Inpatient Treatment Planning

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Nirbhay N. Singh, Giulio E. Lancioni, Evelyn Harris and Alan S.W. Winton

Introduction

There are probably as many ways of undertaking treatment planning as there are clinicians. But most inpatient psychiatric hospitals have or are inching toward an electronic medical records system that sets in stone how each hospital does its treatment planning. The treatment plans in these hospitals range from purely medical models of inpatient psychiatric care, with problem lists and diagnosis-specific treatments, to those that are heavily recovery based, which emphasize each individual's right to self-determination, preferences, and choices that will enable the individual to lead a fulfilling and meaningful life even in the presence of psychiatric disorders (Barber 2016). The nature of the recovery plans may also depend on whether the length of stay is acute or somewhat longer, or even long term due to civil and forensic commitments.

N.N. Singh (✉)
Department of Psychiatry and Health Behavior, Medical College of Georgia, Augusta University, Augusta, GA, USA
e-mail: nisingh@augusta.edu

G.E. Lancioni
Department of Neuroscience and Sense Organs, University of Bari, Bari, Italy

E. Harris
Division of Behavioral Health and Developmental Disabilities, Atlanta, GA, USA

A.S.W. Winton
Massey University, Palmerston North, New Zealand

Spaulding et al. (2016) have described the history and development of the concept of recovery, and Davidson et al. (2016) have cogently articulated the principles for recovery-oriented inpatient care. In this chapter, we present an example of treatment planning in recovery-oriented inpatient care that has been used successfully in state psychiatric facilities to enhance the quality of life of individuals with serious mental illness, including those with forensic involvement. In broad strokes, the chapter focuses on the mechanics of recovery planning for individuals with a length of stay in an inpatient facility that extends beyond acute care, i.e., psychiatric stabilization before discharge within a few days, typically within two weeks of admission. For those needing acute care, the essence of inpatient hospitalization is to provide immediate care, reduce the risk for further psychiatric and behavioral decompensation, attend to immediate medical needs, and to discharge them back to the community for further engagement in their recovery. For those requiring somewhat longer lengths of stay, staff needs to consider how it can support an individual to move from a sense of being burdened with a disability to a more meaningful life, even with mental illness present.

A basic question emerges when staff collaborates with the individual on what a meaningful or fulfilling life would entail for that individual. Most people have what has been termed *experiential interests* and *critical interests* that together

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make life meaningful (Dworkin 1993). Experiential interests are those that the individual likes to do, such as listening to music, eating out, watching football, taking a walk in nature or the first monsoon rain, making love, or reading a novel. These are activities that the individual finds pleasurable or satisfying because they add something extra to that individual's life. If an individual did not experience these kinds of activities the value of life would not lessen; they simply provide something extra. Critical interests on the other hand are interests whose absence would produce a deficit in the individual's quality of life; with them, life is genuinely better. They involve judgment calls which an individual makes with regard to aspirations in life—to give and receive unconditional love, assist the less fortunate, have close relationships with one's family members, engage in spiritual practices, and so on. When supporting the development of an individual's recovery plan, the individual and staff should ensure the inclusion of both experiential and critical interests because, if sustained in the long term, these interests will give meaning to the individual's life and increase that individual's motivation to stay on the path of recovery. An individualized recovery plan, by definition, must involve more than mere symptoms to control; it must include one's life goals.

Individualized Recovery Planning Process

An Individualized Recovery Plan (IRP) is the blueprint or roadmap for recovery that is initiated during an individual's admission to an inpatient hospital and the plan continues to be used when discharged to the next level of care in the community. The development of an IRP proceeds from a synthesis of (a) the reason for admission, (b) anticipated placement, (c) discharge criteria, (d) the individual's life goals and choices, (e) treatment and recovery needs identified by risk and multidisciplinary assessments, and (f) the discharge plan. The discharge process begins at admission, and the reason for admission determines the pathway to discharge. A person-centered planning assumes that the individual will (a) take increasing responsibility for his or her engagement in recovery, as treatment, rehabilitation, and enrichment progress, (b) resolve the reasons for admission, (c) overcome discharge barriers with the assistance of hospital and community agency staff to the greatest extent possible, and (d) be discharged to the next level of care. If admitted on forensic charges, the individual's legal status may determine the next level of care; in their absence, however, discharge should be to the most integrated setting available in the community (e.g., permanent housing with wraparound supports).

The IRP is designed to offer the individual in recovery, family members and significant others, conservators and guardians, and other authorized representatives, an opportunity to participate meaningfully in the recovery and discharge process. The IRP is individualized, person-centered, strength-based, and demonstrates respect for self-determination, personal choices, preferences, hopes, aspirations, and cultural and spiritual values, beliefs and practices. As a general rule, staff should always encourage the individual to engage in recovery planning, fully understand the IRP process, and collaborate with his or her Recovery Planning Team (RPT)—traditionally called the *Treatment Planning Team*—to develop goals, objectives, and interventions that are meaningful for that individual. The individual's signature on the signature page of the IRP is necessary, but not sufficient, to show that these conditions have been met. As recovery proceeds, the RPT should engage, encourage, and facilitate the individual to gradually assume increasing responsibility for reviewing and revising his or her IRP.

RPT

The membership of a RPT is dictated by the particular needs and strengths of the individual in recovery. In addition to the individual, the core team members include a psychiatrist, clinical psychologist, registered nurse, social worker, rehabilitation therapist, and direct care staff (e.g.,

health service technician, forensic service technician who best knows the individual). The core RPT membership should be consistent and enduring, as staffing permits. Other staff (e.g., behavior specialist, nutritionist, primary care physician, physical therapist, occupational therapist, speech and language pathologist, peer specialist, activity therapist) and family members, significant others, conservators, guardians, advocates, friends, and community treatment provider (as authorized by the individual), may be invited to attend, depending on the specific needs and by request of the individual. The core RPT members must verifiably be competent in the development and implementation of IRPs as well as in the principles of recovery.

Role of the RPT

A key role of the RPT is to develop and implement an IRP that optimizes the individual's recovery and sustains the individual in the most integrated and appropriate setting. This setting is based on the individual's legal status, life goals, strengths, and functional abilities, and promotes the individual's self-determination, preferences, choices, and independence. The RPT should ensure that the individual has substantive input into the IRP process including, but not limited to, input with regard to focused interventions, psychosocial treatment mall groups, and individual therapies appropriate to his or her assessed needs. In addition, the RPT should educate the individual regarding his or her roles, rights, and responsibilities with regard to developing the IRP, engaging in treatment and rehabilitation, working on discharge goals, and revising and updating the IRP as recovery proceeds.

Initial Recovery Plan

The initial recovery plan is the individual's first "treatment plan." The admitting physician and the registered nurse develop this plan at the time of admission (i.e., within 24 h of admission). It is based on admission assessments, and includes immediate treatment goals and interventions that focus on the individual's psychiatric, medical, and behavioral concerns, as well as potential risks (e.g., for aggression or suicide). The individual's RPT meets on the second business day of admission and begins the process of updating this plan as new information and assessment data become available. Revision schedules may differ across hospitals, depending on the average length of stay or hospital-specific policies. Usually, the initial recovery plan is updated by the RPT within 72 h of admission. The 72-h update and subsequent periodic updates provide the basis for care of the individual until the first IRP is developed on the 15th day.

Assessments

The admitting physician/psychiatrist and nurse complete the admission assessment within the first 24 h of admission. Usually the nursing assessments begin at admission and are completed within the first 8 h of admission. The individual's psychiatrist completes the Psychiatric Evaluation within 60 h of admission and the social worker completes the Initial Psychosocial Assessment within 72 h of admission. The RPT clinical psychologist, social worker, and activity therapist complete the Integrated Psychosocial Assessment by the 12th day of admission. The RPT team leader or facilitator synthesizes the assessment findings and recommendations, and presents a holistic picture of the individual when developing the first IRP. This synthesis incorporates other assessments, including the admission assessment, Psychiatric Evaluation, Initial Psychosocial Assessment, violence risk assessment, suicide risk assessment, clinical risk profile, input from the individual (as much as possible, depending on his or her mental health), his or her family (as appropriate) and community sources, as necessary and appropriate.

Focused Assessments

Periodically, the RPT may request additional assessments, as clinically indicated. Examples include neuropsychological and behavioral assessments, personality tests, speech, dysphagia, nutrition, physical therapy, occupational therapy, and other assessments that may assist differential diagnosis, assessments related to specific psychiatric disorders and psychological distress, and outcome measures. The results of these assessments are also integrated into the IRP.

Cognitive Assessments

These are a specific example of focused assessments. Individuals with cognitive impairments (e.g., developmental disabilities, dementia, traumatic brain injury, or other conditions that may lead to cognitive decline) should be assessed at admission and periodically after that, as clinically indicated. The purpose of the cognitive assessment is to provide an individual's RPT with information and recovery recommendations so that it can assist the individual to make appropriate choices with regard to treatment, psychosocial rehabilitation, and enrichment activities. These assessments should be in the form of cognitive screening or a full neuropsychological battery, and should specify particular types of cognitive remediation programs that will best enhance the individual's recovery (Hill et al. 2016).

Strengths

Knowledge of an individual's strengths or protective factors can enable the RPT and care staff to provide specific social and instrumental supports, and enable group facilitators in the Psychosocial Rehabilitation Malls (for details, see PSR Malls below) to motivate the individual to fully participate in recovery activities. In this context, whatever the individual presents (including personal attributes, characteristics, skills, diseases, disability, or disorders) can be used as strengths to achieve symptom and functional recovery, and to enhance quality of life. The *Strengths-Based Conversation* is a 40-item protocol that clinicians can use as the basis for conversing with the individual (see Table 6.1). The aim of this conversation is to facilitate the mutual exploration of the individual's general strengths and highlight specific strengths that the individual wishes to enhance or use in recovering from mental illness. The *Strengths-Based Conversation* is not used as a tool for a structured interview; strengths will emerge from discussions of an individual's life goals. These strengths should be updated as the individual begins to recover and is increasingly able to use identified strengths in the recovery process.

Stages of Change

In a recovery model of mental health service delivery system, it is important to consider the concept of stages of change. Psychotic behavior may be so serious in terms of severity, frequency, intensity, and duration that it interferes with an individual's quality of life. The clinician may think that the person needs to be in treatment. Whether the individual agrees with this assessment will depend on that individual's understanding of the disorder and the need for treatment, and a willingness to engage in the treatment. To determine the approximate level that treatment should begin, clinicians often assess the individual's stage of change using a transtheoretical model (DiClemente and Prochaska 1998; Prochaska and DiClemente 1983; Prochaska and Velicer 1997). There are five nonlinear stages in the transtheoretical model—precontemplation, contemplation, preparation, action, and maintenance. Stages of change do not assess the individual's capacity to change because that quality is a given in all individuals.

The University of Rhode Island Change Assessment (URICA) is a widely used tool that can be used to assess an individual's stage of change (McConnaughy et al. 1983). Traditionally, the URICA is completed by a clinician who has the greatest rapport with the individual, or by

Table 6.1 Strength-based conversation

Name of Individual:	Age:
Hospital ID#:	Admission Date:
Unit/Program:	DOB:
Dates of Conversation:	Facilitator:

Respondents, if other than individual (e.g., parents, advocates, siblings):

You can use this instrument as the basis for a conversation with an individual in recovery. It is usually advisable to hold the conversation in a pleasant area, preferably in a social setting where the individual feels comfortable. Invite the individual to have something to eat or drink (e.g., coffee, soda, water) when you have a conversation, or when you are engaged in some task that does not require focused attention (e.g., a walk on the grounds). Make notes following, but not during, the conversation. The areas you should cover are determined by the type of information you need to assist the individual with his or her recovery. For example, if you want to know something about his or her life goals, you can use the Miracle Question and the Possibility Questions, or if you are interested in knowing how the individual will handle discharge, focus on the Discharge Questions as the basis of the conversation. You can use the conversation like a "focused assessment," by developing a conversation around only those areas that are most pertinent at the time.

Survival Questions:

1. How have you managed to survive or thrive, thus far, given all the challenges you have had to contend with?
2. What is going well for you right now?
3. What are you willing to do to make things work well for you?

Support Questions:

4. Who are the special people on whom you can depend?
5. Who is important to you in your life?

Exception Question:

6. In the past, when you felt that your life was better, more interesting, or more stable, what about your world, your relationships, and your thinking was different or special? [Several issues are embedded in this one]

Possibility Questions:

7. What do you want out of life?
8. What is important to you in your life?
9. What makes life worth living for you?
10. What are your hopes, visions, and aspirations?
11. If things were different, what would you wish for?
12. If you had three wishes, what would they be?
13. What are you willing to do to make your wishes come true?

(continued)

Table 6.1 (continued)

Esteem Questions:

14. When people say good things about you, what are they likely to say?
15. What do you think is unique about you that people should know?

Discharge Questions:

16. Are you anxious about being discharged?
17. Do you have any fears about being discharged?
18. What can we do to make it easier for you to live in the community?
19. Who can you count on in the community to be there for you?
20. What are you willing to do to make this transition successful?

Housing Questions:

21. What sort of housing arrangements have worked for you in the past?
22. Under ideal conditions, where would you like to live?
23. When you lived in the community, what sort of place did you live in?
24. What sort of place would you like to live in when you are discharged? Why?
25. How can we help you to find a place like this?
26. What are you willing to do to live in a place like this?

Employment Questions:

27. What jobs have you had in the past?
28. Which one(s) did you like the best? Why?
29. What sort of work would you like to do in future?
30. How can we help you get this kind of work?
31. What are you willing to do to get this kind of work?

Daily Activities Questions:

32. What do you do in a regular day?
33. What did you do before you were hospitalized (. . . or before your current hospitalization or in your previous Unit)?
34. What would you like to do in the future?
35. What are you willing to do make this possible?

General Conversation Questions:

36. What makes you happy?
37. Is religion or spirituality important in your life?
38. What are your priorities in life?
39. Who are the most important people in your life?

The Miracle Question:

40. The miracle question is often a good way to stimulate thinking about life goals and aspirations:

    Suppose that while you are sleeping tonight a miracle happens. The miracle is that the issues that you have (e.g., being incarcerated, having mental illness, homelessness) are somehow solved, but you don't know that because you are asleep.

(continued)

Table 6.1 (continued)

a. What will you notice different tomorrow morning that will tell you that a miracle has happened?
b. What is the first thing you will notice after the miracle happens?
c. What might your … (family member, friend) notice about you that would give him or her the idea that things are better for you?
d. When he or she notices that, what might he or she do differently?
e. When he or she does that, what would you do?

the individual. The URICA is used for specific issues, and not as a general or global measure of a person's stage of change. It measures the person's stage of change for a specific area of life functioning (e.g., substance use), and this may vary over time or with treatment. A skilled clinician may clinically determine an individual's stage of change without using a rating scale.

Individualized Recovery Plan

The IRP—traditionally called the *Master Treatment Plan*—is the individualized recovery plan that provides a roadmap for an individual's recovery while in the hospital. It is developed by the 15th day of admission, reviewed for progress on a preset schedule, incrementally completed as new assessment, consultation, and treatment data, or other information become available, and is fully developed by the 60th day of admission, although the days specified might vary with hospital-specific policies.

Recovery Planning Schedule

Inpatient hospitals usually have specific schedules for initiating, completing, and updating the IRP. In broad terms, these include an initial IRP, followed by monthly, quarterly, and annual reviews. In addition, hospital policy will also specify the tasks that the RPT will undertake for the initial IRP and for the scheduled IRP reviews. Typically, the initial IRP and monthly and quarterly reviews take between 20 and 30 min, while annual reviews take a little longer because of the interval length. In this context, it is useful to remember that the IRP should not be a long document. Although there may be exceptions, a fully developed IRP is usually no more than 8–12 pages in length, and is written at the reading and comprehension level of the individual.

IRP for Internal Transfers

When an individual is transferred between units or programs, a RPT conference is scheduled on the day following the transfer, and then the regular cycle from the original admission date is continued. If the transfer is made within five business days of a scheduled conference, the RPT may complete the 15-day, monthly, quarterly, or annual IRP in lieu of the one-day post-transfer IRP review. The receiving RPT is required to review the entire IRP and make revisions based on current information and as clinically indicated.

IRP for Readmissions

Some individuals may be discharged and readmitted to the hospital for a number of reasons (e.g., court returns, outside medical care, failure to integrate fully in the community). When an individual is readmitted in less than 90 days after discharge, an IRP is completed within the first 24 h. The individual's RPT meets on the second business day of admission and updates the individual's original IRP (from the previous admission). The first RPT conference is scheduled on the 15th day following readmission. If the integrated assessments indicate no major changes in condition, the individual is placed on a monthly

IRP review cycle from the date of the previous admission. If the integrated assessments indicate major changes in the individual's condition, the RPT should follow the new admission sequence for review meetings. In either case, the assessment findings should be documented in the Present Status section of the individual's IRP. For readmissions longer than 90 days, the individual should be treated as a completely new admission.

IRP for Transfer to Another Hospital

When an individual is transferred to another inpatient hospital, all assessments and the recovery plan follow the individual. Clinicians at the receiving inpatient hospital complete new assessments after meeting with the individual, but the process may be treated like an update, as the receiving hospital should utilize the information from the sending facility. The first IRP is based on the final IRP before discharge of the individual from the prior hospital. The first IRP meeting is an opportunity to update, revise, or add any new goals and objectives to the IRP, and will allow the recovery team to work with the individual to identify the interventions that are available at the receiving hospital to meet the recovery goals and objectives of the individual.

Sample IRP Template

A sample IRP template is provided in Table 6.2. This can be modified to suit the specific requirements of any inpatient hospital. Typically, the IRP is a part of the hospital's electronic medical records, and the RPT members, together with the individual, collaboratively discuss and complete the form. In addition to inserting the demographics, the RPT team leader assists the members to conceptualize the case and develop goals, objectives, and interventions.

Case Formulation

A case formulation assists an individual in recovery to understand the likely origins of his or her problems, what triggers them, and what maintains them. It assists the individual's RPT to collaborate with the individual to develop optimal treatment and support options that put the individual on a trajectory to recovery. The case formulation is developed by the RPT, not just by a single team member. Using a team process to develop, review, and revise the case formulation ensures that the team is focusing on the individual as a person opposed to just specific diseases, disorders, or deficits of that individual.

There are numerous ways that cases can be formulated. For example, in this IRP, the case formulation is structured as follows:

Pertinent History

History can be within any timeframe, but typically includes historical information that may impact current treatment. The individual's pertinent history is not repeated in other sections of the case formulation. The following sequence can be used to describe pertinent history: (a) *Personal*: Includes a brief sketch of the individual's social history (i.e., age, education, employment, family of origin, course of life, current support system); (b) *Psychiatric, Behavioral, and Medical*: Includes a brief description of the individual's history of mental illness (i.e., psychiatric history, course of illness, past hospitalizations including reasons for admission), maladaptive behaviors, and a medical history; and (c) *Legal*: Includes a brief description of the individual's legal history (i.e., interaction with the legal system) and, if applicable, a very brief statement of the instant alleged offense.

Predisposing Factors

A predisposing factor is any condition that predisposes the individual to possible adverse

Table 6.2 Individualized recovery plan

Individual's Name:		**ID Number:**	
Admission Date:		**Date Of Continuous Admission**	
Date of IRP:	☐ **15-Day** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**		
Legal Status:			
CASE FORMULATION			
Pertinent History			
Predisposing Factors			
Precipitating Factors			
Perpetuating Factors			
Previous Treatments and Response			
Present Status			
PREFERRED METHOD OF DE-ESCALATION			
DIAGNOSIS			
Date of Diagnosis:			
Diagnoses			
Medical Conditions			
Psychosocial and Contextual Factors			
Disability			
INDIVIDUAL'S LIFE GOALS			
DISCHARGE PROCESS			
Reason For Admission			
Discharge Criteria For Anticipated Placement			
Discharge Plan			
Discharge Barriers			

(continued)

Table 6.2 (continued)

GOAL # 1		**DATE INITIATED:**	
OBJECTIVES			
OBJ. #	**OBJECTIVE DESCRIPTION**		**NEXT REVIEW DATE**
INTERVENTIONS			
INT. #	**INTERVENTION DESCRIPTION**		
GOAL # 2		**DATE INITIATED:**	
OBJECTIVES			
OBJ. #	**OBJECTIVE DESCRIPTION**		**NEXT REVIEW DATE**
INTERVENTIONS			
INT. #	**INTERVENTION DESCRIPTION**		
(Delete or add blank rows in each section as needed) (Add more goals, as needed)			
DEFERRED ISSUES			
SOCIAL SUPPORT			
Relationship to Individual in Recovery	Contact Person		Telephone

outcomes. At a minimum, if the individual's clinical risk profile has identified high risks (psychiatric, behavioral, or medical), it includes those that could be predisposing factors for conditions that may occur in the absence of preventative interventions. An example of a statement of a predisposing factor is, "Francis has diagnoses of dyslipidemia and hypertension, and a BMI of 35; thus, he is at risk for developing metabolic syndrome." In addition, other documented risk conditions identified in assessments should be considered as predisposing factors.

Precipitating Factors

A precipitating factor is any condition that has been found, through assessment or observation,

to precipitate the occurrence or exacerbation of an adverse outcome (e.g., maladaptive behavior, medical condition, psychological distress, or psychiatric disorder). These factors are based on the individual's current clinical condition and assessments, and any recorded behavioral challenges (e.g., instances of aggressive or destructive behavior). An example of a precipitating factor due to a medical condition would be: "Judy is very irritable when she is hypoglycemic. If a staff member makes a demand when she is irritable, she is likely to be verbally and, occasionally, physically aggressive. With Judy, low blood sugar level precipitates irritation, which may lead to verbal and physical aggression under demand conditions." If an individual is admitted for pretrial evaluation or competency restoration, the focus is on the psychiatric symptoms or behaviors that may interfere with the individual's ability to proceed and participate in the legal process.

Perpetuating Factors

A perpetuating factor is any variable that is untreatable or may continue to perpetuate adverse conditions or outcomes for the individual if left untreated. In some cases, identifying a perpetuating factor (e.g., treatment, or medication non-adherence) may enable an effective treatment to be developed and implemented. In other cases (e.g., cancer), while the disease itself may not be fully treatable, the condition that the disease perpetuates may be (e.g., depression). For example, "Bruce is depressed because of the pain and suffering due to cancer. His cancer is a perpetuating factor for his depression." Certain psychosocial factors (e.g., crowded rooms, unsupervised transition times, fear of discharge in long-term inpatients) are also perpetuating factors for some behaviors. In some cases, there may be an overlap between precipitating and perpetuating factors, and occasionally among predisposing, precipitating, and perpetuating factors.

Previous Treatment and Response

Previous treatment includes treatments utilized throughout the course of the individual's psychiatric and medical illnesses, treatments for maladaptive behavior, including culture-based treatments, and psychosocial interventions (e.g., PSR Mall groups, behavior plans, outpatient programs). The response to these treatments and any adverse effects of psychotropic and other medications should be described. It is useful to include symptoms or target behaviors for which the treatments were provided and not just the psychiatric diagnosis. In addition, it is clinically relevant to include any treatments that were discontinued during the review period. For long-stay individuals, it is acceptable to consider the impact of previous treatments and responses on current treatment for only the preceding 12–24 months. The narrative is a synthesis and not a chronological listing of previous treatments.

Present Status

This section includes a clear description of the individual's current overall status as it pertains to the time period being reviewed (i.e., monthly, quarterly, or annual). It provides a clinical picture across relevant multiple domains, current efforts to provide treatment, and discharge readiness. Again, it is written as a synthesis rather than a chronological listing. The narrative usually begins with symptom status and includes any current signs and symptoms of psychiatric disorders, maladaptive behaviors, and psychological distress. For each symptom, there should be the current interventions (i.e., appropriate medications, psychosocial interventions, and behavioral interventions) and the responses to them. Then there should be a description of all medical conditions, with an update on their current status and treatment and any medication side effects.

This is followed by the current status of any risk profile—psychiatric, medical, or behavioral (e.g., violence, suicide, assault)—or other vulnerabilities covered under predisposing, precipitating, and perpetuating factors. Examples of medical risks include: bowel obstruction, choking, pneumonia, diabetes, falls, fractures, blood or body fluid diseases, metabolic syndrome, osteoporosis, seizures, refractory seizures, status epilepticus, electrolyte imbalance, impaired skin integrity. Include all incidents and behavioral events such as aggressive acts to self, aggressive acts to others, alleged abuse/neglect/exploitation, illicit substance use, property destruction,

elopement, specified observations, restraints, seclusion, suicide, victimization, and unsubstantiated allegations.

Then follows a description of functional status in terms of what the individual is able to do at present (e.g., self-care, adherence to the recovery plan, skills, and strengths). The focus is on skills that may be considered essential at the next level of care (e.g., ADL skills, job skills, independent living skills). It should include a description of the individual's attendance and participation in the PSR Mall groups, level of achievement with current objectives and interventions, and the rationale for changing or maintaining goals, objectives and interventions. It is useful to incorporate any cultural issues that may impact the individual's interventions and wellness and also any general wellness concerns, and areas in need of further intervention. Finally, if applicable include current legal status as related to discharge status.

Preferred Method of De-escalation

Occasionally individuals get irritated, agitated, or aggressive. Often staff can de-escalate the situation by engaging in methods that the individual has found to be particularly effective in the past. In this section, include any de-escalation methods that the individual, on becoming upset, would prefer the staff to use. For example, key information from the initial Personal Safety Interview (see Table 6.3), and updated information based on staff observations, can be included in this section. The key issue is that the information should be practical—staff should be able to understand and use the information to preempt maladaptive or challenging behavior.

Diagnosis

Typically, this information is aligned with the most recent psychiatric evaluation or psychiatric progress note. Documentation of diagnosis is included, with separate notations for psychosocial and contextual factors, as well as disability.

Individual's Life Goals

This is a statement of the individual's vision of recovery, including dreams, hopes, and aspirations. It may include what the individual would like to do while at the hospital, but it is intended to help the individual envision life following discharge. It is best stated as quotations in the individual's own words. If the individual declines to state life goals, document this. The individual's life goals are elicited in strength-based conversations prior to a RPT conference, but never during it. If the RPT feels that the individual's life goals represent delusional thinking, the team records what the individual has stated anyway. However, the team revisits and revises the life goals periodically as the individual's psychiatric condition improves. The main thing to remember is that, notwithstanding any mental illness, it is critical to know what the individual envisions his or her life could be, if given hope and tools for recovery (Shafer et al. 2016). The individual's life goals are updated periodically as they change depending on current recovery status.

Discharge Process

Reason for Admission

This includes a brief statement of the reason(s) why the individual was admitted to the hospital. The statement includes the precursor behavior that resulted in the admission. For example, if the individual was admitted for assault, assault or aggression would be the reason listed, but what is more important for informed intervention is what led to the aggression (e.g., medication non-adherence worsened the individual's underlying psychosis, and the assault occurred during a psychotic episode). At admission, it would be important to assess why the individual was medication nonadherent, and the inpatient treatment or training should focus on this reason.

If an individual is admitted for a pretrial forensic evaluation or competency restoration, this should be stated as the reason for admission, as well as the specific current symptoms or

Table 6.3 Personal safety interview

INSTRUCTIONS: Interview the individual to complete this form or give it to the individual to complete (if preferred). Information can be updated through staff observations.

1. What are some of the things or "triggers" that make you irritated, upset, or angry?

Being Touched	Bedroom door open	Particular time of day (When?)
Loud noise	Being isolated	Time of year (When?)
People in uniform		Being around men or women
Not having control (explain):		
Other (Please list):		

2. It is helpful for our staff to be aware of how you might behave when you get irritated, upset, or angry. How will our staff know that you are getting upset? What behaviors should they look for? (That is, do you start pacing the floor? Do you begin talking to yourself? Do you clench your fists?)

_____
_____
_____

3. How can staff members help you when they notice that you are getting irritated, upset or angry? (That is, what should they do, not do, say or not say when they notice you are getting irritated, upset or angry?)

_____
_____
_____

4. Do you have preferences or concerns regarding who serves you (such as gender, race, language, culture)? ☐ Yes ☐ No
If yes, describe:

_____
_____

5. Seclusion and Restraint:
Have you ever been placed in a seclusion room? ☐ Yes ☐ No
Have you ever been restrained? ☐ Yes ☐ No
If yes, what led up to the incident(s)? Tell me about the experience(s) for you:

_____
_____

(continued)

Table 6.3 (continued)

6. Is there anything you find helpful in emergency situations that could prevent seclusion or restraint being used? ☐ Yes ☐ No
If yes, describe:
_____
_____

7. Do you have any medical conditions or physical disabilities and limitations that may place you at risk if seclusion or restraint is used? ☐ Yes ☐ No
If yes, describe:
_____
_____

8. If you have to be placed in seclusion or restraint to help keep you and others safe, would you want us to notify someone? ☐ Yes ☐ No
If yes, what is that person's name and telephone number and his/her relationship to you?
_____
_____

9. Does it bother you if people get close to you and touch you? ☐Yes ☐No
If yes, describe:
_____
_____

10. Trauma History:
Have you experienced any incidents of: (a) Physical abuse? ☐ Yes ☐ No
(b) Sexual abuse? ☐ Yes ☐ No
If yes, are there things that remind you of the abuse and are difficult for you or cause you to act differently? ☐ Yes ☐ No
If yes, describe:
_____
_____
Would you find it helpful to discuss these issues with staff? ☐Yes ☐ No
Would you like more information on these issues in classes or support groups?
☐Yes ☐ No

11. Is there anything else you would like to tell me or discuss? ☐ Yes ☐ No
If yes, describe:
_____
_____

_____ _____ _____
Date/Time Individual's Signature RN's Signature (Print and sign name)

behaviors that prompted the need for the evaluation or restoration. Also to be referenced are any evaluations that bear on the legal status (e.g., if newly admitted as Incompetent to Stand Trial (IST), what information in the pretrial report is relevant to the finding of incompetency). For forensic admissions, it is critical that only the official account (i.e., law enforcement or court documentation) is used, so that potentially discoverable, legally prejudicial information revealed by the individual is not recorded on his or her chart.

If it is a civil commitment, the narrative should explain the clinical condition and behavior that warranted hospitalization. It is best to describe the specific context of the individual's behavior that led to the hospitalization. If it is a readmission, the reason why the individual was not able to maintain community placement should be clearly stated. Being specific in describing the reason (i.e., the precipitating behavior) helps the PRT and the individual to collaboratively develop goals, objectives, and interventions for overcoming barriers to maintaining community placement upon next discharge.

Discharge Criteria for Anticipated Placement

Anticipated Placement. This is where the individual may be discharged to when discharge ready, or with the court's agreement. If known, the name of the placement is provided; if unknown, the generic class of placement is stated (e.g., independent living, supported apartment, group home). In the recovery model, placement consideration begins at the highest independent level (e.g., independent apartment with supportive services) and works its way down to lower levels, if necessary.

Discharge Criteria. Typically, the hospital's discharge criteria are the admission criteria specified by the receiving agency, or those determined by the legal system (i.e., the penal code specifies competency requirements). The criteria are individualized and, as much as possible, are stated in behavioral and measurable terms. The criteria should be written in simple and clear language in terms of what the individual must do in order to be discharged to a specific place. If a specific placement is not available, the RPT can work on the basis of what the individual must do to be discharged to the most integrated setting available in the community.

The discharge criteria are written in language that the individual understands at first reading. A good way to do this is by (a) discussing each discharge criterion with the individual, (b) asking the individual to restate each criterion in his or her own words, and (c) if stated correctly, recording the individual's version of each discharge criterion. This will ensure that the individual has understood what he or she needs to do and, when the discharge criteria are read to that individual again, will understand these correctly without further discussion or training. It is useful to remember that the discharge criteria are written in terms of what the *individual* needs to do to be discharged. The criteria should be clinical in nature (with the exception of those individuals with a forensic legal status) and translate into goals, objectives, and interventions in the IRP, based on prioritized needs as determined by the individual's RPT.

Discharge Plan

The discharge plan is a chronological sequence of all tasks that hospital staff (i.e., Social Worker, Case Manager, RPT) and/or community agencies will initiate and complete that will enable the individual to be discharged when the last item on the discharge plan is completed and all discharge criteria have been met. For accountability, the actual names of hospital and community agency staff responsible for each step, as well as realistic timelines, are listed. The timelines are specified only for the initial steps, with further timelines provided at successive reviews of the discharge plan. The discharge plan includes action steps specific to the individual as opposed to generic plans that may vaguely apply to all hospitalized individuals. The discharge plan does not pertain to the clinical services that staff provides to the individual (e.g., PSR Mall group, individual therapy), as these are addressed in the goals,

objectives, and interventions in the IRP. The discharge plan is written in terms of what the *staff* needs to do to enable the individual to be discharged expeditiously. A person-centered discharge planning is accomplished in collaboration with all stakeholders, the individual, hospital staff, family, and friends, as well as the community providers. As the RPT determines appropriate community treatment services, it is important to identify other resource needs that an individual may need to achieve successful community tenure. These resource needs may include assisting the individual to obtain both federal and state-funded programs to assist with housing, medical and prescription insurance, transportation, and so on.

The discharge plan for pretrial evaluations and individuals designated as IST should state that they are discharged to the jail as competent. All notifications and recommendations given to the jail regarding continuity of care (e.g., continued medication, suicide watch, conditions needing monitoring/observation) are included in the discharge packet. If the charges are minor and it is likely that the individual will be discharged from the jail to the community, then the standard discharge plan is followed.

Discharge Barriers

These include all systems barriers that arise from implementing the action steps in the Discharge Plan such as legal issues, shortage of a specific type of housing, financial resources, citizenship status, and so on. Only those barriers that are actually encountered when implementing the action steps are listed, as opposed to anticipated barriers. Legal status is not a discharge barrier until the court has denied the hospital's recommendation for consideration of release (e.g., waiting on a court date is not a discharge barrier). Until an actual barrier is identified, it is useful to note, "None identified at this time." When a barrier is identified, the RPT ensures follow up in terms of steps that will be taken to overcome it.

Typically, discharge barriers do not include the clinical status of the individual (e.g., psychiatrically unstable, major medical problems, psychiatric or behavioral decompensation) because this is covered in the individual's IRP. An exception is that they may include any behaviors that the individual engages into thwart placement (e.g., when discharge is imminent, the individual engages in aggressive behavior to purposely delay discharge). When such a barrier is identified, it is followed up with an assessment and appropriate treatment, and documentation in the goals, objectives, and interventions.

Goals

A goal statement documents an assessed treatment, rehabilitation, or recovery need of the individual. In non-recovery terminology, it is the "problem statement" described in behavioral terms. As much as possible, the RPT members collaborate with the individual in determining his goals before developing goal statements. The goal statements are kept realistic and simple by defining the goal as clearly as possible. Forensic goals follow the same basic format, but Forensic RPTs need to be cognizant of the individual's legal status and prioritize goals and objectives based on the reason for the forensic admission.

Goals for Competency Restoration

For individuals who are admitted for competency restoration, the primary goal is to describe the behavior that is believed to be the underlying cause of the individual's inability to participate in court proceedings. The goal should not be simply "Restore the individual to competency." The goal should explain the factors that are leading to incompetency and then the objectives should specifically target these factors. An individual who, due to cognitive impairments, is not competent to understand the roles of courtroom personnel or the adversarial nature of court proceedings, would have a very different recovery plan from that for an individual who cannot work with an attorney because that individual thinks the attorney works for the CIA.

Goals for Pretrial Evaluations

For individuals who are admitted for pretrial evaluations, the primary goal focuses on the

reason for the evaluation being completed on an inpatient basis. As most pretrial forensic evaluations are completed on an outpatient basis, the rationale for bringing an individual for evaluation as an inpatient is critical and should be clearly delineated in the goal statement. If the reason is an attempt to make the person competent on a pretrial basis (circumventing the long IST process), then everything under Competency Restoration applies. If it is to rule out malingering, then the first goal should be related to clarifying a particular behavior (i.e., the behavior that gives rise to the suspicion of malingering). It is not enough to simply state, "rule out malingering;" the suspected malingering behavior needs to be stated so that all staff members will know what behavior they are to observe. Given that the recovery plan is shared with the individual, the context and explanation for this goal should be carefully crafted. An example of a thoughtfully crafted goal would be, "Mr. Dempsey is being evaluated for his competency to stand trial. His self-reported symptoms of seeing little green men and elephants as well as his use of nonsense words in sentences could potentially interfere with his ability to assist his attorney. The goal for this hospitalization is to determine whether the current symptoms are related to a mental illness and for Mr. Dempsey to be able to participate in his trial without symptom interference."

Goals for Civilly Committed ISTs or NGRIs

For individuals with civil commitment designations of IST or Not Guilty by Reason of Insanity (NGRI), the recovery plans would look very similar to mental health recovery plans for long-term stay individuals, emphasizing skills needed to live in the community. Due to a focus on the safety of the individual and the community, the plan should also specify factors identified as contributing to the index offense(s) and any significant historical aggression, and how those risk factors have been ameliorated or managed.

Objectives

Once a goal is clearly defined, the RPT members develop the steps the individual can take to accomplish the goal. When a goal is broken down into small steps then the individual can incrementally engage to achieve it. These small steps form the objectives for the individual. So an objective is written in terms of what the individual is capable of doing to achieve the goal. An objective is always an action statement, e.g., "John will learn (or use) a mindfulness-based strategy to self-manage his rising anger when he cannot get what he wants." In addition, the objective is written in behavioral, observable, and/or measurable terms, and in language that the individual will understand easily and is free of jargon. To make it measurable, it includes performance and termination criteria. The majority of the objectives in a recovery-focused IRP are learning-based, but a few may be service-based. Learning-based objectives are those where the objectives specify what the individual will learn. Service-based objectives are those where the staff, usually the individual's psychiatrist and nursing staff, provides a service to the individual (e.g., prescribe or administer medication, provide specific medical treatments).

Recovery team members use these basic principles when developing or revising learning-based objectives. Each objective is (a) linked to a goal of hospitalization, (b) written in terms of what the individual in recovery is going to learn or do, (c) written in behavioral, observable, and/or measurable terms to provide the individual and staff with specific thresholds for measuring outcomes of interventions, (d) focused on what the individual can do within a specific timeframe, (e) attainable given the individual's current level of cognitive functioning and engagement level, (e) functional and meaningful to the individual, and (f) taught within the context in which the individual will use the skill. In addition, each objective should pass the *dead man's test*, which means that it should focus on not only what the individual should not do (e.g.,

not engage in aggressive acts for 6 months)—which a dead person can pass—but also alternative positive behaviors (e.g., learning anger management skills). Furthermore, each learning-based objective includes the following four components: (a) what the individual will accomplish (e.g., learn, identify, state, demonstrate, discuss, read, draw, play, make, and so on) in measurable terms, (b) a performance criterion, (c) a termination criterion, and (d) where the individual's performance will be documented.

Interventions

Interventions are written in terms of what staff will do to assist the individual achieve the relevant objective. There are two types of interventions: (1) those that pertain to PSR Mall groups (i.e., those typically referred to as active treatment and which count towards the 20 h that individuals are typically scheduled to attend per week), and (2) those that are done in the units (i.e., service interventions).

As noted above, in a recovery model of mental health service delivery system, it is important to consider the concept of stages of change. For example, an individual's substance abuse may be serious enough to interfere with the individual's quality of life, and therapists may think that the person needs to be in treatment. Whether the individual agrees with this assumption or recommendation will depend on the individual's understanding of the disorder, the need for treatment, and agreement to engage in appropriate treatment. To determine the approximate level at which treatment should begin, a clinician (usually a clinical psychologist) assesses the individual's stage of change using the *University of Rhode Island Change Assessment* (URICA).

The following are the five stages of change:

1. **Precontemplation** is the stage in which individuals have no intention of changing their behavior in the foreseeable future. Many individuals in this stage are unaware or not fully aware that they are addicted to one or more substances.
2. **Contemplation** is the stage in which individuals are aware that a problem exists and are seriously thinking about overcoming it, but have not yet made a commitment to take action.
3. **Preparation** is a stage that combines intention and behavioral criteria. Individuals in this stage intend to take action or have just started to take action. These individuals may have unsuccessfully taken action in the past.
4. **Action** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their addiction. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
5. **Maintenance** is the stage in which individuals work to consolidate the gains attained during action, and to prevent relapse.

An assessment of an individual's stage of change, as well as readiness to engage in treatment or rehabilitation, provide the RPT with a starting point for developing interventions and affording the individual choice in selecting one or more PSR Mall groups or individual therapy that are appropriate for that individual. In general, an individual at the precontemplation level will benefit most from therapies that aim to change cognition, i.e., the individual's thinking about his or her condition or functional status. An individual at the other end of the continuum will benefit most from behavioral or action-oriented therapies (see Table 6.4). Interventions for substance abuse are written in exactly the same manner as for other objectives, but are aligned with the mall group or individual therapy offered at the same stage of change, as stated in the objective.

Deferred Issues

Occasionally, there will be issues that RPT members know about and wish to include in the individual's IRP, but cannot do so because the individual does not have the prerequisite skills, the needed supports have not been developed, or the individual's anticipated length of stay is too

Table 6.4 Stages of change continuum and matching of interventions

Stages of change continuum	Approaches to psychiatric rehabilitation
Stage 1: Precontemplation	
• Denial • Defensive • Unwillingness to change • Feels coerced into treatment • Pressured by others to seek treatment • Uncommitted or passive in treatment • Unaware of having a disease, disorder, disability, or deficit • Unaware of the causes and consequences of the disease, disorder, disability, or deficit • Unaware of the need for treatment and rehabilitation • Lack of motivation to engage in treatment and rehabilitation • Pros of the behavior outweigh the cons	• Consciousness-raising interventions, e.g., sharing observations, confronting the individual with specific consequences of their behavior • Therapeutic alliance or relationship building with the practitioner; understanding and emotional relationship • Nonpossessive warmth—the practitioner relates to the person as a worthwhile human being; shows unconditional acceptance of the person (as opposed to the behavior, e.g., addiction, offense) • Empathic understanding—extent to which the practitioner understands what the individual is experiencing from the individual's frame of reference • Catharsis—expression of emotion; practitioner engages in active listening skills, empathic observations, and gentle confrontation (reality checks) • *Motivational interviewing*—a person centered, directive method for enhancing intrinsic motivation to change by helping the individual to explore and resolve his or her "issues;" practitioner facilitates the individual to resolve his or her ambivalence with regard to change. Based on four general principles for practitioners: express empathy, develop discrepancy, roll with resistance, and support self-efficacy • *The intervention*—confronting the individual in a nonjudgmental, caring, and loving manner • *Node-link mapping*—a visualization process tool that enables practitioners and individuals to develop and study the relationships between and among nodes (circles or squares) that contain elements of ideas, feelings, actions, or knowledge. Builds alliance between practitioner and individual, focuses the individual's attention on areas of concern, and enhances treatment readiness • Practitioner approaches—authoritarian approaches to behavior change lead to greater resistance to engage in change • Practitioner emotional well-being—poor emotional well-being inhibits an individual's progress, positive well-being facilitates positive intervention outcomes
Stage 2: Contemplation	
• Aware of their issues ("problems") • Knows the need for change • Not yet committed to change • Wants to know more about their issues • Not yet ready to engage in change process • Thinking about engaging in change process • May have attempted to take action in the past • May be distressed with their situation • May express a desire to take control of the situation • Assessing pros and cons of their behavior and of making changes	• Continue with precontemplative stage consciousness-raising interventions and slowly introduce new interventions • Receptive to bibliotherapy interventions • Receptive to educational interventions • *Presuppositional questions* (from SFT)—used to encourage individuals to examine and evaluate their issues, situation, or predicament. Practitioners can use presuppositional questions to think about change in a non-threatening context. As an example, consider an individual who thinks he does not have a problem and is waiting to be released to CONREP. The practitioner's

(continued)

Table 6.4 (continued)

Stages of change continuum	Approaches to psychiatric rehabilitation
	presuppositional question could be, "Let's agree that what you are saying is true… 'How would you know when you are ready to be released to CONREP?'" • *Circular questions*—used in a nonthreatening manner to ask a question about the individual's issues, situation or predicament from the perspective of an outsider. Consider the individual used in the example above. The practitioner may ask: "How would the CONREP representative know when you know that you are ready to be released?" • *Miracle questions* (from SFT)—used as a method to assist an individual in imaging change and with goal setting. Classic example: "Suppose you go to bed tonight, and while you are asleep a miracle happens and all your issues, situations, or predicaments disappear. Everything is resolved to your liking. When you wake up in the morning, how will you know that the miracle happened? What would be the first thing you would notice that is different?
Stage 3: Preparation	
• Ready to change—behavior and attitude • Needs to set goals and priorities for future change • Receptive to treatment plans that include specific focus of interventions, objectives, and intervention plans • Ready to engage in rehabilitation • Engaged in change process • Cons of not changing outweigh pros	• Continue with contemplative stage awareness enhancing interventions and slowly introduce new interventions • Practitioners encourage the individual's sense of "self-liberation" and foster a sense of personal recovery by taking control of his or her life • Discrimination training and stimulus control interventions can be introduced at this stage. The practitioner enhances the individual's awareness of the conditions that give rise to his issues, situations, or predicaments. Focus is on the presence or absence of antecedents, setting events, and establishing operations • *Scaling question* (from SFT)—used as a tool by the individual to "buy into" the treatment planning process. Practitioners can use it to obtain a quantitative measure of the individual's issues, situation, or predicament, as perceived and rated by the individual and then assist the individual to think about the next step in the change process. Example: "On a scale of 1–10, with 1 being totally not ready and 10 being totally ready, how would you rate your current readiness to be discharged to CONREP?" If the individual self-rates as a 4, the practitioner can follow this up with, "During the next month, what steps can you take or what can you work on to get from 4 to 5?" Scaling questions can be used to (a) obtain a quantitative baseline, (b) assist the individual to take the next step in the process of recovery, and (c) encourage the individual to achieve recovery by successive approximations (i.e., in incremental steps—one point at a time, one month at a time)
Stage 4: Action	
• Committed to and is engaged in change process • Demonstrates motivation to change • Follows suggested change processes and activities	• Cognitive-behavioral approaches • Explore and correct faulty cognitions—catastrophizing, overgeneralizing, magnification, excessive

(continued)

Table 6.4 (continued)

Stages of change continuum	Approaches to psychiatric rehabilitation
• Makes successful efforts to change • Develops and implements strategies to overcome barriers • Requires considerable self-effort • Noticeable behavioral change takes place • Target behaviors are under self-control, ranging from a day to six months	responsibility, dichotomous thinking, selective abstraction • Learning-based approaches • Action-oriented approaches • Skills and support rehabilitation
Stage 5: Maintenance	
• Meets discharge criteria • Is discharged • Maintains wellness and enhance functional status with minimum professional involvement • Lives in environments of choice • Is empowered and hopeful • Engages in self-determination through appropriate choice-making • Develops and implements strategies to sustain and enhance wellness • Avoids relapse through positive action • Expresses fear or anxiety about relapse • Avoids high risk behaviors or situations that may trigger relapse • Engages in a variety of wellness activities • Seeks social supports for maintaining wellness	• Adapt and adjust to situations to facilitate maintenance • Develop and use personal wellness recovery plans • Utilize coping skills in the rhythm of life, without spiraling down (i.e., if substance use is a problem, cope with distressing or faulty cognitions without using drugs) • Continue with dynamic change process • Accept that change is a spiral rather than a linear process • Strengthen social supports and build alliances in the community • Learn about mindfulness, especially unconditional acceptance, loving kindness, compassion for self and others, and letting go • Practice and use mindfulness strategies in daily life
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short to even begin working on the particular issue or problem. In addition, when an individual has too many goals and objectives, there is a need to prioritize them in terms of what the individual can focus on immediately, leaving the rest as substitutes after these are achieved. In this section, the RPT lists all issues that have been deferred, including the reason for deferral. If there are absolutely no deferred issues, the RPT may state, "No deferred issues at this time." It will be very rare for an individual not to have at least one deferred issue.

Deferred issues include only those that the RPT plans to address during the current hospital admission, or refer to the community if the individual is discharged before the team is able to address them. Deferred issues cannot be high-risk issues (e.g., aggressive behavior), or medical conditions for which the individual receives or must receive treatment (e.g., pre-diabetes). RPTs review and update the deferred issues at each scheduled review of the individuals' recovery plan.

Social Support

This is a list of all persons that the individual has approved as members of his or her social support group that can be contacted on behalf of the individual. It is updated periodically because an individual's social supports may change with length of stay at the hospital.

Psychosocial Rehabilitation Mall (PSR Mall)

A PSR Mall is a centralized approach to delivering services that enables an inpatient hospital to maximize the therapeutic time for the individuals it serves by providing them with an array of mental health services that they can select from and attend (Bopp et al. 1996; Matthews et al. 2015; Webster et al. 2009). As much as possible, mall interventions are provided in the context of real-life functioning and in the rhythm of life of each individual. Thus, a PSR Mall extends

beyond the context of a building or place, and its services are based on the needs of the individual, and not the needs of the program, the staff, or the hospital. PSR Malls are designed to ensure that each individual receives intensive and individualized services to promote that individual's increased wellness, enhanced quality of life, and the ability to thrive in the community. All decisions regarding what is offered in a PSR Mall are driven by the needs of the individuals served. Mall services are provided in an environment that is culturally sensitive and strength-based.

Hours of Attendance

An individual is typically scheduled to attend groups for four hours a day (i.e., two hours in the morning and two hours in the afternoon, each weekday) in a PSR Mall that is usually in an off-residential location. These services are directly linked to an individual's assessed needs and documented in the intervention section of his or her IRP. The interventions include the treatment, rehabilitation, and recovery needs of individuals. Services provided in the PSR Mall include groups, individual therapy, and activities designed to help with symptom management, personal skills development, and life enrichment. The PSR Mall capitalizes on clinical and support staff resources from the entire hospital, to provide a larger diversity of interaction and more realistic experiences for all individuals attending the mall groups.

Choice of Groups

The choice of a PSR Mall group begins with an assessment of the individual's needs in terms of treatment, rehabilitation, and enrichment. Assessed needs are written as goals for the individual, as described above. Each goal has at least one objective, which is written in terms of what the *individual* needs to do, and for each objective there is at least one intervention—within a PSR Mall group or in individual therapy. In addition, it is expected that what is taught in the PSR Mall group or individual therapy is reinforced in the therapeutic milieu. The individual makes a choice of PSR Mall group based on the relevant mall groups or individual therapies identified by his or her RPT. Typically, an inpatient service will have a PSR Mall catalog of mall groups and individual therapies that the individual can consult before being assigned to a mall group of his or her choice.

As an example, when an individual has an objective to learn a coping strategy, the RPT may:

1. Review the PSR Mall catalog for all groups that teach coping strategies and find likely groups (or individual therapies) that would enable the individual to learn the required coping strategy;
2. Sort out any qualifiers that narrow down the choices (e.g., stage of change, cognitive level, learning style, group size, mode of presentation, time of group);
3. Present to the individual the relevant groups, describing their characteristics;
4. Request the individual to choose one group for this objective; and
5. Assign the individual to the group the individual has chosen.

The choice is not between what the individual would like to do (e.g., play volleyball) and a PSR Mall group (e.g., coping skills group), but between groups (or individual therapy) that the RPT has identified would help the individual fulfill an assessed need for treatment, rehabilitation, or enrichment. However, group selection can include simultaneous consideration of what the individual likes to do and what the individual needs to be able to do; they do not always have to be mutually exclusive. For example, for an individual who likes to play sports, but who has anger problems, a tai chi or a power yoga group might be appropriate choices for learning anger management. For an individual who likes to play music, but who lacks social interaction skills, a rhythm instruments group may benefit the learning of social skills. This can facilitate motivation and promote adherence to and participation in groups that an individual needs to attend in order to meet discharge criteria.

The total number of groups, and frequency of attending groups is linked to the individual's discharge criteria, and mental and cognitive status. For example, if the individual needs to control physical aggression as a condition of discharge, it would help the individual to have a higher dosage of an anger management group. Thus, the individual may be scheduled to attend an anger management group three times a week, but only one volleyball group a week, as an enrichment activity. Similarly, if an individual has been admitted for competency restoration, the dosage could be at least one PSR Mall group per day, depending on mental and cognitive status.

Levels of Support in PSR Mall Services

The RPT determines the level of support that an individual needs in a particular PSR Mall activity, given the individual's cognitive level, strengths, and weaknesses. The RPT psychologist is responsible for providing the PSR Mall with the individual's level of cognitive functioning. Levels of support can be graded as follows:

1. **Advanced**: Mall activities labeled as "advanced" would be reserved for those individuals who can self-start and direct their own learning with little assistance. These individuals also might be able to teach others.
2. **Independent**: Mall activities labeled as "independent" are aimed at individuals who have the basic skills necessary to continue in a mall activity without any special assistance in learning. These individuals can listen to a facilitator, take basic notes, ask and answer questions without much stress or difficulty. Individuals in an independent mall activity could take a written pre- and post-test.
3. **Assisted**: Mall activities labeled as "assisted" are aimed at individuals who have learning deficits that may require additional support (i.e., reading/writing deficits, poor listening comprehension, short attention spans), but have the basic skills necessary to partake in a mall activity. The content of these courses would not require individuals to do much independent work (i.e., homework) unless a study hall or tutor was available to assist at other times. The in-group content of these classes may include more activities and experiential exercises (i.e., games, role plays) than traditional "chalk and talk" groups.
4. **Supported**: Mall activities labeled as "supported" provide the highest level of support to an individual. Individuals appropriate for these activities mostly struggle to function independently, particularly when it comes to learning. Supported activities might involve individuals who do not possess even the most basic skills to participate effectively in a mall activity (i.e., sitting still for periods of time, turn taking, tolerating others). The staff to individual ratio in these mall activities would probably be no less than 1:3.

Delivery of Interventions in Groups

The majority of services offered in a PSR Mall are in a group format. Although the group is the context for providing treatment, rehabilitation, or enrichment activities, the majority of the groups do not have a group objective. That is, all groups in core service areas have a theme or focus (e.g., job skills, ADL skills, social skills, coping skills, anger management), but each individual's objective is taught within the group. For example, in a social skills group, Katrina may have an objective to refine turn-taking skills in dyadic interactions while Sandi may have an objective to increase her social conversations. In some cases, the group objective may be the same as the individual's objectives. For example, a group objective may be to teach individuals to play basketball and all individuals enrolled in the group may have an objective in their IRP to learn to play basketball as an enrichment activity.

Individual Therapy

If the RPT assesses that an individual requires individual therapy, this is provided. As for PSR

Mall groups the requirements for individual therapy are that:

1. There is an objective in the IRP that requires the individual to participate in individual therapy for a specific purpose;
2. The objective states how progress will be measured;
3. The intervention corresponding to the objective specifies who will provide the individual therapy; and
4. Progress is assessed prior to the individual's next scheduled RPT planning meeting.

The individual's progress is quantified as much as possible for both groups and individual therapy. Some hospitals may require that individual therapy can be provided outside of regular PSR Mall hours because of staffing issues. Individual therapy provided as a requirement in the IRP will be counted as a part of the individual's active treatment regardless of when or where the therapy is provided. Individual therapies vary in scope and include, among others, psychopharmacological treatment (Van Sant 2016), psychological services (Phillips 2016), and nursing services (Myers 2016).

Nonadherence to Therapy

By the second monthly IRP the individual is scheduled to attend 20 h of therapy each weekday, or there should be clinical justification documented in the Present Status section for fewer scheduled hours. While individuals do not have the option of unilaterally dropping out of scheduled group or individual therapy, they often do. If an individual does not attend PSR Mall groups, the RPT should develop alternative strategies for encouraging the individual to re-engage in them. The team may refer the individual for assessment of the reasons for nonadherence and for subsequent treatment, using cognitive behavior therapy, motivational interviewing, node-link mapping, or other evidence-based interventions. Of course, this assumes that at least some of these therapeutic services are offered in the PSR Mall.

Engagement in the PSR Mall

In the context of recovery, engagement is the process of encouraging an individual to fully participate in not only the process of treatment, but also its content (Jackman 2016). Clinicians often rely on their therapeutic alliance with the individual to involve and motivate the individual to engage in treatment (Jackman 2014). A majority of individuals attend, participate, and learn new skills in their assigned PSR Mall groups. Their engagement is dependent on a number of factors that include personal motivation, the goodness of fit between what the individual needs and what is offered, the nature of the group, the ability of the group facilitator to make the group process and learning interest, boredom, and personal variables (e.g., medication effects, cognitive level, stage of change).

A PSR Mall group facilitator can enhance engagement by using various "tested" techniques that have proven to be effective teaching tools. These include some of the following techniques.

Cold Call

Group facilitators like to engage all members in their group by asking questions, waiting for a show of hands, and then choosing someone with a raised hand. However, this often leads to only a few individuals actively participating while others drift into inattention and other activities (e.g., sleep, daydreaming). What would be ideal is for all individuals in the group to pay attention and anticipate being called upon to answer questions, regardless of whether they raise their hands or not. Cold Call is a system that encourages all group members to pay attention, to prepare answers to all questions in their minds, but to respond only when called upon.

A prerequisite for Cold Call is that the group facilitator has the names of all group members. The procedure is simple: The facilitator asks a question, and then calls on the group member to answer the question regardless of whether a hand is raised. After a short while, the group members will realize that the facilitator may call on anyone in the class, so everyone must be ready to answer

the question. This will: (a) increase engagement by the group members; (b) decrease and eventually eliminate inattention and daydreaming; (c) increase learning time because the group facilitator does not have to ask a question, wait for individuals to raise their hand, ask individuals other than the usual three or four members to raise their hand, ask an individual to respond, and then wait for an answer—the facilitator asks a question, and then immediately asks an individual to respond; and (d) it enables the facilitator to distribute the questions broadly across the group members—it signals to them that not only are they likely to be asked, but also the facilitator is interested in their answers and opinions. They had better be prepared!

Used skillfully, Cold Call is very productive in encouraging engagement by individuals who are shy or reluctant to raise their hands. If used consistently, it is predictable—it builds an expectation that anyone can be asked a question. Thus, it is a positive behavior change technology; group members begin paying more attention and mentally prepare answers in anticipation of being asked a question. Some group facilitators keep a visible chart that tracks who has been called upon, thereby sending a clear message that everyone gets their share of questions, and that engagement is an expectation, not a choice.

Scaffolding

Most groups have individuals at different cognitive levels, with varying degrees of knowledge of the topic covered by the group. Scaffolding can be paired with Cold Call very effectively, especially if the group facilitator begins with simple questions and progresses to more difficult ones in each session. This enables the group facilitator to engage all group members at their skill level, reinforcing what they already know and challenging them to learn more by listening to others in the group with greater knowledge of the topic.

Typically, a group facilitator begins with a simple question that is at the skill level of a group member to whom the question is directed. Once this individual is engaged, the group facilitator "unbundles" a single larger question into a series of smaller but graduated questions, and directs the questions at the skill level of successive group members, ending with the most difficult question directed at the most accomplished group member. The sequence involves calling on several, though not necessarily all, group members in rapid succession with incrementally more difficult questions. Scaffolding enables the group facilitator to parse a question to multiple group members instead of just one, thus increasing group engagement, learning, and cohesion. One useful strategy is to begin with what the group members learned in prior sessions, and then move the questions systematically into the topic that is to be covered in the present session. This enables the group members to think their way into the next topic.

Cold Call and Scaffolding work best if the group facilitator asks a question, follows it with a pause while the group members formulate their responses, and then asks a specific individual to answer the question—i.e., Question, Pause, Name. This ensures that every group member hears the question and mentally prepares the answer in anticipation of being asked to respond. If the sequence is changed and the individual's name is called first, there is some likelihood that all other group members will sit back with a sigh, knowing that they have been excused from answering at least this question!

Call and Response

In many cultures, call and response is a form of spontaneous verbal and nonverbal interaction between a speaker and listeners in which the statements (calls) of the speaker are punctuated by responses from the listeners. Group facilitators can utilize this form of engagement in a number of ways. For example, the group facilitator can ask a question and ask all members of the group to respond together. The group facilitator can ask questions in rapid succession, and ask different individuals from the group to respond to each question. Another form of this involves the group facilitator directing a question to a specific person, who responds correctly, and then asking the entire group for a response to the same question. This is akin to high-energy performance where there is a lot of fun because the

entire group is involved in calling out the answers to the group leader's questions in rapid succession. It invigorates the entire group, motivates high attendance, and enables learning to occur in the context of positive engagement.

Everybody Writes

In some groups, the group facilitator describes the topic, and follows it with a question to the group. When there is silence, the group facilitator is either flustered or simply answers it and moves on. This is not atypical in many groups. One way of engaging the group members is to give them some time to respond to the question by asking them to write their responses before discussing the answers verbally. Once the group members have had time to write their responses, the group facilitator can use Cold Call and Scaffolding to elicit the group's responses, e.g., "What did you write, Max?" This will promote engagement, both in terms of writing and responding verbally. Using a Participant Workbook will serve this purpose beautifully!

These are just some ways of engaging individuals in mall groups in the PSR Mall. The methods chosen will depend on contextual factors—nature of the topic, group characteristics, motivational level of the participants, cognitive status, skill level of the group facilitator, and so on. However, regardless of how well we do, a minority of group members will be nonadherent. They may refuse to attend the group, or attend but refuse to participate. These individuals may require different kinds of interventions to get them incrementally or fully engaged.

Conclusion

A recovery-focused treatment planning system is based on asking what would make the individual's life better from the perspective of the individual. Given that the individual is in an inpatient psychiatric hospital, it does not mean that the right to recovery is sacrificed in the interests of treating the individual's mental illness by way of symptom control. Indeed, the individual may never need to agree with a diagnosis of a mental illness, as long as that individual knows how to engage in self-care activities when feeling unwell, low, or out of touch with reality. If the individual has developed a set of skills to not only manage in the real world, but also thrive in terms of his or her own goals, then that individual is on a successful path to recovery. In a general sense, recovery is a journey and the journey is the goal. On this journey, the individual invests in experiential and critical interests that provide meaning to his or her life. Like life itself, recovery has its ups and downs, highs and lows, sun and rain, but the individual can learn to navigate through these. The role of clinicians is to support individuals on their particular journey of life.

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