

CF OPERATING PROCEDURE  
NO. 155-16

STATE OF FLORIDA  
DEPARTMENT OF  
CHILDREN AND FAMILIES  
TALLAHASSEE, May 16, 2019

Mental Health/Substance Abuse

RECOVERY PLANNING AND IMPLEMENTATION IN MENTAL HEALTH TREATMENT FACILITIES

1. Purpose. This operating procedure defines the requirements for providing recovery-oriented services through a person-centered planning and implementation process. The operating procedure describes the various components of the recovery planning and implementation process, including the resident's admission, assessment, recovery plan development, plan review and update, and interdisciplinary recovery team processes.

2. Authority.

- a. Chapter [394](#), Florida Statutes (F.S.), Florida Mental Health Act.
- b. Chapter [395](#), F.S., Hospital Licensing and Regulation.
- c. Chapter [916](#), F.S., Mentally Deficient and Mentally Ill Defendants.
- d. Chapter [744](#), F.S., Guardianship.
- e. Chapter [65E-5](#), Florida Administrative Code (F.A.C.), Mental Health Act Regulation.
- f. Chapter [65E-20](#), F.A.C., Forensic Client Services Act Regulation.
- g. Code of Federal Regulations; Title 42 Public Health, Chapter IV Subchapter C, Part 482, Subpart E, February 29, 2008.
- h. Children and Families Operating Procedure 155-1, Guidelines for the Use of Psychotherapeutic Medications in State Mental Health Treatment Facilities.
- i. Children and Families Operating Procedure 155-19, Evaluation and Reporting of Competency to Proceed.
- j. Children and Families Operating Procedure 155-20, Use of Seclusion in Mental Health Treatment Facilities.
- k. Children and Families Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities.
- l. Children and Families Operating Procedure 155-17, Guidelines for Discharge of Residents from a State Civil Mental Health Facility to the Community.
- m. Children and Families Operating Procedure 155-22, Leave of Absence and Discharge of Residents Committed to a State Mental Health Treatment Facility Pursuant to Chapter 916, Florida Statutes.
- n. Children and Families Operating Procedure 155-53, Suicide and Self-Injury Prevention.

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This operating procedure supersedes CFOP 155-16 dated December 15, 2017.

OPR: SMF

DISTRIBUTION: X: OSGC; ASGO; SMF; Region/Circuit Mental Health Treatment Facilities.

o. Financial and Services Accountability Management Systems (FASAMS) Pamphlet 155-2. [Staff Identifier Education/Credential Level section in Appendix 5 Data Code Values of Pamphlet 155-2 and https://www.myflfamilies.com/service-programs/samh/fasams/docs/Chapter%2005%20Treatment%20Episode.pdf](https://www.myflfamilies.com/service-programs/samh/fasams/docs/Chapter%2005%20Treatment%20Episode.pdf)

3. Scope. Guidelines described in this operating procedure apply to all state mental health treatment facilities serving residents committed to or in the custody of the Department under Chapter 394, F.S., or Chapter 916, F.S. This operating procedure is not applicable for Sexually Violent Predator Program residents at the Florida Civil Commitment Center.

4. Explanation of Terms. As used in this operating procedure, the following terms shall mean:

a. Annually. Within 365 calendar days of admission, and within 365 calendar days subsequent to admission.

b. Assessment. A written process of information gathering used to determine a resident's current level of personal functioning, mental and physical health conditions and needs, training and recovery needs, and the resident's preferences regarding recovery goals and the interventions that will lead to goal attainment.

c. Clinician. For the purpose of this operating procedure, a Physician licensed pursuant to Chapter 458 or Chapter 459, F.S., Advanced Practitioner Registered Nurse (APRN) licensed pursuant to Chapter 464, F.S., Physician Assistant licensed pursuant to Chapter 458, or Clinical Psychologist licensed pursuant to Chapter 490, F.S.

d. Competency Restoration Training. Education provided to the individual by a mental health provider to gain understanding and comprehension of the charges, legal process, possible court dispositions and the individual's rights under the law. This education may be provided over a period of time until the clinician is confident that the individual has demonstrated both a factual and rational understanding and comprehension of the information or it has been determined that the individual will not regain competency in the foreseeable future.

e. Functional Assessment. A process of gathering information regarding the resident's skills and abilities, linked to achieving the recovery goal(s) to enable the resident to live successfully in the community of choice. The functional assessment assists residents in understanding what skills and resources they will need to develop to achieve their goals.

f. Goals. Time-framed written statements developed with the resident which leads to the attainment of the resident's preferred living, learning, social, and vocational environment by resolving or managing issues.

g. Guardian. A person who has been appointed by the Court pursuant to Chapter 744, F.S., to act on behalf of a resident or property or both.

h. Guardian Advocate. A person appointed by the Court pursuant to Chapter 394, F.S., who is temporarily authorized to consent to mental health treatment on behalf of a resident who is committed under Chapter 394, F.S., and residing in a state mental health treatment facility.

i. Incompetent to Proceed (ITP). An individual who does not have sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding or an individual who has no rational, as well as factual, understanding of the proceedings against him or her. This adjudication is determined by the court pursuant to Chapter 916, F.S., and Florida Rules of Criminal Procedure 3.212.

j. Interventions. Treatment approaches, services, training or rehabilitation activities, and written methodologies (e.g., visual aids, journals, and other materials) used to assist residents in achieving identified goals and objectives.

k. Issue/Need List. A written document referencing recovery issues and needs which begins at admission and is maintained and updated throughout the resident's stay. The recovery issues must be clear, concise and simply stated.

l. Level of Care Utilization System (LOCUS). A quantifiable measure used to guide individual assessments resulting in level of care decisions. The LOCUS consists of six clinical and rehabilitative dimensions for composite scoring which corresponds with a particular level of care. Training on the administration and use of the LOCUS is required for all recovery team members providing input into the scoring of the LOCUS.

m. Periodic Review. A review of the recovery plan, conducted by the recovery team to evaluate and consider the resident's progress toward goals and objectives, and to modify the plan as appropriate.

n. Objective. A written statement of intermediate steps toward a goal which will assist the resident in attaining long term community outcomes or competency to proceed to trial, as appropriate. Objectives must be written in behavioral terms and must be measurable.

o. Personal Safety Plan. A document containing information regarding calming strategies identified by the resident as being helpful in avoiding a crisis, such as the use of seclusion or restraint. This document is completed by the resident, with assistance from facility staff, if needed. It is used as a guide to increase awareness of strategies that can be used to de-escalate situations before a crisis arises. For each resident, the plan identifies calming strategies; actions that are "triggers" to a potential crisis situation; personal signs or signals of distress; individual preferences regarding staff interactions during a pre-crisis situation and the type of emergency intervention used; medications which the resident has found to be helpful in emergency situations; and, information regarding past traumatic experiences. This plan is reviewed by staff upon initial admission to the facility, after any significant event (seclusion, restraint, altercation, etc.) and is updated at least annually (see form CF-MH 3124, available in DCF Forms).

p. Qualified Staff Person. A staff member who is qualified to perform a specified function by virtue of the following: education, experience, competence, and/or applicable licensure, certification, or credentials as determined by the facility and in accordance with state and federal regulations.

q. Recovery. Recovery is a process by which a person with mental illness and/or emotional disturbances overcomes the negative impact of such conditions despite their continued presence and which incorporates hope, personal responsibility, education, self-advocacy, and developing and maintaining of a support system.

r. Recovery Plan. A written plan developed within 30 calendar days of admission by the resident and his or her recovery team. This plan is based on assessment data, identifying the resident's clinical, rehabilitative and quality of life/enrichment service or recovery needs, the strategy for meeting those needs, documented treatment and recovery goals and objectives, criteria for terminating the specified interventions, and documented progress in meeting specified goals and objectives. Also referred to as the "plan". The recovery plan is reviewed at least every 30 calendar days.

s. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community or forensic case manager, family member, and other treatment professionals commensurate with the resident's needs, goals, and preferences.

t. Resident. A person who resides in a state mental health treatment facility. The term is synonymous with “client”, “consumer”, “individual”, “patient”, or “person served”.

u. Risk Assessment. A process of gathering information relating to issues impacting the health, safety, or security of a resident or others through identification of factors that could result in harm or serious injury.

v. Screening. A tool used to identify a potential issue for the resident that may require further assessment to identify a need or establish a diagnosis.

w. Stabilization Plan. A plan developed within five (5) calendar days of admission, which includes, but is not limited to, treatment interventions initiated in the initial psychiatric evaluation. This plan is developed by the resident, the recovery team, and guardian/guardian advocate (if the resident has a guardian/guardian advocate), to address immediate personal, behavioral, mental, and physical health care needs to assist the resident with stabilization and adjustment to the facility environment during the first 30 calendar days.

## 5. Assessments.

a. Physical Examinations. A physical examination will be completed by a physician or Advanced Practitioner Registered Nurse (APRN), under the direction of a physician, within 24 hours of the resident’s admission and at least annually thereafter. The physical exam will include a neurological screening; provisional or admitting diagnosis of current diseases; medical history; and current therapies. A neurological consultation will be requested if warranted. The components of the physical examination and medical care plan are outlined in CFOP 155-1. The medical examination will include a summary of findings and a medical care plan for each acute or chronic medical illness identified, including planned interventions, specific measurable outcomes and timeframes for treatment, and will be provided to the Recovery Plan Coordinator (or designee) for inclusion on the Recovery Plan. A comprehensive medical history and physical examination conducted within 30 calendar days prior to the resident’s admission will be acceptable if a legible copy is provided and updated within 24 hours of the resident’s admission.

b. Psychiatric Evaluations. The admitting psychiatrist or psychiatric APRN, under the direction of a psychiatrist, will complete a psychiatric evaluation within 60 hours of admission and at least annually thereafter. The components of the psychiatric evaluation and psychotherapeutic medication treatment plan are outlined in CFOP 155-1. This evaluation will include a provisional diagnosis and development of an initial plan of care. The psychiatric plan of care will be developed by a psychiatrist/psychiatric APRN, in conjunction with the resident or his guardian/guardian advocate (if applicable) and the other members of the recovery team.

(1) The psychiatrist or psychiatric APRN will discuss the diagnosis, target symptoms, and recommended treatment options with the individual, guardian or guardian advocate (if appropriate), and recovery team when developing the recovery plan.

(2) Identified issues resulting from this assessment along with observable and measurable objectives and objective-related treatment interventions shall be provided to the Recovery Plan Coordinator (or designee) for inclusion in the resident’s stabilization and recovery plan or justification for not addressing identified issues shall be documented in a progress note.

c. The Nursing Assessment will be completed by a registered nurse within 24 hours of the resident’s admission and at least annually thereafter. The components of the nursing assessment and nursing care plan are outlined in CFOP 155-1. The assessment shall include a nursing diagnosis or identified nursing issues; and nursing planned interventions to address the resident’s identified needs. Identified issues resulting from this assessment along with observable and measurable objectives and

objective-related treatment interventions shall be provided to the Recovery Plan Coordinator (or designee) for inclusion in the resident's stabilization and recovery plan or justification for not addressing identified issues shall be documented in a progress note. Initiation of a Personal Safety Plan in the form of identified personal safety strategies shall also be identified on the nursing assessment.

d. The Psychological Assessment is completed by psychological services staff within 30 calendar days of the resident's admission and at least annually thereafter. Information generated from this assessment along with observable and measurable objectives and objective-related treatment interventions shall be provided to the Recovery Plan Coordinator (or designee) for inclusion in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note. The psychological assessment may include, but will not be limited to interviews, observations, review, and formal evaluation results as deemed necessary by psychology staff.

e. The LOCUS must be administered for all residents committed pursuant to Chapter 394, F.S. (Baker Act), and all residents committed pursuant to Chapter 916, F.S., as Not Guilty by Reason of Insanity. The LOCUS will be completed using input from the resident's recovery team. If issues are identified on the LOCUS, they shall be provided to the Recovery Plan Coordinator for inclusion in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note. The LOCUS assessment score sheet shall be placed in the resident record. The LOCUS will be completed and reported as follows:

(1) Within 14 days of the resident's admission to the facility;

(2) Within 14 days of each six-month anniversary of the resident's admission; and,

(3) Within 14 days of the resident's actual discharge from the facility. If a resident is discharged unexpectedly and the discharge LOCUS has not been completed prior to departure, the LOCUS may be completed by the staff involved in the resident's treatment within five (5) working days of the resident's discharge (in absence of the resident).

(4) Assessment results will be reported to DCF by the 18<sup>th</sup> of every month utilizing the LOCUS assessment score sheet and will include the following fields (\*\*NOTE\*\* all fields must be included unless otherwise specified):

(a) First name;

(b) Middle name (this field is only required where middle name is known);

(c) Last name;

(d) Evaluation date;

(e) Medical record number (must be unique for client);

(f) Legal status (NGI, 394);

(g) Evaluation interval;

(h) Facility;

(i) Risk of harm score;

(j) Functional status score;

(k) Co-morbidity score;

- (l) Recovery environment-stress score;
- (m) Recovery environment-support score;
- (n) Treatment and recovery history score;
- (o) Engagement and recovery status score;
- (p) Composite score;
- (q) Level of care recommendation; and,
- (r) Reviewer name.

f. The Dental Assessment will be completed by the dentist within six (6) months of the resident's admission and at least every six (6) months thereafter. If a dentist is not available, the dental assessment may be completed by medical staff with a referral to an outside dentist if there is an acute problem.

g. Comprehensive Psychosocial History will be completed by social services staff within the first 15 calendar days of the resident's admission and updated at least annually thereafter. Identified issues resulting from this assessment along with observable and measurable objectives and objective-related treatment interventions shall be provided to the Recovery Plan Coordinator (or designee) for inclusion in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note.

h. Rehabilitation Assessment will be completed within 15 calendar days of the resident's admission and updated at least annually thereafter. The Rehab Assessment shall include a Vocational and Educational Preference Screening and will include the resident's educational and work history and any desire to further or enhance education or job skills during treatment. The assessment shall address functional living, learning, working and social barriers to discharge. Identified issues, observable and measurable objectives and objective-related interventions shall be provided to the Recovery Plan Coordinator (or designee) for inclusion in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note.

i. Each resident will have the following required screenings completed at the indicated frequency. Identified issues resulting from these screenings along with treatment interventions shall be included in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note.

(1) History of trauma, abuse, and neglect screening will be completed by a recovery team member within 60 hours of the resident's admission. Results of the screening will be documented on the psychiatric assessment and/or nursing assessment.

(2) The need for specialized rehabilitative services (e.g., Occupational Therapy, Physical Therapy, speech, language, and hearing) will be assessed by the admitting physician within 24 hours of the resident's admission. This assessment can be included in the physical examination. Referral for consultation will be ordered as needed.

(3) Substance abuse screening to determine the need for substance abuse related programs or services will be completed within 15 calendar days of the resident's admission, and as needed thereafter. This screening focuses on determining if the resident has had problems with abusing substances in the community prior to admission. The focus is not to determine whether the resident is actively experiencing addiction withdrawal.

(4) Nutritional Screening will be completed during the nursing assessment (within 24 hours of the resident's admission). Each resident identified as needing a full nutritional assessment during the nutritional screening will be referred to a registered dietician for a full assessment to be completed within 30 days.

j. A Personal Safety Plan will be initiated within 24 hours of the resident's admission and documented on the initial Nursing Assessment as indicated in paragraph 5c above. The Personal Safety Plan will be completed within 30 calendar days and updated at least annually thereafter. It will be reviewed/updated within 2 working days of a significant event, a level 2 altercation or resident's release from seclusion or restraint. Per operating procedures CFOP 155-20, Use of Seclusion in MHTF and CFOP 155-21, Use of Restraint in MHTF, secluded and restrained individuals are required to have an opportunity to meet with staff for a debriefing of the event within 24 hours of release. Identified issues resulting from an episode of seclusion or restraint along with treatment interventions shall be included in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note.

k. Assessment of each resident's risk of suicide shall occur within 24 hours of admission, annually, and when indicated using the latest version of the Columbia-Suicide Severity Rating Scale (C-SSRS). The C-SSRS shall be administered by a clinician as defined in this operating procedure, a Registered Nurse, or Psychology Intern/Resident under the direct supervision of a licensed Psychologist. Results shall be documented in a progress note and included in the resident's recovery plan if clinical concerns are present. Refer to CFOP 155-53 for the minimum standards in suicide and self-injury prevention.

l. ***The HCR-20 Version 3***, Coding Sheet will be used to assess forensic residents prior to their transfer from a secure inpatient forensic site to a less restrictive environment and within 90 days preceding conditional release from the facility. Residents with known histories of felony convictions for crimes of violence or related arrests, who are committed under Chapter 394, F.S., shall be assessed utilizing the HCR-20<sup>V3</sup> Rating Sheet upon admission and within 90 days prior to discharge from the facility. Assessment will be conducted by a Qualified Staff Person trained in the use of the assessment tool.

m. For individuals committed for competency restoration in a mental health treatment facility, refer to CFOP 155-19, "Evaluation and Reporting of Competency to Proceed," for competency restoration and reporting guidelines. Aftercare recommendations should be part of the competency report to the court if community release is recommended and this recommendation should be consistent with the Transition / Discharge plan in the recovery plan.

## 6. Assessment Process.

a. Assessments are a continuous process occurring throughout the resident's treatment in the facility. Assessment results will be utilized to identify goals, objectives, interventions, and clinical needs to address restoration of competency to proceed to trial (if committed to the facility as Incompetent to Proceed), or to address functional living, learning, working, and social activities for recovery.

b. Assessments of each resident's needs and preferences will be based on collection and analysis of data including:

- (1) Interviews;
- (2) Observations;
- (3) Formal assessment results;

- (4) Review of records;
- (5) Responses to previous treatment; and,
- (6) The resident's preference.

c. Annual assessments should not be completed more than 30 calendar days prior to or 30 days after the anniversary of the resident's admission date.

d. The results and interpretation of all completed assessments shall be reviewed with the resident and documented in the medical record.

e. Documentation of assessment results will be completed at specified intervals and shall include:

- (1) Relevant data;
- (2) A written summary of findings;
- (3) Recommendations for treatment or services (issues/needs if indicated), including proposed objectives with identified measurable outcomes for inclusion in the resident's recovery plan; and,
- (4) Documented discussion of assessment results and interpretation with the resident including any feedback or input from the resident.

f. Each resident will be formally reassessed and his or her information will be updated no less than annually, or at a frequency indicated below with the results reflected in the recovery plan:

- (1) At regularly specified times related to the resident's course of treatment as needed;
- (2) Whenever indicated to determine the resident's response to treatment, i.e., when a resident meets their objective, or when a resident does not make progress toward an objective;
- (3) When a significant change occurs in the resident's condition; and,
- (4) When a significant change occurs in the resident's clinical diagnoses.

g. The recovery team along with the resident will assess the resident's recovery needs within 30 calendar days of admission and every 30 calendar days thereafter.

## 7. Issues/Needs.

a. Issue statements are brief, succinct statements of issues/needs/challenges. Identified issues may be related to a resident's behavior, psychosocial manifestations, medical concerns, abnormal laboratory findings, recovery process or anything that is identified by the resident as necessary for improving his/her quality of life or functioning. The Issue list will be maintained and updated throughout the resident's treatment in the facility. It is updated, at a minimum, during scheduled recovery team meetings. Once an identified issue is assigned an issue number, it maintains its original number throughout hospitalization. Ongoing psychiatric symptomatology, physical health care issues, discharge barriers, etc. must be identified on this list.



b. Issues will be designated as:

(1) Active, indicating the issue is currently a focus of treatment, services, or ongoing monitoring, or is being successfully treated and managed;

(2) Inactive, indicating the issue is no longer active and is not a current focus of treatment; and,

(3) Deferred, indicating the issue is important but is not currently the focus of treatment or services. The recovery team members will revisit the issue within 90 days and determine if it should become active or continue to be deferred for an additional 90 days. Deferred issues will become active or resolved after the second 90-day period of being deferred by the recovery team.

c. Corresponding documentation by the responsible recovery team member shall be provided to describe the reason for the assigned status. The responsible recovery team member/designee shall sign (or initial) the issue when identified and when the status of the issue changes. The appropriate dates must be indicated each time the status of an issue is changed.

d. All active issues must be maintained on the list and addressed in the recovery plan. Resolved issues will remain on the issue list, but do not need to be maintained in the recovery plan.

e. All issues, with the exception of medical issues, in the recovery plan shall reflect resident specific behaviors/needs.

f. Acute Medical/Temporary Issues. A list of acute medical problems not added to the Recovery Plan by the physician and/or nurse, based on laboratory results or presenting symptoms. This list is separate and apart from the primary issues list utilized in the plan. These health care concerns are expected to be of a transitory or temporary nature that will not persist for more than 30 days. The assessor and primary provider of care for the need is responsible for adding the problem to the acute/temporary list and documenting care and progress in their discipline progress notes. Examples include upper respiratory tract infections, urinary tract infections, ingrown toenails, and athlete's foot. Declaration of a temporary issue implies that treatment will be delivered and might include medication, nursing care, and comfort measures.

8. Stabilization Plans.

a. A written stabilization plan will be developed by the resident and recovery team based on resident input, the current community admission information and preliminary assessment results. The plan will be based on an interdisciplinary assessment of risk and any other available medical records.

b. The recovery team will meet and develop the stabilization plan within five (5) calendar days of the resident's admission.

c. The written stabilization plan and subsequent recovery plans will include, but are not limited to:

(1) Up-to-date Diagnostic and Statistical Manual of Mental Disorders diagnoses;

(2) Active issues, needs, concerns, and plans for resolving them with time frames and responsible person(s) indicated;

(3) Barriers to discharge and proposed actions to resolve;

(4) Level of access to grounds, with restrictions justified, and plans for restoring freedom of movement when appropriate. This does not apply in forensic facilities where residents do not earn freedom of movement;

(5) Resident input in the development of this plan with each discipline involved (either documented on plan, relevant assessment, or progress note); and,

(6) Goals and objectives related to resident recovery and discharge.

d. For residents who are admitted as Incompetent to Proceed, the stabilization plan and subsequent recovery plans will address the issues listed above and focus on providing clinical and rehabilitative treatment for restoration of competency to proceed to trial and subsequent return to the court system and potentially the community.

e. A copy of the stabilization plan and all subsequent recovery plans will be given to the resident and mailed to the legal guardian and/or guardian advocate (as required by consent status) for review and approval. If necessary, the plan may be negotiated and revised to the satisfaction of such persons without compromising the health, safety, or security of the resident or others.

## 9. Recovery Plans.

a. Within 30 calendar days of the resident's admission, the resident and recovery team will develop an individualized recovery plan. This plan will be developed in a collaborative manner utilizing information from the comprehensive assessments.

b. Based on evaluations, assessment findings and resident input, the Recovery Team Coordinator (or designee) will compile a list of proposed treatment and recovery issues and needs for consideration. The Recovery Plan Coordinator (or designee) will discuss the issues and proposed interventions with the resident prior to initial recovery plan development. The facility's catalog of services should be reviewed with the resident at this time. This meeting will be documented on a team progress note and included in the medical record.

c. To the extent possible, the resident's involvement and participation is required in the development of the plan. The resident will be given the opportunity to identify and/or concur with goals, objectives, interventions, schedules and other aspects of the recovery plan.

d. The recovery plan will be organized in a manner listing goals, objectives, and interventions that assist the resident in moving toward recovery goals.

e. The plan will be written in specific, measurable, descriptive terminology easily understood by the resident and team members.

f. The recovery plans will include:

(1) The resident's perspective on their treatment needs, goals, and progress.

(2) Issues that are defined to reflect resident specific legal, psychiatric, medical, rehabilitation, enrichment, and discharge needs designed to bring about return to the community or to the judicial system.

(3) Measurable overall recovery goal with targeted completion date.

(4) Resident's Long-Term View that reflects their future plans for living/learning/working/socializing. If the resident is unable to express their Long-Term View during initial recovery plan development, it should be developed over time as the resident's condition permits.

(5) Observable and measurable objectives with target dates for completion. Objectives should describe the expected outcome, behavior or response in measurable terms that can be observed or heard, linking directly to either an issue on the Issues list or discharge barrier.

(6) Planned interventions to address objectives that include frequency of services and responsible team members. Interventions should address the following areas as appropriate:

(a) Clinical treatment services focusing on assessing, diagnosing, and stabilizing mental and physical health;

(b) Rehabilitation services focusing on developing skills and resource supports to enable residents to adapt to or overcome the functional living, learning, working and social challenges that result from mental illness;

(c) Competency restoration services to assist residents committed as incompetent to proceed;

(d) Quality of life services allowing the resident to participate in activities they find personally rewarding; and,

(e) Barriers to discharge and actions to resolve them.

(7) When the recovery team anticipates or recommends discharge to the community, a Transition / Discharge Plan that identifies issues impacting community placement, including:

(a) LOCUS level of care outcomes.

(b) Recommended Discharge Placement.

(c) Functional Assessment Summary that identifies resident's strengths and challenges. Refer to CFOP 155-17, "Guidelines for Discharge of Residents from a State Civil Mental Health Facility to the Community" for additional details. This summary should guide the discharge plan and should address all potential discharge barriers affecting;

1. Activities of Daily Living;
2. Communication skills and basic education;
3. Economic resources;
4. Employment / Vocational choices;
5. Legal and commitment status including past and present charges;
6. Leisure / recreation interests;
7. Physical, medical and mental health issues;
8. Relationship and support systems;
9. Identification and citizenship issues;

10. Religious/spiritual interests and cultural orientation; and;

11. Psychological / behavioral issues.

(d) Risk Assessment.

(e) Discharge Plan.

g. Recovery plan meetings will occur according to the following guidelines for residents in civil and forensic facilities:

(1) The recovery plan will be reviewed by the recovery team at least every 30 calendar days. All recovery team members should attend recovery plan meetings.

(a) Prior to each review, all progress notes and assessments will be reviewed to ensure identified needs are addressed in the plan. If the identified needs are not addressed, a justification must be provided.

(b) At each review, a comprehensive progress note or team meeting note will be placed in the medical record to document the meeting.

(2) The recovery team will meet and update the plan any time it is clinically indicated, and according to the following conditions:

(a) When changes are warranted based on periodic review of resident's progress toward each objective, and any time in between these reviews when reassessment identifies a new or revised issue;

(b) After a significant event has occurred;

(c) After review by the team to restrict or continue restriction of access to grounds;

(d) When a risk factor is identified impacting the health, safety, or security of the resident or others;

(e) When a lack of progress toward meeting an objective has occurred for 60 days; and,

(f) A comprehensive, new Recovery Plan will be placed in the medical record annually.

h. Each service provider shall evaluate individual progress toward identified goals and objectives and shall discuss progress with each resident at least monthly for the treatment or service they are providing and document in the monthly service / progress notes prior to each review of the recovery plan. The documentation should include the resident's perspective regarding their services, progress, and future desires if any.

i. A new objective should be written when the identified objective is met but the issue remains active. If the achieved objective remains in the plan, justification for continuing the objective shall be documented.

j. Recovery team members will ensure that the recovery plan is developed, implemented, reviewed, and revised according to the guidelines herein, and with participation, as appropriate, of the resident, his or her family, and his or her natural support system.

k. The recovery team coordinator or designee will document the effort to communicate (written, orally) the contents of the plan to the resident, and guardian or guardian advocate as appropriate at any time the plan is updated.

l. Each facility will maintain a catalog of services.

(1) The catalog will list the following:

- (a) Interventions and services;
- (b) The benefits of such services;
- (c) Referral source; and,
- (d) Format and intended population.

(2) These services will be evidenced-based, promising practices, or practices with demonstrated effectiveness, and will be approved by the Hospital Administrator of the facility.

(3) Services that are not evidenced-based or promising practices must be approved in advance by the Hospital Administrator.

(4) The Hospital Administrator of the facility will support and ensure training, coaching, and fidelity monitoring are provided to the service providers and will monitor outcomes related to program fidelity and resident achievements.

(5) Each facility will provide their catalog of services, and any subsequent updates, to the Director of Policy and Programs.

m. Each facility will maintain a master schedule of interventions/services outlining the days, times, location, instructor and availability of each.

BY DIRECTION OF THE SECRETARY:

*(Signed original copy on file)*

WENDY SCOTT  
Director, State Mental Health Treatment Facilities, Policy and Programs

**SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL**

Deleted paragraphs 2e, 2g and 2i because there were no references to any of these documents in the operating procedure; in paragraph 4c and throughout the operating procedure, changed ARNP to APRN; in paragraph 4o, revised the definition of Personal Safety Plan to be consistent with other operating procedures; changed paragraph 4r to require Recovery Plan review every 30 days regardless of length of stay; added requirement in paragraph 5 for those conducting assessments to provide findings, objectives and interventions to the Recovery Plan Coordinator; revised paragraph 5a to be consistent with CFOP 155-1; revised paragraph 5b(2); added paragraph 5e(4); deleted paragraph 5g which addressed vocational and education preference screening; in paragraph 5g (formerly paragraph 5h) changed the timeframe for completing psychosocial history from 15 working days to 15 calendar day; added new paragraph 5h to require rehabilitation assessment; deleted paragraph 5i which addressed nutritional screening, and added nutritional screening as the new paragraph 5i(4) and changed the timeframe for full nutritional assessment to 30 days; revised paragraph 5i(3) timeframe for substance abuse screening from 30 days to 15 days; in paragraph 5j (formerly 5k) revised Personal Safety Plan review requirements; in paragraph 5m (formerly 5n) revised timeframe to conduct competency evaluations in to be consistent with CFOP 155-19 and added clarifying report requirements for those recommended for community placement; in paragraph 6c revised annual assessments to 30 days prior or 30 days after anniversary of admission; deleted paragraph 6e as a duplicate statement; in paragraph 6f(2) (formerly 6g(2)) added clarifying statement indicating when reassessment might occur; in paragraph 6g (formerly 6h) revised recovery needs review to every 30 days regardless of LOS; in paragraph 8d added language for ITP residents recommended for community placement; and significantly restructured and revised paragraph 9.

[To see "INSTRUCTIONS," click paragraph symbol ¶ on "Home" tab at top of your computer screen.]

**State Mental Health Treatment Facilities (fillable version available in DCF Forms)**

Master     Annual (enter "X" in applicable field)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

**Legal Status: Involuntary Commitment Status Forensic – ITP**

**Consent Status for**

**Order Expires:**

***ALL DISCIPLINES MAY WRITE ON THIS DOCUMENT (sign and date what is added)***

- This Recovery Plan has been reviewed with me in words and language that I understand.
- This Recovery Plan reflects my input and suggestions.
- I understand that a copy of my Recovery Plan will be made available to me at my request.)

Check One:     COPY PROVIDED     COPY REFUSED

Name of Interpreter (if applicable): \_\_\_\_\_

Resident Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian/GA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Recovery Goal:**    Date Entered:                      Target Date:

Goal:

**Resident's Perspective of Treatment Needs, Goals and Progress:**

**State Mental Health Treatment Facilities**

Master  Annual (check one)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

**Long Term View (in resident's own words):**

Date Entered:

Living:

Learning:

Working:

Social:

**Issues**

Issue #: 1.0 Issue Date:

Issue Status:

Issue Type:

Issue Description:

**Objectives:**

Objective #1 Staff:

Measurable objective with target dates for completion:

Objective # Staff:

Measurable objective with target dates for completion:

**Interventions with frequency:**

Date Entered:

Discipline Responsible:

Staff Name:

Intervention with frequency:

Date Entered:

Discipline Responsible:

Staff Name:

Intervention:



**State Mental Health Treatment Facilities**

Master  Annual (check one)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

<p>Date Entered:</p> <p>Discipline Responsible:</p> <p>Staff Name:</p> <p>Intervention:</p> <p>Date Entered:</p> <p>Discipline Responsible:</p> <p>Staff Name:</p> <p>Intervention:</p>
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**Issues**

Issue #: 2.0 Issue Date:

Issue Status:

Issue Type:

Issue Description:

<p><b><u>Objectives:</u></b></p> <p>Objective #1 Staff:</p> <p>Measurable objective with target dates for completion:</p> <p>Objective # Staff:</p> <p>Measurable objective with target dates for completion:</p>
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<p><b><u>Interventions with frequency:</u></b></p> <p>Date Entered:</p> <p>Discipline Responsible:</p> <p>Staff Name:</p> <p>Intervention with frequency:</p> <p>Date Entered:</p> <p>Discipline Responsible:</p> <p>Staff Name:</p> <p>Intervention:</p>
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**State Mental Health Treatment Facilities**

Master     Annual (check one)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

Date Entered:
Discipline Responsible:
Staff Name:
Intervention:
Date Entered:
Discipline Responsible:
Staff Name:
Intervention:

<b><u>DSM Diagnosis:</u></b>	Date:
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**State Mental Health Treatment Facilities**

Master     Annual (check one)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

**Transition to Community Placement**

**Functional Assessment Summary**

Date:

**Activities of Daily Living**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Basic Education and Communication Skills**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Economic Resources**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Employment / Vocational**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Legal and Commitment Status**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Leisure / Recreation Interests**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Physical / Mental Health**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Identification / Citizenship**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Relationships and Support Systems**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**Religion / Spiritual Interests and Cultural Orientation**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>
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**State Mental Health Treatment Facilities**

Master  Annual (check one)

Originally Completed:

Last Updated:

Resident Name:

Admission Date:

**Psychological / Behavioral**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>

**Identification / Citizenship**

<u>Strengths and Assets</u>	<u>Needs and Concerns</u>

**LOCUS Outcome:**

**Recommended Discharge Environment:**  
Discharge Options:  
Comments:

**Risk Assessment:**  
Violence / Aggression to Others: Risk Level:  
Recovery Plan Issue:  
Suicidality / Self-Injury: Risk Level:  
Recovery Plan Issue:  
Escape / Elopement: Risk Level:  
Recovery Plan Issue:  
Vulnerability: Risk Level:  
Recovery Plan Issue:

**Discharge Barriers:**  
Comments:

**Discharge Plan:**

