

Recovery Toolkit

**BHRS is an ideal treatment modality
to assist children and families along
the journey to recovery**



Value Behavioral Health of Pennsylvania, Inc.

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Behavioral Health Rehabilitation Services (BHRS) are an ideal treatment modality to assist children and families along the journey to recovery. Services follow a unique path, determined by the needs and hopes of the family. They build on strengths, and work to empower children and families to make meaningful changes. Service providers are flexible and work in cooperation with all child-serving systems, to help build trust and support within the child's community.

However, there are inherent challenges to BHRS that can make a recovery orientation difficult to effect. Service providers are consistently challenged to engage families and other child-serving systems in a process of active participation and growth, while resisting dependency and stagnation.

The VBH-PA BHRS Recovery Toolkit is intended as a tool for BHRS providers, to enhance the provision of recovery focused BHRS.

This toolkit was collaboratively developed by BHRS providers, county mental health staff, oversight agencies and VBH-PA managed care staff through participation in VBH-PA BHRS Summits. Each brought experience and perspective that, taken together, contributed to a practical and clinically sound document. The BHRS Summit participants are commended and thanked for their ongoing efforts to improve the quality of BHRS delivery in Western Pennsylvania.

The information contained in this toolkit is organized under 4 headings: *Overview, Engagement, Treatment and Discharge.* Each section contains an overview of practice standards relating to recovery focused BHRS delivery. Also included in each section are relevant supporting documents that are available for use by BHRS providers if desired.

This “recovery toolkit” is intended to support providers in the effort to deliver BHRS using recovery principles. All materials are intended to be used freely and may be copied by VBH network providers without permission.

Recovery based Behavioral Health Rehabilitation Services: An Overview

Behavioral Health Rehabilitation Services (BHRS) are intended to be individualized, community based enhanced mental health services that are delivered in an intentional and goal directed manner. They are to be based upon the strengths of the child and family, and work continually toward establishing and empowering natural supports, so that each child can eventually be maintained in a healthy environment with as little intrusion or restriction as possible.

The recovery model is an ideal framework around which to organize the delivery of BHRS services.

Recovery implies a journey toward optimal mental health, in which the child and family are empowered to recognize the possibility of change, build on their strengths and achieve self responsibility.

Challenges: For many reasons, it is less easy to work within a recovery model in BHRS than from more traditional mental health services. BHRS is not specifically time limited, and goals can be complex and long term. Both families and providers will often not conceptualize an end point to services, except in the distant future. A great deal of energy is focused on managing problem behavior, with less attention typically to transfer of skills, development of natural supports and self empowerment.

BHRS by its very nature is at risk for encouraging dependency. Services provided within the home are more intimately involved with the family in their natural setting, and relationships developed between families and caregivers can sometimes cross traditional caregiver/family boundaries into dependency. The services may incidentally ease burdens for family members, by assisting them with care giving, educational support or transportation, and thus become difficult to function without. Community based services can be convenient for families, because they literally come to the family, not requiring transportation. They can be confusing because they may mimic the help provided by other services such as respite or babysitting. Schools often make plans to manage behaviorally challenging children that are heavily dependent upon the presence of Therapeutic Staff Support, rather than educational supports, and resist discharges.

In addition, there are often gaps in natural supports needed to make life bearable and functional for families with mentally ill or behaviorally disordered children. Families living in rural areas are particularly challenged to find transportation, nearby site based services, respite services, support groups or other assistance.

A deliberate choice to deliver BHRS within a recovery framework is essential to success in helping families develop optimal independence. Providers must recognize that poorly delivered BHRS

actually may impede recovery, and take deliberate steps to deliver services consistently grounded in recovery principles.

Best practice for creating a recovery focused therapeutic relationship in BHRS will consistently include the following elements:

Begins before admission with:

- Discussion of range of services that can address symptoms during evaluation
- “Brainstorming” during ISPT, with perspectives from all parties, and attention paid to what is currently working and other available supports.
- All parties working together to educate parent about resources, including County, MCO, prescriber and provider.

Continues at time of admission, with:

- Written information about nature of services - simple and short, including roles and expectations
- Repeated realistic discussion including what end goals for services will be
- Discussion of parent opportunities and expectations for involvement

Solidified in treatment planning process by:

- Stressing family role in BHRS process: as decision makers, defining goals, learning all they can toward increasing independence
- Including natural supports, identifying activities and linkages - at least 25% of interventions through natural supports
- Clearly defining roles and expectations for each staff member
- Crisis plans that define crisis behaviors, include roles of caregivers and specific contact information for assistance, and that are reviewed regularly.

Played out during treatment by:

- Highlighting skill transfer as part of each therapy
- Using “teach-model-coach” approach to increase parent independence
- Reinforcing when child is showing normal developmental challenges, as opposed to symptoms of mental illness
- Encouraging parent ownership in reviews, rather than passive role.
- Reviewing goals and progress regularly with family
- Using visual aids to show progress
- Educating constantly
- Teaching specific skills
- Celebrating progress
- If dependency is noted, changing staff or take other measures to correct it
- Addressing therapy issues as needed- transference, dependency, resistance, etc.

Supported during transition:

- Begin trials of reducing frequency of services and work through any resulting behaviors
- Help family understand that temporary regression may occur when cutting down or eliminating BHRS
- Consider plans to support family, after TSS has ended
- Set positive tone- graduation vs. loss
- Support family through grief/loss; recognize that relationships are meaningful
- Develop written specific plan for supports and crisis numbers
- Have family engage multiple systems prior to discharge as appropriate, especially education
- Manage staff feelings around discharge through clinical supervision
- Celebrate endings; consider graduation “party” or certificates
- Work on relapse prevention, and indicate how services could be restarted, if necessary

Staff clinical supervision should include a philosophy of service providers “working toward helping the person become as self reliant as possible.” TSS should be trained to empower families in their absence. Services need to be provided with the parent present and actively involved. Skill transfer needs to be addressed in clinical supervision regularly. It is easier and more popular to perform service in a way that encourages dependency. Doing it right is difficult.

Business challenges always accompany a recovery focused BHRS model. Staffing issues are a reality of BHRS. Providers may wish to plan creatively for ways to employ staff during periods when service hours are being titrated, to avoid loss of income for staff members. This will also help with staff retention.

Engagement

education



trust & clarity

Engagement

Therapeutic Engagement involves creating a therapeutic alliance, and commitment to joint work toward positive change for the individual. When done successfully, the engagement process results in a relationship based on clarity, trust, and mutual responsibility in the change process.

The engagement process is enhanced by:

- Emphasizing the family role in BHRS as an integral part of orientation and treatment planning
- Providing clear verbal and written guidelines regarding the BHRS process, as an ongoing reference for parents
- Assisting the family to define and prioritize their personal desires for outcomes, and giving these desires foremost consideration when planning interventions
- Creating a culture of creativity extending beyond the professional caregivers that explores all possible supports for the family and child

Some tools for engagement to use in discussion with parents at the beginning of treatment are included in this chapter. These tools are intended to help parents understand and clarify their expectations for BHRS treatment.

1. Written “roles and goals” defining staff roles and the BHRS process, adopted from one of the Pennsylvania DPW Guides to BHRS
2. Written suggestions for parents pertaining to their involvement and responsibilities
3. A parent guide to professional rules and boundaries required of BHRS staff

A Guide to Behavioral Health Rehabilitative Services (BHRS) in Pennsylvania

BHRS FAQs

Note: Information included in this document covers BHRS services as a whole and is not AUTISM specific.

What are BHRS services?

Behavioral Health Rehabilitation Services (BHRS) are Medicaid-funded services, based on medical necessity, provided through trained professional support for children under age 21 with a serious emotional or behavioral disorder, to reduce or replace problem behavior with positive, socially appropriate behavior. BHRS are family and child-centered, and they can take place in variety of settings, not just one place. Services are guided by the Treatment Plan. Progress is monitored with data, updated regularly and reevaluated as necessary. Also, BHRS are often very personal. Some families may need to adjust to new persons actively joining their daily activities.

How are services decided?

An evaluation is done by a psychologist or a physician who recommends appropriate services. A Treatment Plan is developed by an interagency team representing several support agencies, including the county Mental Health/Mental Retardation (MH/MR) program representative. This team includes parents, any lead teacher, a Behavior Specialist Consultant (BSC), any services coordinator, any therapist or counselor, and any person(s) the family wishes, including an advocate. If appropriate, your child is included. The plan includes goals, objectives, and treatments. Goals may target safety, functional, communication, social and classroom behavior and each member of the team is assigned responsibility to help meet the goals. Goals are individual to the needs of your child and family, and are updated as often as needed.

Who provides services?

BHRS are usually provided directly to clients by Therapeutic Staff Support (TSS) workers, Therapeutic Staff Support Aides (TSSA), a Behavior Specialist Consultant (BSC) and possibly a Mobile Therapist (MT), who work for a local agency. Your community may have several agencies, but not all of them may serve children with autism of your child's age.

When and where do services occur?

The evaluation includes the prescription for “level of care,” or the treatment hours assigned each week to TSS, MT and BSC, and in which setting. Settings often include school, community (camp, scouts, or other various community-based activities), and/or home.

What do services look like?

TSS and TSSA provide one-on-one service. For instance, your child’s therapist may instruct a child on how to take turns using cards, a worksheet, games, checklists, scripts and other strategies. The TSS and TSSA may then prompt the child to practice that skill in natural settings such as circle-time, recess or during a play date. This instruction may occur at your home and be practiced there, and at some point with other children. The TSS or TSSA take data and record treatment notes to measure the client’s progress toward independent use of the skill. The BSC regularly reviews these notes to adjust treatment and goals as needed. **For more details see: THERAPEUTIC STAFF SUPPORT FAQs.**

How can my child get services?

Contact your county MH/MR office and request services. Your child must be found eligible for services by a local agency. Families should contact agencies and determine which may have the best experience and staff for their child’s needs.

BHRS are medically necessary services.

What BHRS is not:

BHRS is not a substitute or supplement for speech and language, occupational or physical therapies.

BHRS is not a substitute for academic instruction by a teacher.

BHRS is not a Big Brother/Big Sister-type program.

BHRS is not a babysitting service.

Why does my child need BHRS when I already have education services?

There are similarities between BHRS and education services. However there are important differences because the long-term goals of these two systems are different. School services are designed to meet

the goals of IDEA, a federal education law that focuses on functional and academic skills that prepare a student for independent living, a job or further education. BHRS focus on community integration and skill development to increase the independence of individuals and their families.

BHRS serve behavioral health needs exclusively, with the purpose of helping the child learn skills to become independent in their daily environments as they develop. Services to teach independence can occur anywhere a child needs them, including play-dates, community outings, and recreation. This may include school activities, whether public or otherwise.

BHRS staff are hired and trained for the sole purpose of supporting the needs of the child and their family arising from the child's disability. Staff hired must have state- mandated minimum levels of education and experience. Therapeutic Support Staff (TSS) who provide direct support must have a two-year college degree or 60 credit hours toward a degree, but often have a four-year college degree, if not advanced health training. They teach and support the learning of specific positive behaviors, such as safety skills and social interactions, like dealing with conflict and maintaining conversations.

Long-term goals are addressed with short-term objectives in a Treatment Plan. Parents are encouraged to be actively involved in creating, carrying out and following through on the Treatment Plan.

In contrast, education services historically focus on the school setting. School staff is historically trained to serve the needs of children without disabilities, but may receive additional training about children with disabilities. In addition, school staff aides may be hired without a college degree or advance training. Training usually relates to typical activities of a public school. School services for children with disabilities are designed to meet a legal obligation to provide the child access to the general education curriculum and provide individualized services and support that enable them to benefit from a public education.

THERAPEUTIC STAFF SUPPORT FAQs

Note: Information included in this document covers BHRS/TSS services as a whole and is not AUTISM specific.

What does a Therapeutic Staff Support (TSS) do?

- Carries out specific interventions that are identified in the behavioral treatment plan developed by the Behavioral Specialist Consultant (B SC) and the Interagency Team that lead to a reduction in the need for services
- Prevents the need for more restrictive settings or provides a transition from a more restrictive setting
- Provides one-to-one interventions to a child or adolescent while the caregivers are acquiring the skills necessary to manage the child's or adolescent's behavior
- Assist caregivers in promoting age-appropriate behaviors
- Helps the child avoid or eliminate social inappropriate, threatening or dangerous behavior
- Transfers the appropriate intervention to the child, family and/or teacher by working collaboratively with them.
- Supports caregivers in providing immediate rewards or consequences for behavior
- Provides emotional support to the child and family
- Supports the child in their participation in activities identified by the treatment plan
- Supplement, but not replace less formal resources such as Big Brothers/Big Sisters, child care workers, and other more long-term or custodial services
- Provide interventions and activities consistent with the family's cultural values and economic limitations
- Records data and charts the progress of the child's goals

A Therapeutic Staff Support does NOT:

- Provide services not included in the treatment plan
- Exclude the family or appropriate school staff from the on-going treatment
- Work with a sibling or other child – unless outlined in the identified child's treatment plan
- Baby-sit for the child or any other siblings
- Substitute for a parent or caregiver by attending to any needs that are not identified on the treatment plan or perform parenting functions
- Perform the duties of school personnel such as teacher, teacher's aide, or academic tutor
- Perform caregiver duties such as feeding, dressing, or attending to personal hygiene needs
- Prepare meals or perform housekeeping chores
- Administer medication
- Provide transportation (unless to a community-based activity) – THIS MAY VARY AGENCY-TO-AGENCY ACCORDING TO POLICIES

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- Provide therapy or counseling rather than supportive interactions
- Provide respite care
- Involve themselves with personal family activities or relationships that are separate from the child's treatment
- Utilize manual restraint or seclusion of a child (unless in accordance with the OMHSAS Bulletin issued 4/8/02).

What are the responsibilities of the family and the child (and/or educational staff) when working with a TSS?

- Identify the child's strengths and needs
- Identify their own strengths and needs in relation to working with the child
- Participate actively with the Interagency Team
- Work to regularly carry out the treatment plan in a positive, constructive way
- Engage with the TSS during all prescribed hours so that the appropriate skills are being transferred to the long term caregiver, family, and/or educator
- Provide a safe and substance free working environment for staff
- Bring all questions and concerns to the attention of the Interagency Team
- Notify staff of any infectious illness in the home that could affect a staff member
- Respect the personal boundaries of the TSS staff while working with the child in the home, school, or community – they are not a family member and they should not be treated as one
- Inform TSS of family vacations and/or illnesses which will prevent the TSS from working their regular hours and provide adequate notification to the TSS when prescribed hours are going to be affected

What should you expect from a TSS?

- Your child and family will be treated with dignity, respect, sensitivity, and emotional care
- All rules and regulations regarding confidentiality will be adhered to (HIPAA)
- Your family's questions and concerns will be taken seriously and will be responded to promptly
- The TSS will invite and encourage your child and family to participate actively with treatment and the planning process
- The TSS will conduct themselves as professionals in your home – they will keep a clear, professional boundary with all family members at all times
- The TSS will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises)
- The TSS will not bring others to your child's home or school – such as their own children, other clients, significant others, etc.
- The TSS will not engage in personal matters such as talking on the phone, running personal errands, reading a book, etc.
- The TSS will adhere to activities only identified in the treatment plan

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Common Treatment Goals and Potential TSS Interventions

1. Obtaining information about the child's problematic behaviors, in order to determine the child's behavioral patterns. The TSS records this information systematically, and conveys it to the primary clinician so that it can be incorporated into the treatment plan. The TSS may also share information with the parents and child, as determined by the primary clinician. The following are some examples of information to be obtained and documented:
 - a. Where problematic behaviors occur (e.g., at school, during recess, at home, during dinner, in the community, when with older peers, etc.)
 - b. Frequency of behavior
 - c. Apparent precipitants
 - d. Specific behavioral responses by child
 - e. Duration of episodes
 - f. Typical reactions and responses by others, and effect of these on the child
 - g. Most effective interventions to interrupt cycle
 - h. The child's own ways of maintaining control, problem solving, and self-calming
 - i. The child's response to TSS during times of emotional upset, as compared to other times.

2. Reinforcing parental roles and responsibilities with the child:
 - a. TSS discusses, with parent, the plan for scheduled contact with the child that day
 - b. TSS worker obtains updated information from parent, about the child's functioning, since last contact
 - c. TSS highlights and verbally reinforces cooperative, respectful, age-appropriate responses by the child toward the parents (e.g., "I was impressed with the way you responded to your mother's request right away, and how you looked right at her when you spoke to her.")
 - d. TSS supports parental adherence to specific protocols developed by primary clinician, for use with the child (e.g., Stop and Think approaches, sticker charts with specific tasks for the child, consistency in limit-setting)
 - e. TSS offers positive statements to the child individually, at appropriate times, about his or her parents (e.g., "Did you notice how proud your dad looked when you showed him the terrific point sheet from school today?")
 - f. TSS helps the child practice expressing him or herself to parents, using techniques as directed by the primary clinician in the treatment plan (e.g., "Do you really think your mother is going to listen to you if you yell at her like that? Why don't you try it again, more slowly and calmly?")

3. Helping the child integrate into an identified community activity:
 - a. Prior to a specific activity, the TSS reviews with the child the nature of the activity and likely expectations for that activity (e.g., "Part of the reason that you are joining this team is to try to make friends and get along better with other kids. During the game, it may get intense, but that's no reason to lose your cool.")

- b. TSS observes the child’s interactions with any staff and peers, in terms of:
 - 1. Degree of attentiveness and responsiveness to the coach or other adult authorities
 - 2. Ability to follow specific rules
 - 3. Positive individual and team efforts by the child (e.g., the child approaches a peer and starts a conversation; the child actively participates during team activities/ play; the child offers encouragement to others; the child demonstrates teamwork)
 - 4. Responses to aggressive and/or inappropriate behavior by peers
 - 5. Degree of self-control
 - c. Based on systematic observation of the child’s functioning, the TSS actively supports the child’s participation in the community and other settings. Specific individualized TSS responses may include the following:
 - 1. Non-verbal cues of support for child’s positive responses (e.g., “thumbs up” or a clap of hand, when the child scores a basket, catches the football, or ignore an elbow by another peer during the game)
 - 2. Non-verbal cues for the child to change an immediate behavioral response (TSS points at forehead, to signify “stop and think” or points at wristwatch to tell the child to “slow down and calm down”)
 - 3. Taking the child aside momentarily, if necessary, to discuss the situation and to consider positive choices to be made
 - 4. Discussion about the experience afterwards (social autopsy) with the child and parents (e.g. To the child: “I was impressed with how focused you stayed during the game and how you didn’t let yourself get angry when that other guy started ‘trash talking’ you.” To parents: “Your son made good progress with his treatment plan today. Billy, do you want to tell them first, or should I start?”).
4. Helping the child improve interactional skills with peers:
- a. TSS encourages the child to identify areas of interest, competence, and familiarity, which he/she can use in social conversations (e.g., “We both know you have many interests and you are an interesting person. What are some things that you can talk about with our classmates tomorrow at the party?”)
 - b. TSS encourages the child to learn to ask questions with peers, and to listen actively to responses
 - c. TSS encourages the child to practice use of social skills (role-plays)
 - d. TSS helps the child build confidence in preparing for social interactions through practice of conversations with TSS
5. Helping the child to de-escalate when angry.
- a. TSS helps the child identify, even write down, specific trigger points for anger, as directed by primary clinician (e.g., “What was it that got you so angry? Do you think it has to do with his tone of voice or what he said?”).

- b. TSS helps the child identify the benefits of non-aggressive responses, and when possible consequences of aggressive responses (e.g., “Do you realize that when you let Justin get you to lose your cool, you’re giving him the power to control you? What can you do instead of punching him?”).
 - c. TSS helps the child implement a specific protocol for decision-making/deescalation (e.g., stop and think), if identified within treatment plan (e.g., “O.K. Billy, this is what we’ve talked about. I can see that you are starting to get upset. Remember what you’re supposed to do when this happens?”) and offer prompts for known calming strategies
 - d. TSS cues child non-verbally and indirectly, at sign of escalation, or uses simple verbal cue, as previously agreed upon (e.g., pointing to forehead to signal “stop and think”).
 - e. TSS reviews the de-escalation plan with adults in the setting where services are being provided (e.g., with parents in the home, teachers in the school, or coach in the community) and with child, so that implementation is predictable and consistent for child and others
 - f. TSS uses time-out interventions, as needed and as previously determined by primary clinician and parents.
 - g. TSS uses verbal praise for the child when the child is showing self-control or improvement in other skill areas as determined by the treatment plan.
 - h. TSS discusses or reflects on the situation with the child after a specific incident, near-incident occurs.
 - i. TSS encourages the child’s keeping of a journal or diary, as directed by the primary clinician, for the child to record feelings or instances of positive coping.
6. Promoting appropriate attitude and decision-making by the child:
- a. Building on earlier efforts by the primary clinician, the TSS helps the child identify positive role models with the family, neighborhood, or larger culture (e.g., “you said that you want to get off of probation. What do you think will happen if you hang out with those guys who are breaking into cars?” “What’s more important, getting money fast, no matter how you get it, or taking the time to earn it?”).

BEHAVIORAL SPECIALIST CONSULTANT (BSC) FAQs

Note: Information included in this document covers BHRS/BSC services as a whole and is not AUTISM specific.

What does a Behavioral Specialist Consultant (BSC) do?

- Serves as a consultant to the Mobile Therapist (MT) and/or the Therapeutic Staff Support (TSS) while maintaining some direct contact with the child and the family.
- Works with the family and other members of the treatment team such as school staff to design and direct a behavior modification plan that will meet the needs of the child and family
- Provides assessment , program design and monitoring of treatment interventions rather than direct therapy

A BSC does NOT:

- Exclude the family or appropriate school staff from the on-going treatment
- Work with a sibling or other child – unless outlined in the identified child’s treatment plan
- Baby-sit for the child or any other siblings
- Substitute for a caregiver by attending to any needs that are not identified on the treatment plan
- Perform caregiver duties such as feeding, dressing, or attending to personal hygiene needs
- Prepare meals or perform housekeeping chores
- Administer medication
- Provide transportation (unless to a community-based activity) – THIS MAY VARY AGENCY-TO-AGENCY ACCORDING TO POLICIES
- Replace or substitute for the parent, teacher, or educational aide
- Involve themselves with personal family activities or relationships that are separate from the child’s treatment

What are the responsibilities of the family and the child (and/or educational staff) when working with a BSC?

- Identify the child’s strengths and needs
- Identify their own strengths and needs in relation to working with the child
- Participate actively with the Interagency Team
- Work to regularly carry out the treatment plan in a positive, constructive way

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- Engage with the BSC during all prescribed hours so that the appropriate skills are being transferred to the long term caregiver, family, and/or educator
- Provide a safe and substance free working environment for staff
- Bring all questions and concerns to the attention of the Interagency Team
- Notify staff of any infectious illness in the home that could affect a staff member
- Respect the personal boundaries of the BSC staff while working with the child in the home, school, or community – they are not a family member and they should not be treated as one
- Inform BSC of family vacations and/or illnesses which will prevent the BSC from working their regular hours and provide adequate notification to the BSC when prescribed hours are going to be affected

What should you expect from a BSC?

- Your child and family will be treated with dignity, respect, sensitivity, and emotional care
- All rules and regulations regarding confidentiality will be adhered to (HIPAA)
- Your family's questions and concerns will be taken seriously and will be responded to promptly
- The BSC will invite and encourage your child and family to participate actively with treatment and the planning process
- The BSC will conduct themselves as professionals in your home – they will keep a clear, professional boundary with all family members at all times
- The BSC will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises)
- The BSC will not bring others to your child's home or school – such as their own children, other clients, significant others, etc.
- The BSC will not engage in personal matters such as talking on the phone, running personal errands, reading a book, etc.

MOBILE THERAPIST (MT) FAQs

Note: Information included in this document covers BHRS/MT services as a whole and is not AUTISM specific.

What does a Mobile Therapist (MT) do?

- Identifies the strengths and needs of the child and family
- Provide individual and family therapy to the child
- Listens to the family, asks questions, and provides clinical information to help the family
- Determines the need for any necessary family support services, special evaluations and/or other systems such as mental retardation, child welfare, juvenile probation, etc.
- Assists the family to promote the independence of the family in managing mental health needs and/or behavior problems
- Develops a crisis plan with other involved professionals and the family

A Mobile Therapist does NOT:

- Work with the child in isolation of their caregivers. Therapy sessions should always be conducted with another adult available to the child or clinician
- Work with a sibling or other child – unless outlined in the identified child’s treatment plan
- Baby-sit for the child or any other siblings
- Substitute for a caregiver by attending to any needs that are not identified on the treatment plan
- Perform caregiver duties such as feeding, dressing, or attending to personal hygiene needs
- Prepare meals or perform housekeeping chores
- Administer medication
- Provide transportation (unless to a community-based activity) – THIS MAY VARY AGENCY-TO-AGENCY ACCORDING TO POLICIES
- Replace or substitute for the parent, teacher, or educational aide
- Involve themselves with personal family activities or relationships that are separate from the child’s treatment

What are the responsibilities of the family and the child (and/or educational staff) when working with an MT?

- Identify the child’s strengths and needs
- Identify their own strengths and needs in relation to working with the child
- Participate actively with the Interagency Team

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- Work to regularly carry out the treatment plan in a positive, constructive way
- Engage with the MT during all prescribed hours so that the appropriate skills are being transferred to the long term caregiver, family, and/or educator
- Provide a safe and substance free working environment for staff
- Bring all questions and concerns to the attention of the Interagency Team
- Notify staff of any infectious illness in the home that could affect a staff member
- Respect the personal boundaries of the Mobile Therapist while working with the child in the home, school, or community – they are not a family member and they should not be treated as one
- Inform the MT of family vacations and/or illnesses which will prevent the MT from working their regular hours and provide adequate notification to the MT when prescribed hours are going to be affected

What should you expect from a Mobile Therapist?

- Your child and family will be treated with dignity, respect, sensitivity, and emotional care
- All rules and regulations regarding confidentiality will be adhered to (HIPAA)
- Your family's questions and concerns will be taken seriously and will be responded to promptly
- The MT will invite and encourage your child and family to participate actively with treatment and the planning process
- The MT will conduct themselves as professionals in your home – they will keep a clear, professional boundary with all family members at all times
- The MT will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises)
- The MT will not bring others to your child's home or school – such as their own children, other clients, significant others, etc.
- The MT will not engage in personal matters such as talking on the phone, running personal errands, reading a book, etc.

Suggestions for Parental involvement and responsibility

Parents and BHRS Staff need to be in a good partnership! How can we make that happen?

As a parent, I am responsible and can:

1. Identify my child's strengths and needs
2. Identify my own strengths and needs in relation to working with my child
3. Participate actively with the interagency team
4. Work to carry out the treatment plan in a positive, constructive way
5. Engage with the TSS during all of the prescribed service time, so that I learn skills to help my child when the TSS is not present
6. Provide a safe and substance free work environment
7. Bring all questions and concerns to the interagency team
8. Notify staff of any infectious illness in my home that could affect a staff member
9. Respect the professional boundaries of the staff; remember that they have a professional role that is different from family, friends or other types of workers.
10. Inform staff in advance of plans for vacations or other interruptions that will prevent the staff from working their regular hours.

What can a parent expect from BHRS staff?

1. Your child and family will be treated with dignity, respect, sensitivity and care
2. All rules and regulations regarding confidentiality will be strictly adhered to
3. Your family's questions and concerns are taken seriously and responded to promptly
4. Your child's service hours will be fully staffed. You will not have to wait beyond 10 days for a full complement of staff.
5. Replacement staff will be provided promptly if your regular staff is not able to fulfill the hours.
6. The staff will encourage your full participation in treatment.
7. Data about progress and goals will be shared with you on a regular basis.
8. The staff will be well educated about the needs of children with your child's diagnosis, and will have creative and effective strategies to try in working with your child.
9. The staff will work with you to build natural supports for your child to increase independence and success in all settings.

Professional rules and boundaries for BHRs staff working with your child:

1. The staff will conduct themselves as professionals within your home. They will keep a clear professional boundary at all times.
2. The staff will arrive on time and remain for the duration of the scheduled session, (unless an emergency or illness interferes.)
3. The staff will not bring other people to your child's home or school, such as their own children or family members, other clients, or significant others.
4. The staff will not engage in personal matters such as talking or texting on the phone, running personal errands, reading a book or magazine.
5. The staff will not take on other roles in your home, such as babysitting, substituting for a parent or caregiver, or doing housekeeping or cooking.
6. The staff will not perform the duties of school personnel, such as a teacher's aid, substitute teacher or academic tutor.
7. The staff will not perform personal care or nursing duties, such as feeding, dressing, attending to hygiene or toileting, or administering medication.
8. The staff will not provide transportation for you or your child, including to appointments.
9. The staff should not involve themselves in personal family activities or relationships that are separate from the child's treatment.
10. The staff will not restrain your child, except in accordance with the OMHSAS bulletin issued 4/8/02.
11. The staff will only perform activities outlined in the treatment plan.
12. The staff will take utmost care to protect you and your family's privacy, according to HIPAA laws.
13. The provider agency is responsible to ensure that your service hours are fully delivered as prescribed, at the times that best meet the needs of your family. Substitute staff members should be provided if your staff is not able to work.
14. Staff will make sure that you clearly understand and agree with any paperwork you are asked to sign. They will not ask you to sign blank documents.

Treatment

positive change



independence

Treatment Practices

Guidelines for BHRS service delivery permit tremendous latitude in how and what treatment is delivered to children under the BHRS umbrella. This has both a positive and negative effect. When providers are able to marry clinical expertise with creativity, the result can be exceptionally effective interventions that help children resolve mental health and behavioral deficits.

In a negative scenario, however, a provider could have gaps in expertise, as well as a lack of clinical supervision and oversight. The resulting interventions delivered in the home, school and community would then be weak in theoretical or practical competence. No provider wishes for this to be true of their services.

A written program description must guide the BHRS operations and delivery of services. This description should identify the core clinical orientation of the program, as evidenced in program policies and procedures. The core clinical orientation should be based on widely accepted clinical best practices. The staff training curriculum should also reflect this core clinical orientation. When using evidence based practice models, fidelity to the model is essential to the effectiveness of treatment and should also be evident in the training and policies.

Regardless of the clinical orientation, best practice services are designed to be trauma informed, evidence based and recovery focused:

- **TRAUMA INFORMED:** Many children experience mental health and behavioral symptoms as a result of trauma, whether or not that trauma is known. The provider must make continuous effort to develop and sustain a trauma informed culture, in which the structures, processes and staff interactions with the child and family are intended to facilitate healing and growth. The treatment culture reflects non violence, shared governance, open communication, respect and responsibility. Skill building toward affect management and self regulation is built into treatment interventions. The organizational structure and policies must reflect commitment to this culture at every level.
- **EVIDENCE BASED:** Interventions are to reflect current evidence based practice at all times. BHRS providers are to be committed to incorporating best practices through ongoing skills training, staff supervision and quality improvement.
 - ▶ Example1: The Positive Behavioral Intervention and Support (PBIS) model is an example of evidence based intervention that is becoming part of the educational culture of schools across Pennsylvania. This approach embraces direct teaching of pro-social behaviors, using positive reinforcement and minimizing negative critical feedback. The school environment is adapted to provide clear expectations, healthy structure and routines, and support of all students. Individual support is layered in for children experiencing difficulty, at the level they need. BHRS interventions in schools should become a seamless part of the entire school system of PBIS based interventions.

▶▶ Example 2: Therapy should be delivered using a clinical model known to be effective for the population that is served. This may include Dialectical Behavioral Therapy for children with severe mood dysregulation or self injurious behavior, CBT for anxiety and depression, and ABA for teaching skills to children with diagnoses on the Autism Spectrum. BHRS staff delivering therapy must show training and expertise before attempting interventions. Clinical supervision of all staff is expected.

- **RECOVERY FOCUSED:** Interventions will support children and families in achieving their potential for functioning. Recovery principles will be reflected in a focus on hope, maximizing strengths, self-determination, development of coping strategies and supportive relationships.

This toolkit includes several tools for use with BHRS clients, including information about:

- Crisis planning
- De-escalation techniques
- Recovery Oriented Treatment Planning
- Teaching skills through BHRS
- Natural supports in the community and in the family

Crisis Planning in BHRS

What is a mental health crisis?

A crisis is any situation in which the individual's moods and/or behaviors are out of control. Crises also occur when the individual or parent/caretaker are not able to resolve the situation with the skills and resources available.

What causes a mental health crisis?

Many things can lead to a mental health crisis. Increased stress, changes in family situations, bullying at school or substance use may trigger an increase in behaviors that lead to a mental health crisis.

Why develop a crisis plan in BHRS?

- To provide the consumer with a roadmap of what to do when he or she feels out of control and/or when crisis event(s) occurs;
- To boost the capacity of the child and family to increasingly rely on themselves to successfully manage their behaviors and independently cope with crisis situations;
- To promote appropriate reliance on natural supports in the event of a crisis;
- To utilize crisis/emergency personnel only in the event of a true emergency after personal and natural supports have been called upon to manage the event and the crisis situation still persists

What belongs in a crisis plan?

Effective crisis plans are thorough and individualized. Useful crisis plans typically include a progressive series of steps that allow each person involved to see their part in the crisis response.

Step 1. Identification of Behavior- Describe the behavior which causes the greatest danger or disruption to the individual or those around him/her. Identify the earliest indicators that the behavior may be starting.

Step 2. De-Escalation techniques- Describe the techniques that have been most successful in helping the person interrupt escalating behavior or cope successfully with significant stressors. Brainstorming can identify these techniques, which may include redirection, changing location, non-verbal cueing, verbal cueing and coaching or providing more assistance. Clearly identify a series of action steps/interventions that will be implemented in the event of a crisis. Eliminate any identified action steps that were tried in the past and made things worse. Recognize and address any barriers to proposed interventions. *If de-escalation techniques are not successful, proceed to Step 3.*

Step 3. Outside informal assistance- List the informal support persons who can provide on site or telephone assistance. These are usually people who have a calming effect on the person in crisis or can provide assistance with the other children while parents or educators concentrate on implementing the crisis plan. Sometimes the informal support persons will not directly focus on

the child in crisis, but will provide support and coaching to the adults involved. Identify several support people in the event that the first person(s) is not available. Include their phone numbers on the crisis plan. *If outside assistance is not successful, go to Step 4.*

Step 4. Outside formal assistance- It may be necessary to call a crisis line or the police. Include a crisis hotline number in the crisis plan. If police are called, officers may appreciate suggestions and clear expectations when making this call. Their primary activity will always be to assess safety, but they may also be the most skilled people on the team in calming people down. Knowing what was tried in previous steps and the outcomes will be important to them. *If crisis responders take the person into custody, go to Step 5.*

Step 5. Hospitalization or law enforcement custody- Learn how the crisis system operates and identify the decision-makers at this stage. Advise crisis responders of possible safe environments for the child to go to for the purpose of calming down, if a mental health or juvenile detention placement will not be utilized. The plan should include a suggestion about the best place for the child to be released to after custody by law enforcement, if that is a possible outcome. List the relatives, family friends or respite foster homes along with phone numbers so they can be contacted to pick up the child.

Safety is the first consideration at each step. It might be necessary to skip from Step 1 or 2 to Step 4 or 5 depending on the level of safety/crisis.

Practical Tips for Crisis Plan Development

Inclusion- It is important to include others in the creation of crisis plans. A first draft may identify those informal and formal supports who will be invited to provide input and/or participate in the final draft meeting. Inclusion in the discussion will give each person invited to be part of the plan an opportunity to express their strengths and limitations in implementing their role.

Distribution- Each person or organization participating in the crisis plan must receive a copy of the plan. All involved school staff will need copies of school crisis plans, for example.

Contingencies- The success of the plan may rest on including a range of options and back-ups. Prepare for contingencies by asking such questions as “What if that does not work.....or that person cannot be reached....or that option is not available?”

Review and update- Review the effectiveness of the crisis plan promptly after a crisis event occurs. This is to be a supportive, blame free discussion of the effectiveness of the plan. It is an opportunity to refine the plan and address obstacles. This gives the team an opportunity to evaluate how the crisis plan worked, whether it has any weaknesses, or if anything on the plan needs to be changed.

Crisis plans are also to be updated whenever a major family or school change occurs. Periodic reviews are also recommended, such as every 6 months.

The goal of treatment is always to increase independence and skill levels in the child and family. Increasing independence in self-managing crises is considered a hallmark of growth and recovery.

De-Escalation techniques

All BHRS staff need to be appropriately trained in de-escalation techniques for safety reasons. The primary objective in de-escalation is to calm the person down and maintain safety. De-escalation techniques that may help resolve a crisis include but are not limited to the following:

Non-Verbal De-Escalation:

1. Remain calm and self-assured.
2. Maintain limited eye contact.
3. Maintain a calm, attentive facial expression.
4. Keep a relaxed and alert posture. Stand up straight with feet about shoulder width apart and weight evenly balanced.
5. Minimize body movements. Do not point or shake your finger. Avoid sudden movements that could startle or be perceived as threatening. Move slowly.
6. Position yourself for safety:
 - Do not turn your back for any reason.
 - Maintain a distance of at least two arms' length between yourself and the agitated person.
 - Angle your body about 45 degrees in relation to the individual. This stance reduces your target size in the event of an attack, and also prepares you for escape if necessary.
 - Place your hands in front of your body in an open and relaxed position, making sure they are visible and free of any objects.
 - If possible, position yourself behind a barrier such as a sofa, desk, large chair, counter, table, or other large object.
 - If indoors, position yourself closer to the exit than the agitated person, but do not block the exit.
 - If you have time, remove necktie, scarf, necklaces, and hanging jewelry before you see the agitated person (out of sight of this person).

7. Encourage the individual to be seated, but if he or she needs to stand, stand up also.
8. Avoid touching the individual or getting into their personal space.
9. Actively attend and show you are listening by cocking your head slightly to one side or nodding once or twice.
10. Avoid an audience given it may escalate the situation. If other people are in the vicinity, ask them to leave the room to decrease distractions and protect the person's dignity.
11. Keep stimulation level low.

Verbal De-Escalation: The following are general guidelines for verbal de-escalation:

1. Speak slowly, gently and clearly.
2. Do not yell. Keep your voice calm and at an average volume.
3. Do not defend yourself or anyone else from any verbal comments.
4. Use short sentences.
5. Be very respectful even when firmly setting limits or calling for help.
6. Respond selectively. Answer only informational questions and keep responses brief and factual.
7. Be honest. Lying to calm down an agitated person may lead to future escalation.
8. Explain limits and rules in an authoritative, firm, but respectful tone. Offer options, whenever possible, in which both alternatives are safe ones.
9. Empathize with feelings but not with the behavior. Acknowledge any grievances, concerns or frustrations by briefly repeating the issue(s).
10. Suggest alternative behaviors if appropriate.
11. Do not ask how a person is feeling or interpret feelings in an analytic way.

12. Do not try to argue or convince.
13. List consequences of inappropriate behavior without threats or anger.
14. Represent external controls as institutional policy rather than personal.
15. Announce actions before initiating them.
16. Trust your instincts. If you assess or feel that your de-escalation strategies are not working, direct the person to a safe area. If the person does not leave to go to the safe area, remove yourself from the immediate area and call for help.

Cueing & Coaching

1. Use stress management or relaxation techniques such as breathing exercises. Verbally list simple steps the person can follow to begin to calm down or relax. Offer to do the stress reduction exercises with the person if they are receptive to the verbal prompts to begin the exercise. Share your willingness to coach them in performing the stress management techniques.
2. Use verbal cues such as “Tell yourself to calm down”, “Breathe slowly and deeply”, and “Stop and Think”.
3. Consider use of non-verbal cues such as raising and lowering your hands to signal to calm down.

Recovery Oriented Treatment Planning

Treatment planning should be a vital, engaging and relevant process for individuals. After all, it embodies the hoped-for life changes that brought them to seek services in the first place! No provider wishes to spend time and energy on a treatment plan that is peripheral to the consumer and family, and represents merely a document to be signed and filed away. However, learning to write a thoughtful treatment plan is challenging.

How does a provider make the treatment planning process a guide to hope and recovery, instead of an exercise in irrelevance?

1. Envision the plan as a “road map” for the journey to recovery:

- Supporting personal preferences
- Oriented toward independence and freedom
- Built on partnership between care providers, consumer, and family
- With defined landmarks and destination points

2. Make a plan that is functional and easily understood:

- Having specific intended outcomes/transitions/discharge criteria
- Defining expected results of service
- Promoting inclusion of alternative supports
- Establishing the role of the person served, and their family, in their own recovery

A well written recovery plan provides hope by breaking a seemingly impossible journey into manageable steps!

What are the elements of a recovery oriented treatment plan?

- The goal of the person served, and that of the family
- Discharge/transition criteria
- What are the child and family strengths to build on?
- What are the barriers?
- Objectives: steps to reduce and overcome barriers, and build on strengths
- Interventions: who will do what, to get to the goals
- Includes estimated duration

What is the process of creating a plan?

- Begin with assessment
- Develop understanding of the child and family’s needs and desires for treatment

- Prioritize what achievements will mean the most to the child and family
- Identify goals
- Identify strengths and barriers
- Define what objectives will serve as clear indicators of progress
- Create services to help child and family meet objectives
- Measure outcomes and adjust plan accordingly

Some discussion of goals:

Goals express the hopes and dreams of a child and family. They should be the wished for destination to be achieved through treatment. Goals are broad, long term and not always measurable. They show what is impossible in the present circumstances, but possible in the imagined life of the child and family.

A good goal inspires the individual to reconnect to their dreams.

Reaching agreement on the goal is essential. The goal must have relevance and meaning for the child and family, and be understood and appreciated by the service provider. **The goal is the shared vision of success.** Goal development then becomes an essential part of engagement and creating a therapeutic, collaborative relationship.

To be an effective road map, the treatment plan will need to define the smaller steps leading to the destination.

1. **Objectives** are milestones indicating progress. They show key measurable changes that the child and family wish to accomplish. An achieved objective should be acknowledged and celebrated!
2. **Barriers** are what get in the way of a person achieving their goal. They are found by asking, “What prevents this person from achieving the goal tomorrow?” The focus of the plan is reducing and resolving barriers that are a result of mental illness.
3. **Interventions** are the “how” of achieving the objectives. They answer the questions “How are we going to get there?” and “What action steps will bring us closer?” **Interventions must include a task for the family and other natural support systems to accomplish.**

Creating a person-centered, recovery oriented plan expresses the vision of the child and family for their hoped-for change. Each plan should reflect self direction, growth and enhancement of the core gifts of the child and family. Community integration and partnering with natural supports is essential for helping a child and family experience freedom and belonging in the world they inhabit.

Teaching skills through BHRS

The goal of BHRS is not simply to manage problematic behaviors. Children and families can learn new ways to approach challenges, regulate emotions and interact well with others. Recovery focused BHRS uses **skill transfer** as the primary means to increase the child and family's independence and growth. Skill transfer is the process of "giving away" knowledge about how to manage behaviors and affect desired change.

If done well, BHRS is *work* for families and children. The process is active rather than passive. The rewards of learning new skills can impact success over a lifetime. Skill development is the primary strategy for helping to alleviate skills deficits that contribute to problem behaviors

The goal of BHRS is not simply behavior *management*, but instead is behavioral *modification* and change. When attempting behavior modification rather than behavior management, interventions will need to address all dimensions of behaviors: setting events, antecedents, behaviors, and consequences.

Skill-focused therapeutic approaches such as Skill Streaming and Functional Behavioral Assessment suggest that problem behaviors develop out of skill deficiencies. This would imply that if a child is taught and supported in using the skills to perform the desired behaviors, the child will have an increased chance of changing their behaviors in a meaningful way.

One of the first steps in developing a skills focused approach is to identify the skill deficiencies that are preventing a child from using more appropriate behaviors. Once a team identifies the skill deficits for a child, the Behavioral Specialist Consultant, along with the family, can develop activities that support the development of the appropriate skills.

Implementing a Behavior Modification Plan includes:

- Development of a Master Skills List
- Identifying skill deficiencies through assessment
- Development of activities that support the development of the necessary skills

These skill oriented items should be present on all BHRS treatment plans. Skills needed by caregivers and family members are an additional critical part of this plan.

BHRS staff should use the "Teach-Model-Coach" approach to gradually give more responsibility to children and families.

Natural Supports

Research shows building and maintaining a social support network will improve the health and wellbeing of children and their families. Having support strengthens resiliency to stress and lowers the risk of suicide. To boost links to natural supports, a person can:

- **Identify a short list of family and friends** they wish to connect with.
- **Initiate contact with a small number of family and friends**, selecting how to connect (via in person, over the phone, or through electronic communication) and how frequently they should do so.
- **Establish realistic expectations** for oneself to contact and communicate with others. Openly communicating about topics, events, concerns, interests, needs, etc. as well as actively listening to others are important components of building a core social support network.
- **Plan social activities** and following through with participation are key elements as well. Regularly scheduling time to spend with a limited number of supports and engaging in either a positive communication and/or any meaningful activity, especially fun, strengthens one's support base.

Widening the circle of social support beyond immediate family and initial friendships is protective of health. Opportunities to socially engage present themselves during the course of every day living. The neighborhood, school, and community often offer social resources worth exploring. Interests, strengths, and skills can often lead an individual or family to join a group or organization. Also, being willing to try new activities or consider new ideas can expand a person's social network. Affiliations with religious, interest, support, and/or sports group can add to a person's support system.

Providers are encouraged to prompt individuals to build and foster natural supports to utilize in the recovery process. **At least 25% of all interventions on the treatment plan should reflect natural supports.**

Websites for exploring Natural Supports:

1. networkofcare.org Network of Care is a highly interactive, single information place where consumers, community-based organizations and municipal government workers all can go to easily access a wide variety of important information. The resources in this “virtual community” include a fast, comprehensive Service Directory; links to pertinent Web sites from across the nation; a comprehensive, easy-to-use Library; a political advocacy tool; community message boards; and many others.
2. paconnectingcommunities.org PA Connecting Communities (PACC) offers opportunities to individuals that need support to live at home and within the community to be as independent as possible. The focus is on job training and volunteer opportunities, friendship development, and engaging in the arts and community programs. PACC is currently active in Allegheny, Butler, Beaver and Washington Counties.
3. www.dpw.state.pa.us/About/ODP The Office of Developmental Programming (ODP) provides individuals with mental retardation and autism, and their families, services and supports to help them participate fully in community life.
4. vbh-pa.com Value Behavioral Health of Pennsylvania website offers families information about resources in each VBH-PA county, as well as state wide links and information about educational opportunities.
5. pafamiliesinc.com Pennsylvania Families Incorporated provides a statewide internet resource guide for child services. They also sponsor parent support groups and educational forums.

Discharge

empowerment



wellness

Discharge and Transition to next level of service

In a recovery driven model of BHRS, the child and family's progress will be encouraged and responded to by ongoing reduction of highly intrusive services. The expected outcome is eventual discharge from BHRS to services reflecting increased empowerment, natural supports and responsibility.

Thoughtful and planned transition and discharge from BHRS reduces the likelihood of a poor experience or even treatment failure for many families.

Attention must be given to the child's eventual discharge from services, both at the beginning of treatment, and throughout the entire process. Establishing a therapeutic relationship based on appropriate boundaries and expectations is critical. The provider must also ensure that dependency on BHRS does not prevent essential development of natural supports and individual and family skills.

As discharge approaches, specific provider actions are recommended to address the challenges of transition out of services. These include:

- Beginning next level of services well before discharge
- Planned trials of titration or weaning from services
- Using data from these trial periods to respond to any spike in negative behaviors
- Assisting the family to be comfortable with normal temporary regression during transition period
- Increasing BSC support as TSS is weaned
- Treating the upcoming separation from BHRS staff as the loss that it is. If relationships are meaningful, then families should be helped to manage the feelings associated with the end of that relationship.
- Clinical supervision to help staff manage their own feelings about discharge
- Engaging other child serving systems during transition. Early preparation is needed to avoid gaps in addressing the needs of the child.
- Developing with the family a written plan for preventing and responding to crises, relapses in negative behaviors, and new challenges.
- Giving the family a written outline of the discharge plan, including contact information for supports.
- Celebrating discharge as goal achievement, including at times a "graduation" ceremony or celebration.

This toolkit includes suggestions for helping families develop their own "toolkit" to aid them in working toward recovery and wellness.

Recovery & Wellness Toolkit for families

- A Recovery & Wellness Kit is a list of actions a person can take or tools a person can use to feel better when they are not feeling well or to stay well.
- Given stress affects everyone and has been found to have significant effects on a person's health and wellbeing, it is important to have a Recovery & Wellness Kit to cope successfully with stress and to promote one's mental and physical health.
- Research has shown that using a Recovery & Wellness Kit can enhance the quality of a person's life.
- For many people, developing a Recovery & Wellness Kit is an important first step in assuming personal responsibility and feeling empowered in managing their mental and physical health.
- It is critical to have the individual actively participate in developing a Recovery and Wellness Kit, and then assume ownership of it.
- To develop the kit, the individual might consider obtaining input from peers, family members, support groups, school or religious organizations, providers, managed care companies, governmental agencies, among others.
- The Recovery & Wellness Kit can include actions the person is taking now to feel better/well or other positive coping strategies they wish to practice. The kit can also include use of reliable and valid health and wellness tools and resources.
- Helping the person to identify their strengths and encouraging inclusion and creative usage of these strengths in their Recovery and Wellness Kit can be an important role for the provider.
- New actions and tools can be added to the Recovery & Wellness Kit as the person learns about new useful strategies and resources. Actions and tools that are not improving the mental and physical health of the consumer can be removed from the kit.
- As a person's needs and circumstances change, their Recovery & Wellness Kit should be updated to reflect those changes.
- Threats to recovery and wellness are also to be identified in building a Recovery and Wellness Kit. For example, behaviors such as alcohol and substance abuse or hurting self or others need to be

addressed and significantly reduced or eliminated. Consider educating and recommending self screenings for alcohol and drug abuse, and encourage the individual to take actions to reduce such health risks. Valid self screening tools are readily available on the SAMHSA website www.samhsa.gov as well as information about a vast array of alcohol and drug support groups and resources.

- Recognition of early warning signs that symptoms and/or illnesses are returning are especially important to identify and address in the Recovery & Wellness Toolkit. If the person becomes aware of these early warning signs, they can successfully learn how and when to take actions and to use the tools in their toolkit. Supportive others can also be educated about early warning signs and can rely on the Recovery & Wellness Toolkit to prompt or guide the consumer to take the healthy steps identified in their kit. Such relapse prevention steps are especially important in protecting one's mental and physical health.
- Incorporating a crisis plan into the Recovery & Wellness Toolkit can provide the individual, supportive others, and/or providers a roadmap of what to do when a person feels out of control and/or when crisis event(s) occurs. Frequently, people are at a loss to know what to do or who to turn to when they are in crisis. Preparing oneself (and others) with emergency contact information as well as a simple, concrete step by step plan to follow can often protect the safety of the person and others, lead to higher reliance on positive coping skills, and bring more rapid and appropriate help for the individual when they require help.
- Having ready access to updated information about recovery and available resources promotes recovery and wellness. The following links can aid consumers in taking charge of their recovery:

http://www.vbh-pa.com/member/mbr_resources.htm

www.valueoptions.com/members “Click on
“Tips & Resources”.

Resources about Recovery:

Sheedy C.K. and Whitte M., *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research?* HHS Publication No (SMA) 09-4439. Rockville, MS: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

Dunst, C. J., Trivette, C. M., & Deal, A. G. (Eds.). (1994). *Supporting and strengthening families: Methods, strategies, and practice (Vol 1)*. Cambridge, MA: Brookline Books.

Kettlewell P. W., Morford M.E., & Hoover H.V.A. (2005). *Evidence-Based Treatment: What It Is and How It Can Help Children*.

Kral, R. (1989). *Strategies that work: Techniques for solutions in the schools*. Milwaukee, WI: Brieg Family Therapy Center.

Nelson, C. M., & Pearson, C. A. (1991). *Integrating services for children and youth with emotional and behavioral disorders*. Reston, VA: Council for Exceptional Children.

Halvorson A., and Whitter M., *Approaches to Recovery-Oriented Systems of Care at the State and Local Levels: Three Case Studies*. HHS Publication No. (SMA) 09-4438. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

Pennsylvania DPW publications:

Guidelines for Best Practice in Child and Adolescent Mental Health Services. Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, Bureau of Children's Behavioral Health Services (2007)

Coatsworth, J.D, and Duncan, L., *Fostering Resilience: A Strengths Based Approach to Mental Health*. Publication Series, PA Office of Mental Health and Substance Abuse Services (2008)

Kettlewell, P.W., Morford, M.E. and Hoover, H.V., *Evidence Based Treatment: What It Is and How It Can Help Children*. Publication Series, PA Office of Mental Health and Substance Abuse Services (2005)

Websites:

<http://mhrecovery.com/referenceguide.pdf> Ohio Department of Mental Health's guide to readings about recovery.

nami.org National Alliance for the Mentally Ill is a grassroots public education and advocacy group.

samhsa.gov The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. Website has authoritative and up to date information on recovery movement.

parecovery.org Information about the Youth and Family Training Institute initiatives, including Hi Fidelity Wraparound Services.

Recovery Principles

Consumers and Providers are encouraged to endorse the Recovery Principles set forth in the Substance Abuse and Mental Health Services Administration's Consensus Statement on Mental Health Recovery.

Mental health recovery is considered a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions including the allocation of resources that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Source:

www.samhsa.gov

National Mental Health Information Center • 1-800-789-2647, 1-866-889-2647 (TTY)

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice, while striving to achieve his or her full potential.

(SAMHSA consensus statement on recovery)



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