SECTION - THERAPY SERVICES
ADMINISTRATIVE DIRECTIVE NO. 446
(Replaces AD 446 dated 9/15/2005)

Effective Date: August 10, 2006

SUBJECT: WELLNESS AND RECOVERY PLANNING

I. PURPOSE

The Wellness and Recovery Plan (WRP) establishes the primary clinical interventions provided to the individual served. It incorporates the results of a comprehensive, multidisciplinary assessment that identifies the individual's relative strengths, aspirations, and his goals. It focuses interventions on personal change and disposition ally relevant, psychosocial rehabilitative skills. Developing the WRP is the responsibility of the Wellness and Recovery Team (WRT). Plan development and documentation begins as soon as the individual arrives at the hospital. The WRT, which includes the individual as an active member, reviews assessment information and formulates the individual's WRP. This plan is reviewed and modified as frequently as is required by conditions and needs of the individual served.

II. AUTHORITY

Authority is obtained from the California Administrative Code, Title 22, Division 5; Mental Health Documentation System policy, established in conformity with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and policy and procedures as approved by the Hospital Executive Director.

III. POLICY

Coalinga State Hospital (CSH) uses a wellness and recovery model that is defined by its person-centered attitudes, beliefs, and actions.

A. There are various definitions of recovery offered by mental health professionals, family members and individuals within the mental health community. Each definition is almost as varied as the unique life journeys of those who have experienced recovery. Those living with severe and persistent mental illness have offered a number of recovery narratives that include the following themes:

1. Recovery is the reawakening of hope, after despair.

2. Recovery is moving from withdrawal to engagement, to active participation in life.

3. Recovery is a journey from alienation to purpose.

4. Recovery is active coping rather than passive adjustment.

5. Recovery means no longer viewing oneself primarily as a mental patient, and reclaiming a positive sense of self.

6. Recovery is not accomplished alone - it involves support and partnership.

B. Professionals within the mental health community define recovery in the following ways:

1. "Recovery is a continuing, deeply personal, individual effort that leads to growth, discovery and change of attitudes, values, goals and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony 1993).

2. "Recovery is a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence" (Ohio Consumer Services 2002).

3. "Recovery is an ongoing process of growth, discovery and change" (Stocks 1995).

C. There are certain concepts that are common in the recovery literature, including:

1. HOPE – This is the desire accompanied by confident expectation. Hope is foundational to recovery from mental illness. Having a belief that things can get better is a powerful force and can fuel the recovery process.

2. MEDICATION AND PSYCHO SOCIAL REHABILITATION (PSR) SERVICES – Many consumers report that both medications and PSR Services play an important role in their recovery. This is especially true when they are engaged in a partnership with their provider and are involved in their PSR planning.

3. A SENSE OF EMPOWERMENT – This means that individuals have a belief that they have power and control in their life, including over the effects of their illness. As empowerment grows, they begin to take responsibility for self and advocating for themselves and others.

4. SUPPORT – An important ingredient in recovery is that of support from peers, family, friends and mental health professionals. Multiple sources of support are especially helpful as it decreases isolation.

5. EDUCATION AND KNOWLEDGE – Information about illness, medications, best wellness and recovery practices, and available resources is a necessary element of a recovery program.

6. SELF HELP - Although professional "treatment" is a valuable component of the recovery process, self-help is often viewed as the conduit to growth in recovery.

7. SPIRITUALITY AND CULTURE – For many individuals, spirituality and culture provide hope, solace during their illness and a source of social support.

IV. METHOD

It is the responsibility of the Program Director in collaboration with the psychiatrist, psychologist, and the WRT to ensure that there is a complete, timely, and accurate wellness and recovery plan for each individual, a plan that addresses his rehabilitation and recovery goals.

A. Wellness and Recovery Planning Requirements: The following standards represent the minimum requirements for WRT planning and review with each individual.

1. Admission Wellness and Recovery Plan (A-WRP): The WRT shall strive to develop the initial wellness and recovery plan within twenty-four (24) and no later than seventy-two (72) hours following admission. This plan is based on the initial psychiatric, nursing, and medical assessments. For transfers from other State Hospitals, no A-WRP is required.

2. The Wellness and Recovery Plan (WRP*):* The Team shall develop a master WRP that updates the Admission plan based on the integrated assessments. This plan is develop at a master WR planning conference, which is held between seven (7) and fourteen (14) days following admission.

3. Thereafter, the WRP shall be reviewed and updated as frequently as clinically indicated. The minimum required schedules for review and updates are:

   a. Transfer Conference: Within seven (7) days of transfer from Admissions to an acute or residential unit, a wellness and recovery planning conference must be conducted.

   b. Monthly Conferences: Wellness and recovery planning conferences are conducted every thirty (30) days thereafter.

   c. Transfer from WRT to another: Within seven (7) days following transfer from one team to another, a wellness and recovery planning conference is conducted. The next monthly conference would occur thirty (30) days later.

d. Absence from the hospital: Whenever a individual returns to the hospital after an absence of thirty (30) days or more, a wellness and recovery planning conference shall be completed within seven (7) days of return.

4. Mini-Team: In addition to the regularly scheduled wellness and recovery planning conferences, a mini-team can be convened as needed. The minimum staff required for a mini-team includes two staff from different disciplines and the individual, with the plan's concurrence by a psychiatrist or psychologist. In an emergency, two staff representing two separate disciplines with the concurrence of the physician/MOD, may modify the wellness and recovery plan subject to review and approval by the WRT the next working day.

5. Documentation: All WRP are recorded on the appropriate Wellness and Recovery Model Support System (WaRMSS) form and are subject to the requirements of WaRMSS. Program Directors and Senior Psychologists are accountable for ensuring that the plan is comprehensive and complete.

B. Assessment: Pursuant to the WaRMSS requirements, staff gathers data and provide integrated information about the individual's history, attributes, psychiatric symptoms, risks, psychosocial skills, and relationships with people outside of the hospital. Within the context of the individual's most likely post-hospital placement, members of the WRT work with the individual to identify his goals, strengths, cognitive functioning, personality factors, and available social network. Each discipline uses tools that are best suited to their individual areas of expertise. Where appropriate, the results of these assessments are used to identify and document barriers to learning for consideration in service planning and delivery.

C. Planning: The professional members of the WRT convene with the individual and significant others involved in his care (including family when appropriate) to set goals and objectives based on the reason(s) for admission to CSH and pertinent assessment findings. Goals, objects, and the identified foci of the WRP are prioritized according to the danger posed, the degree of distress, and the degree to which skill levels are important for discharge success, both from a legal and a functional point of view. All services are planned with the goal of optimizing the individual's discharge and successful adaptation to his dispositional setting.

D. Intervention:

1. Active treatment interventions are designed to address specific WRP goals and objectives, serving individuals at different stages of changes and at different levels of cognitive functioning. For each goal and objective, the team considers four different types of interventions: medications, PSR Mall courses/activities, milieu services, and positive behavioral support.

2. When indicated, the psychiatrist determines whether medicines would be helpful in meeting the individual's WR goals. The psychiatrist collaborates with the individual and other team members in evaluating the risks and benefits of medications and other medical treatments, and in defining expected responses.

3. The WRT selects active treatment interventions from the catalog of PSR Mall courses and activities to address specific WRP objectives. Individuals may be able to choose from available courses to achieve their objectives; when this occurs, course options must address equally the specified plan objective. The WRT selects activities, which progressively meet the individual's recovery readiness, skill building, and discharge preparation needs. These activities assist the individual to develop the requisite skills to function in spite of his mental illness/disorder-assisting in self-management and prevention of relapse-and to be able to live at the highest level of independence within the constraints of his condition and of his post-hospital placement. Active Treatment Interventions are described in "course outlines" pursuant to the WaRMSS software and PSR Mall Services. Each outline specifies the appropriate WRP for which focus, stage of change, and functional level of participants.

4. Milieu interventions that are to be carried out as part of the general unit environment are listed and described in the WRP. The need for positive behavioral support interventions are addressed by a separate consultation and described in the WRP.

E. Evaluation:

1. The individual's responses to his active treatment interventions and wellness and recovery plan are evaluated at the time of each regularly scheduled WRT conference and as dictated by the needs of the individual. Various rating scales, tools, and self-assessments are utilized in considering this response.

2. An integrated evaluation system continuously monitors the overall impact of the aggregated wellness and recovery programs and guides the ongoing adjustment or redesign of interventions, the training and monitoring of staff competence, and the allocation of resources. This system is described in Administrative Directive No. 438, and is based in part on clinical data generated during the wellness and recovery planning process.

W. T. VOSS
Executive Director

Cross Reference(s):
A.D. No. 434 – Active Treatment Interventions
A.D. No. 438 – Clinical Outcome Evaluation System
A.D. No. 516 – Wellness and Recovery Team