

A TREAT FIRST APPROACH:

ENSURING A TIMELY, EFFECTIVE RESPONSE TO A PERSON'S NEED WHILE ENGAGEMENT, SCREENING, ASSESSMENT, AND PLANNING PROCESSES UNFOLD

PURPOSE OF THIS DOCUMENT

This document provides an overview of a Treat First Approach and describes service elements and activities associated with the first four visits or sessions provided to a person requesting services. It is intended to provide guidance for practitioners who are implementing the practice concepts and steps during a formative testing phase.

BENEFIT OF A TREAT FIRST APPROACH

Approximately 20% of all consumers will believe that their issue is adequately resolved after one visit and will not return for a second visit for positive reasons. Currently, no-show rates in many sites are between 40-60% and are usually because of the client's need (i.e., their reason for requesting services) was not addressed at the first visit. The Treat First Approach corrects the problem of delay by emphasizing the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency:

Use of a Treat First Approach overcomes historic difficulties encountered by a person requesting services of having to wait for help until many required data collection tasks are completed before getting help. Delays discourage some persons from returning for a second visit. Ensuring a timely and effective response to a person's request for services is a first priority in the Treat First Approach. This strategy provides a way to achieve immediate formation of a therapeutic relationship and initiation of a response to the person's concern while gathering needed historical, assessment and treatment planning information over the course of a small number of sessions or visits.

BASIC DESIGN OF A TREAT FIRST APPROACH

Making the most of the initial contact with a person seeking help is recognized as a key to successful engage-

ment and quick results that benefit the person. The Treat First Approach begins with a quick screening, rapid engagement, and short intervention approach in which the reason that a person requests assistance may be addressed or resolved within the span of one to three sessions or visits.

A segment of the population of persons requesting behavioral health services may be served successfully using a short intervention approach. For others who may require longer, more extensive, or specialized interventions, the early steps in the Treat First Approach would enable the service provider to gather sufficient assessment information in order to develop a clinical case formulation and comprehensive service plan by the fourth visit. The concepts, principles, and processes used in the Treat First Approach provide a responsive way of initiating a service process for a person requesting help. Brief intervention techniques such as a Treat First Approach are part of a full continuum of behavioral health care services provided in Certified Community Behavioral Health Centers, Medicaid Health Homes, and other community-based services.

A Treat First Approach provides a useful way of engaging and assisting new persons requesting help from a service provider by providing a quick response to their concerns. Using a Treat First Approach requires that practitioners engaging with the person quickly scan (screen) the person's situation to determine if any presenting factors may constitute a threat of harm to the person or to someone in the person's life. If so, necessary steps are quickly taken to keep people safe or healthy. Thus, the Treat First Approach is used as a non-crisis model. In an identified crisis situation, the practitioner follows the local crisis protocol.

Another quick discernment made by the practitioner involves the prospect that a person's request for help could be resolved within one to three sessions or visits. Some life issues (e.g., coping with the break-up of a relationship or a job loss) may be amenable to resolution with a short intervention. Other life circumstances (e.g., multiple problems, acute psychoses, cognitive inability to focus, severe substance abuse, long history of relapse, low level of social support) for which a person is requesting help may require more intensive and sustained efforts and supports.

Thus, a practitioner should quickly understand the range and severity of presenting problems and the type of services that may be necessary to meet needs and solve problems. Doing so may require conducting additional assessments, using any necessary protective strategies, gathering of collateral information, or involvement of others supporting the person may be determined and accomplished.

STRENGTHENING CLINICAL PRACTICE

Strengthening clinical practice is a goal when implementing the the Treat First Approach. Practitioners employ core practice functions and clinical activities to join with a person receiving services to support a positive life change process that helps the person get better, do better, and stay better.

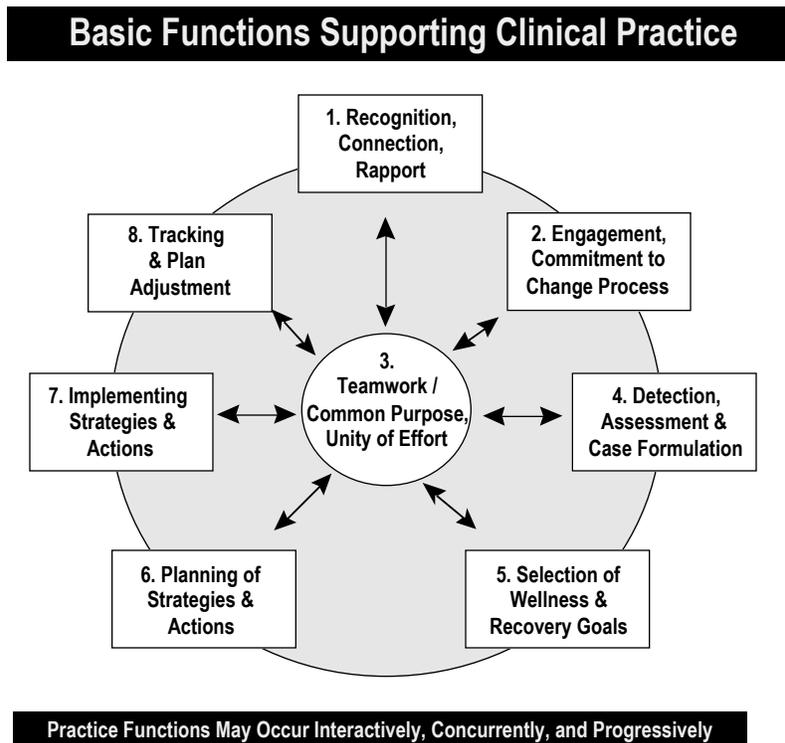
Typical practice functions include: connecting with a person based on a recognition of the person’s identity and situation; detecting and responding to any urgent problems; building positive rapport and a trust-based working relationship; engaging the person in a positive life-change process; understanding the person’s strengths, needs, and preferences; defining wellness and recovery goals to be achieved; building common purpose and unifying efforts

though teamwork (when longer-term services are indicated); planning intervention strategies, supports, and services; implementing plans; and tracking and adjusting strategies until desired outcomes are achieved. The diagram shown below provides a framework of core practice functions typically encouraged by service providing agencies.

The diagram illustrates early and ongoing clinical practice functions that progressively come into action over the course of the first four sessions of the Treat First Approach. Tip Sheets are provided in the *Addenda* for the practice functions used in first order actions of a Treat First Approach. Tip Sheets cover the following suggested core practices and clinical techniques:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Solution focused brief therapy
- Motivational interviewing

Tip Sheets are provided to promote and strengthen clinical practice.



Visit 1

Visit 1 Goals and Activities: General Guidance

OVERVIEW

The first visit focuses only on the person's request for help, clarifying the concern, and beginning a solution-focused intervention process. The conversation should center on the following areas:

- Who and what are important to the person;
- The person's vision of a preferred future;
- The person's exceptions, strengths, and resources related to the vision;
- Scaling of the person's motivation level and confidence in finding solutions;
- Person's expectations in seeking help;
- Ongoing scaling of the person's progress toward reaching the desired future.

TREAT FIRST PRACTITIONERS

A therapist would be the first point of contact if a presenting problem is psycho-social in nature, including relationship difficulties. A Community Support Worker (i.e., CSW/CPSW) may be the first point of contact if the identified problem is social, functional, or involves basic human needs or linkage to community resources.

VISIT 1 GOAL

The goal of the first visit is to gain a full understanding of the presenting problem and the impact of that problem on the person's life. This is done using relationship building skills for Recognition, Connection, and Rapport to build on the person's understanding of his/her concern or situation and what the person wants to be different in the future. The foundational elements of Treat First Clinical Practice applied in the first visit are:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Brief and solution-focused interventions

ACTIVITIES & EXPECTATIONS

Registration. The client completes registration materials before meeting with a therapist or CSW. Basic one or two question screens can be included in the registration materials relative to substance use disorder, depression, risk and

crisis, and trauma. The materials may include a section for the person to list medications and a Community Engagement Checklist indicating current or historical linkages to community resources, identification of a Primary Care Physician (PCP), or other providers. This should allow the therapist or CSW/CPSW to have a quick sense about the status of the individual so to be fully engaged and present with the person rather than consumed with paperwork.

Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning of the session, and how useful and beneficial the session has been in making progress towards achieving the person's desired future. There are four specific questions for both check-in's. If the person is in an immediate crisis that must be addressed before moving on to any other portion of the visit.

Information Gathering. While the first visit is focused on developing a therapeutic alliance and building trust to first address urgent needs, it should also be a time to initiate the gathering of information. This includes information necessary to complete a Diagnostic Evaluation at the conclusion of the fourth visit.

Screening & Assessment. If there are significantly alarming indicators in the responses provided in the registration process, more in-depth screening may be necessary. It is important to ensure the person's safety and that the person understands the boundaries of scope of practice of the practitioner so to set appropriate expectations. Besides the information gathered in the registration process a therapist should complete a Mini-Mental Status Exam (MMSE) as an important part of the first visit and determine a provisional diagnosis. A full MSE (Mental Status Exam) may be necessary pending registration information.

NEXT VISIT & FOLLOW-UP

A second visit is scheduled for the following week and before the person leaves, if warranted.

RECOMMENDATIONS & TIPS

- Using Solution Focused Brief Therapy (SFBT) concepts - See the Tip Sheet in the Addendum.
- Check-in questions and rating scales can be found in the *Addenda*.

Visit 2

Visit 2 Goals and Activities: General Guidance

OVERVIEW

During the second visit, additional historical data are gathered. The focus is placed on medical and behavioral health history, extended support systems, identification of strengths and barriers to treatment, and other issues specifically related to presenting problem(s).

TREAT FIRST PRACTITIONERS

Formative information for developing a clinical case formulation may be assembled, and the beginnings of a treatment or comprehensive service plan are noted.

VISIT 2 GOAL

The service provider discusses with the person the probable number of visits needed to resolve this particular episode of care. If it becomes apparent that the person has a newly identified condition (e.g., SMI or SED) that requires complex rehabilitation services, up to and including psychiatric medication, then a more formal approach to assessment, case formulation, and planning will be initiated.

Foundational elements of clinical practice that may be used or added during the second visit include:

- Recognition, connection and rapport
- Engagement and commitment
- Detection and quick response
- Motivational, brief and solution focused intervention
- Assessment and formulation
- Wellness and recovery goals

These basic practice elements are initiated in visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help. Tip Sheets explaining these elements of practice are provided in the *Addenda* of this document.

ACTIVITIES & EXPECTATIONS

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate

the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Information Gathering. Information for developing a clinical case formulation is being gathered and assembled. With a focus on behavioral health, medical history, strengths and barriers to treatment, extended support systems and other issues related to goals/problem. The provisional diagnosis is further explored utilizing a more formal approach to assessment through various techniques, strategies and diagnostic review tools.

Treatment Planning. Elements of a treatment plan are beginning to develop. Initial wellness and recovery goals are explored. The service provider and the person discuss the possible number of visits that may be necessary to resolve current and/or future goals or problems.

NEXT VISIT & FOLLOW-UP

A third visit is scheduled before the person leaves, if necessary for resolution of the reason that the person is requesting help.

RECOMMENDATIONS & TIPS

Building on the prior functions it is anticipated that from 50 to 65% of all needed data for a diagnostic evaluation, treatment plan (including complete crisis plan if needed), and modified diagnostic review should be available following the completion of the second therapeutic visit.

- Daily Living Activities- Functional Assessment (DLA-20)
- Functional Skills Evaluation
- Motivational Enhancement
- Brief Solution Focused Techniques/Strategies
- How to interpret self/session check-ins

Visit 3

Visit 3 Goals and Activities: General Guidance

These basic practice elements are initiated in Visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help.

OVERVIEW

Therapeutic services provided during a third visit are framed by a substantially sound understanding of the person's diagnostic situation, functional status, and evolving clinical case formulation. Additional targeted data (following local assessment and treatment planning templates) are systematically gathered to flesh-out a shared understanding by the person and provider on how to effectively address the issues raised by the person and to plan a treatment schedule for the remainder of the episode to resolve the issues.

TREAT FIRST PRACTITIONERS

If concurrent completion of the diagnostic evaluation is possible, then the therapist (not the CSW) should complete it and coordinate the completion of the treatment plan (which may involve more than one direct service provider by now) separately from a visit.

VISIT 3 GOAL

Where possible, data gathering for a complete diagnostic evaluation can be completed in this visit, but therapeutic concerns must be the priority. The new critical element - introduced in Visit 3 is Teamwork - common purpose and unity of effort. If completion of the diagnostic evaluation is not possible the person may be invited back for additional visits with the fourth visit ensuring a mutual agreement between the therapist and consumer on the detail in a diagnostic evaluation and the sharing of a completed written treatment plan with the person. This third visit could be billed as either a diagnostic evaluation or as an individual therapy visit.

The foundational elements of clinical practice that may be used or added during the third visit include:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Solution focused brief therapy

ACTIVITIES & EXPECTATIONS

In summary, these are the activities expected to occur during the third visit:

- A Self Check-In is conducted with the person to assess how well he/she is doing at the beginning of the session and what has changed since the last session.
- Services delivered are based on understanding the person's diagnostic situation, functional status and evolving clinical case formulation. The clinical case formulation evolves over time as more knowledge is gained.
- Additional data are gathered to build a shared understanding by client and therapist on how to effectively address issues raised by the client.
- Determination made about what else may be required to resolve this episode of care.
- Need for more visits are discussed along with goals and any new goals to be met.
- Based on goals selected, more specific and detailed treatment plans are developed.
- A treatment schedule is planned to resolve any remaining ongoing issues.
- A Session Check-In is conducted with the person. Rating scale results are used by the practitioner to evaluate the person's perspective on how useful and beneficial the session has been in making progress.

NEXT VISIT & FOLLOW-UP

The likelihood of a fourth visit is largely dependent on the degree to which the person and therapist/CSW have established the person's identified goals and desired outcomes along with a positive therapeutic relationship.

RECOMMENDATIONS & TIPS

Tips sheets explaining these elements of practice are provided in the *Addenda* to this document.

Visit 4

Visit 4 Goals and Activities: General Guidance

OVERVIEW

By the fourth visit, some of a person's issues may have been resolved in earlier sessions while other remaining concerns may require further efforts to address. The likelihood of reaching a fourth visit may depend in part on the degree to which the person and therapist/CSW have identified further goals, achieved progress to some goals, and formed a positive therapeutic relationship. It is expected that the service provider will have a complete and clinically defensible diagnostic evaluation and treatment plan by or upon completion of the fourth visit in any episode of care.

TREAT FIRST PRACTITIONERS

By this fourth visit for persons having serious diagnosis and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs. The treatment team may now consist of not only a therapist and CSW, but other treatment providers such as a Psychiatrist, a Nurse, and Peer Support Specialist and so on may now be part of the person's treatment team.

VISIT 4 GOAL

By the end of the fourth visit, a broader array of clinical practice functions will have begun unfolding. Early and ongoing clinical practice functions progressively come into action over time the course of the first four sessions. Tip Sheets are provided in the *Addenda* for the practice functions that are applied in first order actions of a Treat First Approach.

ACTIVITIES & EXPECTATIONS

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Accomplishments by Visit 4. By conclusion of a fourth visit, the following items will be completed by the provider:

- Screenings, evaluations, and assessments that provide a sufficient bio-psycho-social understanding of the person's situation (e.g., reasons for requesting assistance, aspirations for wellness/recovery, preferences, risks of harm, and any significant unmet needs) to develop a useful clinical case formulation and course of action.
- Clinical case formulation including a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.
- Final Diagnosis: based on a full Clinical Formulation
- Wellness and recovery goals to guide a course of action.
- Comprehensive treatment plan to define a course of action for meeting the person's wellness and recovery goals.

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

CONTINUATION INTO ONGOING SERVICES

For persons having serious diagnoses and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs.

A Treat First Approach may be useful for all persons receiving services.

RECOMMENDATIONS & TIPS

Tips sheets explaining these elements of practice are provided in the *Addenda* to this document.

ADDENDA - TIP SHEETS

Purpose of the Tip Sheets

The Treat First Approach Overview introduces several core practice functions and clinical techniques that can support effective clinical work with persons requesting assistance -- both during and after the first four visits in an episode of care. These Tip Sheets are offered in the spirit of practice development and intended to promote building of craft knowledge needed by frontline practitioners when implementing a Treat First Approach in their agencies.

Tip Sheets define expected outcomes to be achieved when a practice or technique is used and introduce important concepts and strategies related to the practice or technique. Tip Sheets are not meant to serve as a substitute for necessary training and development of staff competencies required to perform these practices and techniques. Rather, Tip Sheets are meant to alert provider staff members and agency leadership that frontline practitioners require the craft knowledge necessary to perform these practices and techniques as well as the organizational supports necessary to integrate them into their everyday work.

Tip Sheets - Title and Order of Presentation

The Tip Sheets are titled and organized as follows on pages 8 through 15:

- Practice Area: Recognition, Connection, and Rapport
- Practice Area: Engagement and Commitment
- Practice Area: Detection and Rapid Response
- Practice Area: Assessment and Formulation
- Practice Area: Wellness and Recovery Goals
- Practice Area: Teamwork - Common Purpose and Unity of Effort
- Clinical Technique: Solution Focused Brief Therapy
- Clinical Technique: Motivational Interviewing

Readers should note that practice areas listed above are core practice functions described in a general framework used for training, supervision, and measurement of practice. That framework is illustrated in the diagram appearing on page 2.

PRACTICE AREA: RECOGNITION, CONNECTION, RAPPORT

Desired Outcomes of Practice

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

Key Concepts

As an early step in building a relationship with a person entering services, practitioners recognize the nature of the person's situation and life story. Recognition involves discovering the circumstances that have brought the person into agency services and anticipating the life changes necessary for the person to make in order to conclude services successfully. Practitioners recognize the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services. An important element in the process is recognition of any barriers that could thwart formation of positive connections with the person that could undermine acceptance and rapport building necessary for successful engagement. Successful practitioners take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships.

Recognition of a person's identity requires varying degrees of cultural responsiveness, depending on the person involved. Every person has his/her own unique identity, values, beliefs, and world view that shape ambitions and life choices. Some persons may require use of culturally relevant and responsive supports in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services.

Making sensitive cultural accommodations, where needed, involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between the person (and the person's supporters) and service providers who work together in the wellness / recovery process. Many persons may require simple adjustments due to differences between the persons and their providers. Such simple adjustments are a routine part of engagement, assessment, planning, and service provision. A person's identity [e.g., race, tribe, ethnicity; social group; sexual orientation; religion; or disability, such as deaf] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

Practice Tips

1. **LEARN THE REASON** the person is seeking help. CONSIDER whether the person's problem can be **RESOLVED IN A SINGLE VISIT OR A BRIEF INTERVENTION**. **DISCERN** whether the person's problem is emergent/transient or serious/persistent. **DETERMINE** whether the reported problem is a present **THREAT TO HEALTH OR SAFETY** so that any need for crisis intervention or urgent response can be identified and provided.
2. If the person reports being in physical pain or emotional distress, ASK ABOUT its nature, source, history, and impact on the person's life situation. Use the person's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now. *Note: Recognition & Rapport and Detection & Response are performed concurrently by the practitioner when a person is entering services.*
3. In early interactions, DISCOVER the person's sense of identity, culture, values and preferences (especially any arising from religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help.
4. **IDENTIFY** the person's **LANGUAGE & CULTURE**. **DISCERN** any impact that cultural or language differences may play in building rapport and forming a working relationship with the person. **RECOGNIZE any barriers** (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships.
5. **TAKE ACTIVE STEPS** in establishing positive conditions for building **MUTUAL RESPECT AND RAPPORT** with the person.

PRACTICE AREA: ENGAGEMENT & COMMITMENT

Desired Outcomes of Practice

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

Key Concepts

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

Building Trust-Based Working Relationships. Building upon recognition of the person's identity, reason for seeking services, and a positive rapport, ongoing engagement efforts are used to form and maintain a trust-based, mutually beneficial working relationship between the person and those serving the person. Practice approaches that support effective relationship building are:

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

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

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

Practice Tips

1. Remember that building a relationship with a person involves recognizing the nature of the person's life situation and reasons for requesting help. LISTENING is key to learning, empathy, respect, and trust building. Finding and overcoming any barriers to personal connections are essential. Recognition and rapport provide a foundation for building and sustaining a trust-based working relationship.
2. Use a person-centered approach that puts the person's voice and choice at the center of the service process. Recognize and respond to the person's unmet needs related to wellness, well-being, and daily functioning. Use a solution-focused approach that is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. Solution-focused practice aims to bring about desired change in the least amount of time. [Tenets of solution-focused practice include: If it's not broken, don't fix it. If it works, do more of it. If it's not working, do something different rather than just trying harder. A solution is not necessarily related to the perceived problem. Small steps in the right direction can lead to big changes.] A strengths-based practice approach emphasizes a person's self-determination and strengths. Identify and build on the person's strengths and assets to create sustainable resources for solutions.
3. Change-oriented approaches are especially useful in addressing lifestyle modification for disease prevention, long-term disease or disorder management, and addiction. Understanding a person's readiness to make change, appreciating barriers to change, and helping anticipate relapse can improve the person's satisfaction and lower practitioner frustration during the change process. A stages of change approach is useful in stimulating change and overcoming resistance
4. Remember that engagement is an ongoing process that builds and sustains: 1) a mutually beneficial trust-based working relationship between the person and 2) a person's commitment to personally selected wellness and recovery outcomes and to the life change process.

PRACTICE AREA: DETECTION & RAPID RESPONSE

Desired Outcomes of Practice

DETECTION & EARLY RESPONSE. • A person who is at risk of harm due to safety, health, or situational threats is detected via screening and other means and then kept safe from harm by using rapid response strategies to mitigate risks and protect the person from imminent threats to the person's well-being.

Key Concepts

Detection. Upon admission, screening is performed to identify a person who may have an imminent threat of harm from life partners, caregivers or who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment. A person should be screened upon admission and periodically thereafter for certain life situations, conditions, and disorders that may require diagnosis, treatment, and ongoing care. Life situations, conditions, disorders, or diseases for which screening should be routinely performed include:

- Safety/threats of harm at home
- Adverse childhood experiences/complex trauma
- Emotional status/behavioral disorders
- Health status/physical well-being/illness
- Inappropriate or unstable living situation
- Self-endangerment/threats of harm to others
- Intellectual or developmental disability/TBI/learning problems
- Drug/alcohol use/substance use disorder
- Diseases: diabetes, COPD, obesity, hypertension, seizures
- A pattern of instability or a trajectory of physical or emotional decline

Other agencies and practitioners involved in providing services to the person should be identified and contacted to provide necessary opportunities for service delivery, coordination, and integration.

Rapid Response

Rapid Response. Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. A timely and appropriate response is provided for any person who is detected via a screening process as has having a condition, disorder, or disease for which intervention or treatment is indicated.

A Rapid Response [following the detection of a serious threat or rapidly developing condition]: a response commensurate with the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions).

Practice Tips

1. Screenings of the person are performed upon admission and periodically thereafter. Practitioners continue to conduct screenings to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process.
2. Based on results of screenings and self-reports by the person, any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected. The nature, significance, and history of any detected problem are defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care.
3. Any problem requiring a crisis intervention or urgent response is addressed in a timely, appropriate, and sufficient manner so as to prevent unnecessary harm, pain, loss, or hardship for the person. Each response provided is commensurate with the urgency and severity of the presenting problem. Any response provided protects the person from preventable harm or mitigates the impact the problem would have likely had if not treated promptly and effectively.
4. Results of initial and ongoing screenings are incorporated into the ongoing bio-psycho-social assessment and clinical understanding/case formulation of the person's situation. Any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life.

PRACTICE AREA: ASSESSMENT & FORMULATION

Desired Outcomes of Practice

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

Key Concepts

Ongoing assessment and clinical case formulation guide the course of action designed and used by service providers to help a person meet wellness and recovery goals that he/she has selected. Assessment processes are used to gather facts and assemble information and knowledge for developing a functional understanding of the person's situation and desired life change outcomes. Assessment provides answers to practical and clinical questions [see the separate list of clinical questions] that are used to develop a working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge. The formulation is used in developing a course of action (treatment and supports) for meeting the person's wellness and recovery goals.

Assessment & Understanding As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social clinical formulation used in developing a course of action for the person. Assessment techniques, both formal and informal, are appropriate for the person's life stage, ability, culture, language or system of communication, legal issues, and life situation. Areas in which essential understandings are developed include:

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

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

Practice Tips

1. Remember that the outcome of assessment is an essential FUNCTIONAL UNDERSTANDING of the person used in case formulation to guide intervention planning. Assessment is a continuous learning process involving the person and service providers, not a form to complete upon intake or other points in the course of action. Assessment includes the gathering and assembly in facts, information, and knowledge to develop a broad-based understanding of the person's situation used to support decision making.
2. A clinical case formulation includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.
3. Practical reasoning and clinical judgment are used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment. Functional understandings and clinical case formulation are used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.
4. Principles of person-centered practice and self-directed care are applied in all aspects of assessment and clinical case formulation.

PRACTICE AREA: WELLNESS & RECOVERY GOALS

Desired Outcomes of Practice

WELLNESS & RECOVERY GOALS: • Clearly stated, well-informed, and personally-selected wellness and recovery goals are developed with the person and used to guide intervention strategies toward attainment of desired levels of well-being, supports for living, daily functioning, inclusion, productivity, and role fulfillment for the person.

Key Concepts

WELLNESS is an active process in which a person becomes aware of and makes choices toward a more successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential. Wellness is a multidimensional and holistic, encompassing lifestyle, mental and spiritual wellbeing, and the environment. Wellness is positive and affirming. [National Wellness Institute]

RECOVERY is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Ten guiding principles of recovery are: hope, person-driven, many pathways, holistic, peer support, relational, culture, responsive to trauma, strengths and responsibility, and respect. [SAMHSA]

Consistent with the principles of person-centered practice, personally-selected wellness and recovery goals vary among persons having a wide range of personal needs, aspirations, and life trajectories reflective of their age, ability, and situation

- A person experiencing a simple, acute problem, but having no systematic barriers or impediments should improve quickly and reach desired levels of well-being, sustainable supports, daily functioning, and independence with minimal assistance and limited interventions.
- A person experiencing a chronic problem with minimal systematic barriers or impediments should achieve adequate levels of stability, functioning, and well-being while self-managing the condition as independently as possible until he/she requires more intensive temporary care or treatment. Once the person regains adequate levels of stability, functioning, and/or well-being, he/she resumes self-management of the condition with a lower level of ongoing monitoring and support from the system.
- A person having limited capacities and/or major systematic barriers or impediments should achieve and maintain his/her best attainable level of functioning, well-being, and support until his/her status changes. Persons having intellectual disabilities, serious and persistent mental illness, traumatic brain injury, and the frail elderly often require more intensive or specialized long-term care services.

Personal wellness and recovery goals specify: (1) Levels of well-being, supports, daily functioning, productivity, or social integration to be achieved by the person; (2) Aspirations for fulfilling life roles (e.g., employee, parent, life partner, grandparent) the person seeks to achieve including the manner and degree of accomplishment; and (3) Any requirements to be met (e.g., discharge from hospital or detention) before interventions are transitioned to either ongoing maintenance services (e.g., self-management with monitoring, reunification of children from foster care) or independence from the service system. Wellness and recovery goals define outcomes to be accomplished via services.

Practice Tips

1. Use person-centered planning techniques to help the person identify and state what he/she expects to gain or achieve from the service process. Frame these expectations as wellness or recovery goals using the person's own words. Make sure the goals selected for service planning are based on the person's assessed needs, expressed aspirations for wellness and recovery, and socially-beneficial choices.
2. Construct goals that are SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. Clear goals help in planning intervention strategies and measurement of results. Relevant and achievable goals promote the person's motivation and commitment to the change process.
3. Consider the nature, purpose, trajectory, time required, person's motivation, and opportunities available for achieving the goals selected. Recognize that there may be an important order of priority in which goals are addressed. Any compelling urgencies should be addressed first.
4. Use the person's wellness and recovery goals to guide the selection of strategies to be used for their attainment. Identify goals for which the involvement of other practitioners or agencies will be involved in or responsible for the helping the person achieve the desired outcomes.
5. Use teamwork processes to build common purpose and unity of efforts with other supporters, practitioners, and agencies involved in helping the person achieve his or her wellness and recovery outcomes.

PRACTICE AREA: TEAMWORK / COMMON PURPOSE & UNITY OF EFFORT

Desired Outcomes of Practice

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

Key Concepts [These Aspects of Practice are Applied to Persons Having Complex Needs and Ongoing Services]

Person-centered practices and self-directed care principles put the person's needs, aspirations, and choices at the center of service organization. A team-based, shared decision-making process helps the person to create a vision for a better life based on aspirations for wellness, valued social roles, social inclusion, and successful daily living. Informal supporters and service providers join with the person (consistent with the person's preferences) to define wellness/recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success. Together, common purpose and unified efforts create the "glue" that holds things together in practice for the benefit of the person receiving services.

Common Purpose. Common purpose is created when the people involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered, team-based, shared decision-making process may be used to achieve and maintain a consensus on and commitment to a set of wellness/recovery goals and related strategies. These goals and strategies are determined by and with the person, the person's primary supporters, and the service providers involved. CONSENSUS and COMMITMENT are essential for building common purpose.

Unity of Effort. Unity of effort is based on: (1) A common understanding of the person's situation; (2) A common vision for the person's wellness or recovery; (3) Coordination of efforts to ensure coherency and continuity; (4) Common measures of progress and ability to change course, if necessary. Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among providers and supporters, and integration of services across providers, settings, funding sources, and points in time. Unity of effort is the state of harmonizing actions and efforts among multiple service providers and supporters who are committed to helping the person achieve agreed upon goals and shared outcomes.

Practice Tips

1. Remember that effective TEAMWORK and SERVICE COORDINATION help build common purpose and unity of effort in frontline practice. Effective teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, knowledge of the person, authority to act on behalf of funding agencies and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person. **NOTE:** Persons having serious, persistent illnesses (requiring ongoing care and treatment) benefit most from effective teamwork and service coordination. Person-centered teams are useful for persons receiving multiple ongoing care and treatment services
2. The person's team assists in conducting person-centered planning activities and in providing assistance, support, and interventions after plans are made in order to meet the person's wellness/recovery goals. Working together, team members support the person in identifying needs, setting wellness/recovery goals, and planning strategies with related services that will enable the person to meet those goals. Effective, ongoing, collaborative problem solving is a key indicator of effective team functioning.
3. Leadership and coordination are necessary to: (1) form a person-centered team and facilitate teamwork; (2) plan, implement, monitor, modify, and evaluate services provided; (3) integrate strategies, activities, resources, and interventions agreed to by the team; (4) measure and share results for the individual in order to change strategies that do not work and to determine progress; and (5) ensure a unified process involving a shared decision-making approach. While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated leader who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation skills, authority to act, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, negotiation may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient. This may be an appropriate outcome of interventions for the person receiving services.
3. Team functioning and decision-making processes should be consistent with principles of person-centered practice and self-directed care. Evidence of effective team functioning over time is demonstrated by the quality of relationships built, commitments fulfilled, results achieved, unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, dependability of service system performance, and connectedness of the person to critical resources necessary for achieving wellness/recovery goals.

CLINICAL TECHNIQUE: SOLUTION FOCUSED BRIEF THERAPY

Desired Outcomes of Practice

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

Key Concepts

A practice that may be useful in a Treat First Approach is Solution Focused Brief Therapy (SFBT) that focuses on a person's strengths and previous successes rather than failings and problems. SFBT consists of conversations that stimulate and support positive life change for a person receiving services. These conversations are centered on the person's concerns; who and what are important to the person; a vision of a preferred future; the person's exceptions, strengths, and resources related to the vision; scaling of the person's motivation level and confidence in finding solutions; and, ongoing scaling of the person's progress toward reaching the desired future. The goal is helping a person rapidly find a solution to a resolvable life problem. The basis for a brief intervention builds on the person's understanding of his/her concern or situation and what the person wants to be different in the future.

Basic concepts of SFBT are:

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

SFBT has been recognized as an evidence-based practice and is listed on the SAMHSA National Registry of Evidence-Based Programs and Practices.

Solution-Focused Questions

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

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

CLINICAL TECHNIQUE: MOTIVATIONAL INTERVIEWING

Desired Outcomes of Practice

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

Key Concepts: Motivational Interviewing is a Technique Used with Solution Focused Brief Therapy

Motivational interviewing is a method that works on facilitating and engaging intrinsic motivation within the person in order to change behavior. The examination and resolution of ambivalence is a central purpose and the practitioner is intentionally directive in pursuing this goal. Motivational interviewing is a semi-directive, person-centered counseling style for eliciting behavior change by helping a person to explore and resolve ambivalence. It is change-focused and goal-directed. Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. Motivational interviewing recognizes and accepts the fact that persons who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Some persons may have thought about it but not taken steps to change it or may be actively trying to change behavior and may have been doing so unsuccessfully for years. In order for a practitioner to be successful at motivational interviewing, four basic skills should first be established: 1) The ability to ask *open-ended questions*. 2) The capacity for *reflective listening*. 3) The ability to provide *affirmations*. 4) The ability to periodically provide *summary statements* to the person. The motivational approach attempts to increase the person's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, practitioners help the person envision a better future, and become increasingly motivated to achieve it. The strategy seeks to help the person think differently about their behavior and ultimately to consider what might be gained through change.

Motivational interviewing focuses on the present and entails working with a person to access motivation to change a particular behavior that is not consistent with a person's personal value or goal. *Warmth, genuine empathy, and unconditional positive regard* are necessary to foster therapeutic gain within motivational interviewing. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the person. A central concept is that ambivalence about decisions is resolved by conscious or unconscious weighing of pros and cons of making change versus not changing. It is critical to meet people where they are and to not force a person towards change when they have not expressed a desire to do so. The four general principles are:

1. **Express Empathy.** Empathy involves seeing the world through the person's eyes, thinking about things as the person thinks about them, feeling things as he or she feels them, sharing in the person's experiences. The practitioner's accurate understanding of the person's experience facilitates change.
2. **Develop Discrepancy.** This guides practitioners to help persons appreciate the value of change by exploring the discrepancy between how the person wants his or her life to be versus how it is currently (or between their deeply-held values and their day-to-day behavior). Practitioners work to develop this situation through helping persons examine the discrepancies between their current behavior and future goals.
3. **Roll with Resistance.** The practitioner does not fight a person's resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the practitioner uses the person's "momentum" to further explore his or her views. Using this approach, resistance tends to be decreased rather than increased, as persons are not reinforced for becoming argumentative. Motivational interviewing encourages persons to develop their own solutions to the problems that they themselves have defined.
4. **Support Self-Efficacy.** This guides practitioners to explicitly embrace the person's autonomy (even when persons choose to not change) and help the person move toward change successfully and with confidence. As persons are held responsible for choosing and carrying out actions to change, practitioners focus their efforts on helping people stay motivated, and supporting their sense of self-efficacy is a great way to do that.

Key points on Motivational Interviewing are:

- Motivation to change is elicited from the person and is not imposed from outside forces.
- It is the person's task, not the counselor's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally quiet and elicits information from the person.
- The counselor is directive, in that they help the person to examine and resolve ambivalence.
- Readiness to change is not a trait of the person, but a fluctuating result of interpersonal interaction.
- The therapeutic relationship resembles a partnership or companionship.

Thus, motivational interviewing uses an ongoing conversation about life and change as a basis for engagement and encouragement.