

	<b>County of Sacramento</b> <b>Mental Health Division</b> <b>Adult Mental Health Services</b>	Policy No.	03-06
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AREA:	TITLE:		
<b>Clinical &amp; Psychosocial Rehabilitation Services</b>	<b>Psychiatric Rehabilitation</b>		
Approved by:	Approved By:		
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## I. POLICY

Adult Mental Health Service Providers deliver psychiatric rehabilitation services within a recovery framework. Services must be individually tailored to a client’s unique needs based on a comprehensive assessment. The overarching goals of psychiatric rehabilitation are to be fully integrated into the community, and to function as independently as possible. For optimal functioning, treatment must eliminate or diminish the impact of symptoms on daily activities and increase those skills that promote self-efficacy.

## II. DEFINITIONS

- A. **Co-Occurring Disorder:** Having one or more diagnosable psychiatric disorders and one or more diagnosable substance use disorders, with concomitant functional disability in one or more areas of psychosocial function. (Source: Adult MH P&P 03-02 COD Practices)
- B. **Psychiatric Rehabilitation:** “Encompasses coordinated and comprehensive biobehavioral services that enable disabled persons to perform those cognitive, emotional, social, intellectual, and physical skills needed to live, learn, work and function in the community as normally and independently as possible.” (Source: Recovery From Disability, Manual of Psychiatric Rehabilitation 2008)
- C. **Recovery:** Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Source: SAMHSA National Consensus Statement 2004)

## III. PROCEDURE

### A. **Comprehensive Assessment:**

1. A comprehensive assessment serves as the foundation for treatment planning and service provision.
2. When new information is obtained, the assessment, diagnoses and treatment plan must be updated and revised. Examples: identification of a co-occurring disorder, obtaining symptom remission, developing a new skill, etc.
3. See table below for key features of a comprehensive assessment.

## Comprehensive Assessment –

*This serves as the basis for treatment planning and service provision.*

- Client as expert:
  - Cultural and linguistic needs, strengths, challenges, life goals, preferences, understanding of his/her mental disorder, response to prior treatment, coping skills, identified personal supports, etc.
- Mental health assessment including:
  - Demographics, presenting problem, history of present illness, past psychiatric and substance use history including family history, family and social supports, cultural factors, legal issues, mental status exam, risk assessment (suicide / assault), diagnosis or diagnostic impressions including co-occurring substance or dependence (even if in remission), significant medical conditions, developmental disability, etc.
  - Collateral information – chart review, family, significant others, prior treatment providers, LPS Conservator, board and care home, etc.
  - Medical Conditions – including impact on psychiatric disorder and primary or specialty health linkages.
  - Personal Supports – family, significant others, spiritual, etc.
- Cultural Formulation:
  - Each assessment must include a cultural formation including the following: cultural identity, cultural explanations of the illness, cultural factors related to psychosocial environment and level of functioning, cultural elements of the relationship between the service provider and the client, and overall assessment for diagnosis and services. *Levels of evidence may not be established for particular services within the tables of this document. Staff must consider applicability and tailoring of services when indicated.*
- Tools:
  - Co-Occurring Disorders Assessment (CODA), depression scales, etc. to accurately assess diagnosis or symptom levels.
- Level of Service recommendation:
  - Level of Care Utilization System (LOCUS)
- Income/Benefits:
  - SSI, Medi-Cal, Medicare, employment income, etc.
- Housing:
  - Type and stability
- Transportation
- Education, employment or meaningful activities

### **B. Service Plan:**

1. State Department of Mental Health (DMH) and best clinical practice requires annual completion of a service plan.
2. Plan development and plan reviews shall always be completed in collaboration with the client. See the Service Plan table for key areas in service plan development.
3. The Plan should function as a “living document” which is regularly reviewed with client for progress and updates.
4. Key features are noted in the box below.

**Service Plan –****Key Features**

- Completed in collaboration with client
- Is individualized and flexible
- Identifies client’s life goal(s), strengths and challenges
- Includes treatment goals that are measurable, behavioral, specific and assist in meeting life goals
- Articulates agreed upon essential mental health services
- Includes crisis management planning
- Includes service coordination, e.g., primary or specialty medical care, benefits linkage, housing, etc.

**C. Phase of Illness / Stage of Change:**

1. Staff must recognize the phase of illness and the stage of change in order to appropriately plan for services. If these are not accurately identified either the client or the staff member may develop unrealistic service plans or get frustrated.
2. Mental health service delivery must be uniquely tailored based on the assessment. Some clients may be in the “acute phase,” accept their illness and be ready for action. Others in the “acute phase” may be in “pre-contemplation” and not ready for treatment. Therefore, interventions will vary.
3. See table below:

Phase of Illness	Examples of Activities
<b>Prodromal Phase –</b> <i>Manifests precursor signs and symptoms but does not meet full criteria for the diagnosis.</i>	<ul style="list-style-type: none"> <li>▪ Provide early detection, assessment and intervention with pharmacological and psychosocial interventions to attenuate, delay or prevent the development of the full blown disorder.</li> </ul>
<b>Acute Onset or Relapse –</b> <i>Symptoms are at their peak, priority is to stabilize the symptoms and identified target behaviors.</i>  <i>Individuals typically enter services during the acute phase.</i>	<ul style="list-style-type: none"> <li>▪ Complete risk assessment and identify appropriate service intensity.</li> <li>▪ Identify psychotic, manic, or depressive symptoms as soon as they emerge, and provide treatment as early as possible.</li> <li>▪ Foster symptom control by providing optimal medication treatment and education.</li> <li>▪ Reduce social and environmental over-stimulation.</li> <li>▪ Buffer stressors that may be operating at home, at work, or in other situations.</li> <li>▪ Set realistic goals.</li> <li>▪ Collaborate with psychosocial services and psychiatric services.</li> <li>▪ Discuss with client and family expectations regarding the duration of the acute phase. This varies from disorder to disorder and client to client. Level of personal support is critical.</li> </ul>
<b>Stabilization –</b> <i>Symptom control and behavioral changes</i>	<ul style="list-style-type: none"> <li>▪ Ensure continuation of treatment including optimal pharmacotherapy.</li> <li>▪ Educate the client and family about the importance of communication with the treatment team regarding symptoms, side effects of medications and positive behavioral changes or steps.</li> <li>▪ Provide psychosocial interventions or skills to decrease maladaptive target behaviors and increase adaptive behaviors.</li> <li>▪ Support a graduated return to psychosocial functioning based on client’s preferences. Then identify reasonable steps.</li> <li>▪ Develop a relapse plan</li> </ul>

<b>Stable</b> – <i>Symptoms are largely in control and target behaviors are not interfering with activities</i>	<ul style="list-style-type: none"> <li>▪ Monitor stressors and work on relapse prevention.</li> <li>▪ Continue to work on skill building that is in alignment with client’s life goals. This is likely more refined or complex skill building.</li> <li>▪ Assess for client readiness for less intensive levels of service.</li> <li>▪ Adjust goals as indicated.</li> </ul>
<b>Recovery</b> – <i>Achieve and maintain personal goals and community integration</i>	<ul style="list-style-type: none"> <li>▪ Highly individualized services to meet long-term life goals.</li> <li>▪ Client is integrated into community life. Has social supports and meaningful activity, e.g., work, education, volunteer, etc. that s/he values.</li> </ul>
<b>Refractory</b> – <i>Suboptimal treatment outcomes</i>	<ul style="list-style-type: none"> <li>▪ Highly individualized medication and psychosocial interventions.</li> <li>▪ Services must be tailored to discover “what works.”</li> <li>▪ Staff must self-monitor any negative response that may indicate “client failure” versus “treatment failure.” Clinical supervision is indicated.</li> </ul>

Stage of Change	Examples of Techniques
<b>Pre-contemplation</b> – <i>Denies mental health diagnosis, not considering treatment or certain types of services</i>	<ul style="list-style-type: none"> <li>▪ Engagement</li> <li>▪ Education/Pretreatment</li> <li>▪ Explore potential concerns</li> </ul>
<b>Contemplation</b> – <i>Ambivalent about diagnosis or service needs</i>	<ul style="list-style-type: none"> <li>▪ Motivational interviewing</li> <li>▪ Discuss possible treatment options. Discuss risks and benefits of each option and how staff may assist client in meeting his/her life goals.</li> <li>▪ Acknowledge client’s control of the decision</li> </ul>
<b>Preparation</b> – <i>Has decided to take action and are beginning the steps</i>	<ul style="list-style-type: none"> <li>▪ Motivational interviewing</li> <li>▪ Support, encouragement, hope</li> <li>▪ Explore treatment options based on client’s expressed goals</li> </ul>
<b>Action</b> – <i>Engaged in treatment.</i>	<ul style="list-style-type: none"> <li>▪ Provide treatment per protocols</li> <li>▪ Teach skills</li> <li>▪ Begin teaching relapse prevention, wellness and health education</li> </ul>
<b>Maintenance</b> – <i>Practicing steps to maintain wellness</i>	<ul style="list-style-type: none"> <li>▪ Support relapse prevention methods</li> <li>▪ Encourage self-help</li> <li>▪ Provide on-going skills training</li> <li>▪ Teach wellness, health education and self-awareness</li> <li>▪ Promote self-efficacy</li> </ul>
<b>Relapse</b> – <i>Acute phase, symptomatic, prior behaviors return</i>	<ul style="list-style-type: none"> <li>▪ Engagement</li> <li>▪ Monitor for safety</li> <li>▪ Exploration and trials of new treatment</li> </ul>

**D. General Menu:**

1. Based on the client’s life goals and treatment goals noted in Section B, staff in collaboration with the client must design a service package.
2. Some services are applicable across diagnostic groups such as medication (when symptoms interfere with daily functioning), use of personal supports such as family or significant others, peer support, service coordination, or groups based on specific issues.
3. See table below for the General Menu.

<b>General Menu – For All Diagnostic Groups</b> <i>These are based on clients individualized needs.</i>		
Medication	Family or Personal Support Person(s)	Peer Support
<input type="checkbox"/> Medication Management Individual <input type="checkbox"/> Medication Management Group (medical staff) <input type="checkbox"/> SacPort Medication Management Module (medical staff)  <i>See P&amp;P 04-01 Medication Treatment Algorithms for information.</i>	<input type="checkbox"/> Education, consultation and interventions regarding diagnosis, available treatments, relapse, and resources <input type="checkbox"/> Handouts <input type="checkbox"/> Self-Help Books  <b>Referrals:</b> <input type="checkbox"/> NAMI <input type="checkbox"/> MHTC Family Education	<input type="checkbox"/> Peer mentor <input type="checkbox"/> Peer run groups on recovery <input type="checkbox"/> Recovery Plan Group  <b>Referrals:</b> <input type="checkbox"/> Consumer Self-Help / Wellness Recovery Center
<b>Service Coordination:</b> <i>Must be tailored to client's needs with specific contact information and releases when indicated</i>		
<input type="checkbox"/> Primary Health or Specialty Health <input type="checkbox"/> Income & Benefits Acquisition <input type="checkbox"/> Housing <input type="checkbox"/> Vocational Programs – Crossroads, DOR	<input type="checkbox"/> Acute Psychiatric Hospitalization <input type="checkbox"/> Alcohol & Drug Services (ADS) Authorized Service – residential or detox <input type="checkbox"/> Other referrals, specify:	
<b>Rehabilitation Groups:</b> <i>Curriculum Based for Specific Issues</i>		
<input type="checkbox"/> Money Management <input type="checkbox"/> Stress Management <input type="checkbox"/> Health & Wellness <input type="checkbox"/> Anger Management <input type="checkbox"/> Relapse Prevention <input type="checkbox"/> Employment Readiness <input type="checkbox"/> Culture-specific	<u>SacPort</u> (depending on specific issue): <input type="checkbox"/> Symptom Management <input type="checkbox"/> Medication Management (non-medical staff) <input type="checkbox"/> Community Re-entry <input type="checkbox"/> Basic Conversation Skills <input type="checkbox"/> Recreation for Leisure <input type="checkbox"/> Friendship and Intimacy <input type="checkbox"/> Work Place Fundamentals <input type="checkbox"/> Involving Families in Mental Health	

**E. Treatment Menu for Specific Diagnoses:**

1. Treatment menus have been developed for the following:
  - a. Schizophrenia
  - b. Major Depression, Recurrent / Bipolar Affective Disorder, Depressed
  - c. Co-Occurring Substance Use
2. The treatments identified are targeted toward symptom remission or improving functionality for individuals with those diagnoses. Teaching illness management skills for all the diagnostic groups is critical. This is a best practice in chronic disease management.
3. Treatment menu development was informed by the literature, consumer feedback (desire for evidence based services, skill based groups) and provider input.

<b>Schizophrenia</b>		
<b>Education</b>	<b>Skill Acquisition</b>	<b>Therapy</b>
<input type="checkbox"/> Individual education regarding illness / treatment <input type="checkbox"/> Group Class <input type="checkbox"/> Handouts <input type="checkbox"/> Self-Help Books	<u>SacPort:</u> <input type="checkbox"/> Symptom Management <input type="checkbox"/> Medication Management (non-medical staff) <input type="checkbox"/> Community Re-entry <input type="checkbox"/> Basic Conversation Skills <input type="checkbox"/> Recreation for Leisure <input type="checkbox"/> Friendship and Intimacy <input type="checkbox"/> Work Place Fundamentals	<input type="checkbox"/> Individual CBT (for positive, negative symptoms and when in remission)
<b>Tools</b>	<b>Peer Support – Specific</b>	<b>Key Points</b>
<input type="checkbox"/> CODA <input type="checkbox"/> LOCUS <input type="checkbox"/> Consider use of one of the following: Brief Psychiatric Rating Scale (BPRS), Positive and Negative Syndrome Scale (PANSS), or the Thought Disorder Index.	<input type="checkbox"/> Schizophrenia Anonymous	<input type="checkbox"/> Earliest possible intervention to prevent loss of function and disruption <input type="checkbox"/> Learning does not always generalize to new environments. <input type="checkbox"/> Provide basic service coordination early in treatment due to lack of resources (income, benefits), co-morbid medical conditions, etc. <input type="checkbox"/> Address social supports <input type="checkbox"/> Risk monitoring should be a high priority routine activity

<b>Major Depression, Recurrent / Bipolar Affective Disorder, Depressed</b>		
<b>Education</b>	<b>Skill Acquisition</b>	<b>Therapy</b>
<input type="checkbox"/> Individual education regarding illness / treatment <input type="checkbox"/> Group Class – What is Depression? What is Anxiety? <input type="checkbox"/> Handouts <input type="checkbox"/> Self-Help Books (emphasis on education, behavioral basics to manage (i.e., exercise, activity scheduling, etc.))	<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> CBT Depression Recovery Group <input type="checkbox"/> Brief, focused individual or family therapy (maximum 12 sessions) – CBT <input type="checkbox"/> CBT Bipolar Group Therapy

<b>Tools</b>	<b>Peer Support – Specific</b>	<b>Strategies</b>
<input type="checkbox"/> Zung Self-Rating Depression / Anxiety Scales (SDS) <input type="checkbox"/> CODA <input type="checkbox"/> LOCUS	<input type="checkbox"/> Depression / Bipolar Support Group	<input type="checkbox"/> Obtain a baseline and regularly assess symptoms using a depression scale. <input type="checkbox"/> Client should understand the diagnosis, early warning symptoms leading to relapse, impact of stress, specific skills and supports that foster wellness, when to ask for help, etc. <input type="checkbox"/> Address risk / benefits of mania and relapse prevention

<b>Co-Occurring Substance Use Disorder (COD)</b>		
<b>Education</b>	<b>Skill Acquisition</b>	<b>Therapy</b>
<input type="checkbox"/> Individual education <input type="checkbox"/> Pre-Treatment Group <input type="checkbox"/> Handouts <input type="checkbox"/> Self-Help Books	<input type="checkbox"/> SacPort Substance Abuse Management Module (SAMM) <input type="checkbox"/> Managing Dual Recovery <input type="checkbox"/> Self Advocacy <input type="checkbox"/> Relapse Prevention – individual or group	<input type="checkbox"/> Brief, focused individual therapy (maximum 12 sessions) – CBT
<b>Tools</b>	<b>Peer Support – Specific</b>	<b>Key Points</b>
<input type="checkbox"/> CODA <input type="checkbox"/> AOD Screening and Service referral Form (ADS 003) <input type="checkbox"/> LOCUS	<b>Self Help</b> <input type="checkbox"/> DRA <input type="checkbox"/> AA/NA <input type="checkbox"/> Life Ring  <b>Family Support</b> <input type="checkbox"/> Alanon/Narcanon	<input type="checkbox"/> Co-occurring disorders must be expected in all treatment settings. <input type="checkbox"/> Having a co-occurring disorder, increases the likelihood of having additional medical, social and legal problems. <input type="checkbox"/> Integrated treatment is a best practice standard. <input type="checkbox"/> When use is unabated, harm reduction techniques are indicated (refractory disorder) <input type="checkbox"/> Motivational Interviewing techniques are ideal for clients in the contemplative stage of change.

Form References  
N/A

<b>IV. REFERENCES</b>	<b>Related Policies &amp; Procedures</b> <ul style="list-style-type: none"> <li>▪ Adult MH P&amp;P 03-01 SacPort Requirements</li> <li>▪ Adult MH P&amp;P 03-02 Co-Occurring Disorders Practices</li> <li>▪ Adult MH P&amp;P 03-03 Co-Occurring Disorders Assessment (CODA)</li> <li>▪ Adult MH P&amp;P 03-04 Level of Care Determination</li> <li>▪ Adult MH P&amp;P 03-05 CBT Standards</li> <li>▪ Adult MH P&amp;P 04-01 Medication Treatment Algorithms</li> <li>▪ Adult MH P&amp;P 04-02 Primary Care Consultation Service</li> <li>▪ Adult MH P&amp;P 04-03 PCP Collaboration</li> <li>▪ QM P&amp;P 14-01 Review Process for Implementation of New Clinical Practices</li> </ul>	<b>State/Federal Codes/Other References</b> <ul style="list-style-type: none"> <li>▪ Sacramento County Mental Health Plan</li> <li>▪ Sacramento County Cultural Competence Plan</li> <li>▪ Sacramento County Managed Care Contract</li> <li>▪ California Code of Regulations Title 9 (Medi-Cal Specialty Mental Health Services)</li> </ul>				
<b>V. CONTACTS</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Name</b></td> <td style="width: 50%;"><b>E-mail</b></td> </tr> <tr> <td>Designated MH Program Coordinators</td> <td></td> </tr> </table>	<b>Name</b>	<b>E-mail</b>	Designated MH Program Coordinators		
<b>Name</b>	<b>E-mail</b>					
Designated MH Program Coordinators						
<b>VI. SCOPE</b>	<input checked="" type="checkbox"/> Mental Health Staff <input type="checkbox"/> Mental Health Treatment Center <input type="checkbox"/> Specific grant/specialty resource	<input checked="" type="checkbox"/> Adult Contract Providers <input type="checkbox"/> Children's Contract Providers				