity occur, attempts to resolve the disagreement prior to issuing a Notice are expected to be offered by the BHA.

1. The MHCP and/or supervisor shall offer to discuss and attempt resolution of the disagreement within 30 days of disagreement.
2. If the individual refuses to discuss with the MHCP and/or supervisor or resolution does not occur, the BHA shall offer a second opinion or Level 1 (provider level) grievance to the individual. These processes should follow their required timelines as noted in policy (see NSMHA Policies 1002 Grievances and 1520 Second Opinion).
3. If the individual refuses a second opinion or Level 1 (provider level) grievance or these processes do not resolve the disagreement, the BHA designee shall review the disagreement and issue a Notice if he/she determines the issue cannot be resolved at the BHA level within 14 calendar days of refusal or completion of the previous step.

    a. Any issuance of a Notice by a BHA must be completed by the BHA's designee.
    b. Individuals covered by Medicaid receive a Notice of Action; individuals covered by state funds receive a Notice of Adverse Determination.
    c. The Notice shall identify specifically what the individual is disagreeing with and what his/her desired outcome is.
    d. A copy of any Notice issued is sent to NSMHA within one business day.

ATTACHMENTS

None