Community Services Review
For an Adult Service Participant

For Examination of
Adult Mental Health Services

Version 4.0

Developed for the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2004

Person's Name	Person's Location	Reviewer	Case Number

The Community Services Review for Adults

This protocol is designed for use in a case-based Quality Service Review (QSR) process developed by Human Systems and Outcomes, Inc. (HSO). It is used for: (1) appraising the current status of persons receiving services (e.g., adults with serious and persistent mental illness) in key life areas and (2) determining the adequacy of performance of key practices for these same persons. The protocol examines short-term results for adults with mental illness and any home providers and the contribution made by local providers and the service system in producing those results. Case-based review findings will be used by the **Dixon Court Monitor** in stimulating and supporting efforts to improve services for adult participants who are residents of the District of Columbia.

These working papers, collectively referred to as the *Community Services Review Protocol*, are used to support a professional appraisal of adult participant status and service system performance for specific persons in a specific service area and at a given point in time. This protocol is not a traditional measurement instrument designed with psychometric properties and should not be taken to be so. Localized versions of quality service review protocols are prepared for and licensed to service agencies for their use. The QSR is based on a body of work by Ray Foster, PhD and Ivor Groves, PhD of HSO.

Proper use of the *Community Services Review Protocol* and other QSR processes requires reviewer training, certification, and supervision. Supplementary materials provided during training are necessary for reviewer use during case review and reporting activities. Persons interested in gaining further information about this process may contact an HSO representative at:

Human Systems and Outcomes, Inc.

2107 Delta Way

Tallahassee, Florida 32303-4224

Phone: (850) 422-8900
Fax: (850) 422-8487

General Information

Person's Name, Last Name First	Date of Birth	Age	Gender	Race/Ethnicity
	___/ ___/ ___		☐ Male ☐ Female	

Person's Home and, If Appropriate, Caregiver

Person's Present Home Address and Phone Number	Usual Home Address, if different from Present
Address: Phone:	Address: Phone:

Person's Significant Other or Caregiver	Usual Partner/Caregiver, if different from Present
Relationship:	Relationship:

Person's Major Daytime Activity and Contact Person

Person's Current Daytime Activity/Job Location	Usual Daytime Activity Location, if different from Present
Name: Address: Phone:	Name: Address: Phone:

Person's Primary Caseworker/Counselor	Person's Primary Therapist
Person's Title:	Person's Title:

Person's Current Placement Situations

Type of Present Home Placement: check only one

- ☐ Own/personal home
- ☐ Kinship/relative home
- ☐ Friend's home
- ☐ Adult boarding home
- ☐ Supported living
- ☐ Independent living program
- ☐ Group home
- ☐ Detention/jail
- ☐ Hospital/MHI
- ☐ Resid. treatment center
- ☐ Sub. abuse treatment fac.
- ☐ Adult correction facility
- ☐ Homeless/shelter
- ☐ Other: _____

Type of Present Day Activity: check only one

- ☐ Adult education/GED
- ☐ Vocational training/VR
- ☐ Community college
- ☐ Vista/Job Corps
- ☐ Club house
- ☐ Volunteer job
- ☐ Sheltered job
- ☐ Supported employment
- ☐ Competitive employment
- ☐ Street life
- ☐ Partial hospital program
- ☐ Psycho-social rehab.
- ☐ Day treat./activity program
- ☐ Jail activity
- ☐ Other: _____

Residential Behavioral Health Services Received

Key Service Activities	Noteworthy Details
Admission Why and by whom was this person admitted? Was participation court ordered? How many prior admissions has this person had for acute or residential treatment services?	
Service Planning Explain how present supports and services were planned in terms of what information was relied upon, who participated, how supports and services were determined to be necessary, and how conditions for discharge and transitions were planned.	
Service Implementation Explain how implementation of behavioral health services is going in terms of what services are provided, where and by whom, and with what frequency and intensity. If other related services are provided, indicate how those services are coordinated.	
Service Results/Progress Made Indicate how and by whom results of services are determined. Describe present results related to the reasons for which the person was admitted for services. Indicate progress made toward the reduction of symptoms and functional progress made in managing daily life independently or with little assistance, literacy, GED, employment, housing, and self-management.	
Tracking and Adaptation Explain how and when the tracking of the person's status, implementation of services, review of results, and modification of strategies and services based on results are performed for this person. How are significant others selected by the person involved in these processes? Are services provided timely and effective?	
Care Coordination/Transition Explain how care coordination is arranging transition to community settings, home and work, and community living supports following discharge.	

Issues for Persons in Residential Settings

Status and Behavioral Health Service Situation	Flag and Note Relevant Findings
Matters for Review and Consideration	√
1. Person has been at this facility for more than 90 days.	☐
2. Person previously has been in a hospital or residential treatment facility.	☐
3. Person qualifies for services under Section 504, IDEA, or Olmstead.	☐
4. Person lacks an updated individualized recovery plan (IRP) at the facility that is being implemented on a timely, competent, and consistent basis.	☐
5. Person is "stuck" at the facility due to a court order or administrative problem.	☐
6. Person often breaks "house rules" used at the facility.	☐
7. Person has experienced abuse, neglect, or domestic violence at home.	☐
8. Person has no permanent living arrangement to go/return to after discharge.	☐
9. Person has a co-occurring condition (e.g., addiction) or illness (e.g., diabetes).	☐
10. Person needs vocational training, work experience, independent living services.	☐
11. Person abuses alcohol or substances and needs substance abuse treatment.	☐
12. Person has friends engaged in criminal activities.	☐
13. Person does not speak English or is deaf (cannot communicate with staff/others).	☐

Emergency Procedures Applied to This Person

Type of Emergency Procedure	Occurrences since Admission	Occurrences in Past 30 Days
1. Exclusionary time-outs	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
2. Seclusion/locked room uses	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
3. Take-down/hold procedure	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
4. Physical restraint	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
5. Mobile crisis team intervention	☐ Total count, all occurences: # _____	☐ Total occurrences, past 30 days: #_____
6. ECT	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
7. Experimental protocol	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
8. 911 emergency call for EMS	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
9. 911 emergency call for police	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
10.Other: _____	☐ Total count, all occurences: # _____	☐ Total occurrences, past 30 days: #_____

Circumstances that may require Monitoring, Supports, or Services

Possible Circumstances of Concern	Note Circumstances as reported by Informants or Records
Person's Life Situation	√
1. Abuse victim with post-traumatic stress.	☐
2. Experiences domestic violence in home.	☐
3. Has no permanent home.	☐
4. Has a chronic illness requiring care.	☐
5. Has a developmental delay/disability.	☐
6. Lives on the streets/homeless.	☐
7. Lacks adequate daily living support.	☐
8. Lacks adequate nutrition.	☐
9. Lacks access to health or dental care.	☐
10. Is HIV positive.	☐
11. Is pregnant or a parent of dependents.	☐
12. Abuses alcohol or drugs.	☐
Behavioral Concerns	
1. Is hurtful to self.	☐
2. Has encounters with law enforcement.	☐
3. Destroys property.	☐
4. Disruptive behaviors.	☐
5. Has unusual or repetitive habits.	☐
6. Presents socially offensive behaviors.	☐
7. Withdrawal or inattentive behaviors.	☐
8. Uncooperative behaviors.	☐

Person's Strengths, Capacities, and Assets to Build Upon

Areas of Interest	Check and Note Circumstances as reported by Informants or Found in Records
The Person and His/Her Friends	√
1. Person has at least one positive long-term adult friend (not family or staff).	☐
2. Friend gives the person feedback that helps redirect energy and behavior.	☐
3. Friend has positive, nurturing interactions with person at least weekly.	☐
4. Friend is willing to be contacted at various times for various reasons.	☐
5. Friend serves as an advocate, providing unconditional support for recovery.	☐
6. Person identifies at least one friend, one professional, and one source of spiritual guidance as significant in his/her life.	☐
7. Person has frequent positive contact with natural family/significant others even when they don't share residence.	☐
8. Extended family and close friends are near and supportive to the person.	☐
9. Family and significant others are willing to learn more about the person's illness.	☐
Person's Life Situation	
10. Person has a stable, appropriate living arrangement/home in good repair.	☐
11. Person has a private room or adequate space for private conversations.	☐
12. Adults sharing or managing the home setting are supportive and helpful.	☐
13. Person has adequate income for basic needs and a stable living arrangement.	☐
14. Person has adequate child care and support for any minor children.	☐
15. Person has adequate transportation.	☐
16. Person completed high school/GED.	☐
17. Person is employed.	☐
18. Person has adequate health care.	☐
19. Person has an advanced directive.	☐
20. Person has a guardian.	☐

Community Service Planning and Delivery Processes

Key Service Activities	Noteworthy Details
Identification of Special Needs Explain how this person was identified for services. • Who recognized the need and requested assistance? • How much time passed from the request to the receipt of services? • What systems are involved?	
Support/Service Planning Explain how present supports and services were planned in terms of what information was relied upon, who participated, how supports and services were determined to be necessary, and how resources were identified for implementing the plans.	
Service Implementation Explain how implementation of supports and services is going in terms of what services are provided, where and by whom, and with what frequency and intensity. If other related services are provided, indicate how those services are coordinated.	
Service Results/Progress Made Indicate how and by whom results of services are determined. Describe present results related to the reasons for which the person is provided services. Indicate progress made toward the reduction of risks and progress made toward literacy, recovery, and readiness and opportunity to work, as appropriate to age and situation.	
Tracking and Adaptation Explain how and when the tracking of present status, implementation of services, review of results, and modification of strategies and services based on results are performed for this person. How are significant others selected by the person involved in these processes? Are services provided timely and effective?	

Formal Services for the Person and His/Her Minor Children

	Type of Service	For the Person		For Any Minor Children	
		Needed/Received	Needed/Not Received	Needed/Received	Needed/Not Received
1.	Forensic Residential Services	☐	☐	☐	☐
2.	24-Hour Intensive Staff/Supervision	☐	☐	☐	☐
3.	8-16 Hour Residential Rehabilitation Program	☐	☐	☐	☐
4.	Supported Housing	☐	☐	☐	☐
5.	Specialized Residential (sub. abuse/severe beh.)	☐	☐	☐	☐
6.	Crisis Emergency Telephone/Walk-in/Urgent Care	☐	☐	☐	☐
7.	Crisis Mobile Outreach	☐	☐	☐	☐
8.	Crisis Residential	☐	☐	☐	☐
9.	Respite/In-home Support	☐	☐	☐	☐
10.	Evaluations/Assessment	☐	☐	☐	☐
11.	Court-Ordered Evaluation	☐	☐	☐	☐
12.	Somatic Treatment	☐	☐	☐	☐
13.	Individual Therapy	☐	☐	☐	☐
14.	Group Therapy	☐	☐	☐	☐
15.	Family Therapy	☐	☐	☐	☐
16.	Partial Hospitalization	☐	☐	☐	☐
17.	Outpatient Detoxification	☐	☐	☐	☐
18.	Dual Diagnosis/Day Treatment	☐	☐	☐	☐
19.	Intensive Outpatient Substance Abuse Treatment	☐	☐	☐	☐
20.	Consumer Operated/Community Support Clubhouse/Transitional Employment	☐	☐	☐	☐
21.	Psychosocial Rehabilitation	☐	☐	☐	☐
22.	Supported Employment	☐	☐	☐	☐
23.	Supported and Other Education	☐	☐	☐	☐
24.	Vocational Assessment/Counseling	☐	☐	☐	☐
25.	Consumer Advocacy	☐	☐	☐	☐
26.	Homeless Outreach	☐	☐	☐	☐
27.	Jail Diversion Services	☐	☐	☐	☐
28.	Representative Payee Services	☐	☐	☐	☐
29.	Assertive Community Treatment (ACT)	☐	☐	☐	☐
30.	Active Case Management Services (ICM)	☐	☐	☐	☐
31.	Supportive Case Mgt./Case Coordination	☐	☐	☐	☐
32.	Therapeutic Support & Supervision (Flexible)	☐	☐	☐	☐
33.	Client Transportation	☐	☐	☐	☐
34.	Family Psychoeducation	☐	☐	☐	☐
35.	Legal Advocacy	☐	☐	☐	☐
36.	Family Preservation Services	☐	☐	☐	☐
37.	Parent training and support	☐	☐	☐	☐
38.	Day care/child care	☐	☐	☐	☐
39.	Other _____	☐	☐	☐	☐

Assessment and Level of Care Planning Considerations

Matters of Concern	Notes about Assessment and Case Understanding	
1. Risk of harm: • Indication of suicidal or homicidal thoughts or impulses • Indication of physically or sexually aggressive impulses or actions • Developmentally appropriate ability to maintain physical safety • Level of risk for victimization, abuse, or neglect • Binge or excessive use of alcohol or drugs • Engagement in other high risk behaviors, including self-injury • Bingeing/purging, bulimia/anorexia		
2. Functional status/level of impairment: • Consistency of age-appropriate developmental daily living activities • Consistency of age-appropriate academic performance • Consistency of age-appropriate social and interpersonal functioning • Consistency of recent gains in functioning		
3. Co-occurring conditions (comorbidity): • Indications of physical illness or disability • Indications of developmental disability • Indications of substance use or abuse • Indications of psychiatric conditions or forensic involvements • Indications of recent transient, stress-related psychiatric symptoms		**Co-Occurring Conditions** *(check all that apply)*: ☐ Autism Spectrum Disorder ☐ Chronic Health Impairment ☐ Deaf/Blindness ☐ Degenerative Disease ☐ Mental Illness ☐ Mental Retardation ☐ Neurological Impairment/Seizure Disorder ☐ Orthopedic Impairment ☐ Sensory Impairment ☐ Substance Abuse/Addiction ☐ Other: _____ ☐ NONE
4. Environmental stressors: • Traumatic or enduring disturbing circumstances (e.g., violence, sex abuse) • Recent life transitions or losses of consequence • Transient but significant illness or injury • Expectations of performance at home or work that create discomfort • Disruption of social milieu • Danger or threat in home or neighborhood, including domestic violence • Incarceration, homelessness, or extreme poverty • Racial persecution, immigration, social isolation, language barrier		
5. Environmental support factors for return to home: • Housing/independent living arrangement adequate for person's needs • Family/caregiver's willingness and capacity to support the adult in the home • Special needs met through involvement in various systems of care • Community resources sufficient to meet person's rehabilitation needs		
6. Resiliency and responsiveness to treatment and rehab.: • Ability to deal with stressors and use helpful resources • Motivation to participate in and seek benefit from treatment • Previous treatment history and responsiveness to particular interventions • Persistence of symptoms • Speed of functional improvements • Ability to maintain treatment progress • Ability to manage recovery • Developmental pressures and life changes creating sustained turmoil • Pattern of regression		**Recommended Level of Care:** Level Recommendation ☐ 0 Basic services (prevention) ☐ 1 Recovery maintenance and health management ☐ 2 Low intensity community-based ☐ 3 High intensity community-based ☐ 4 Medically monitored non-residential services ☐ 5 Medically monitored residential services ☐ 6 Medically managed residential services
7. Acceptance and engagement in the treatment process: • Ability to form a trusting and respectful relationship with service providers • Person's awareness and understanding of goals and treatment plan • Acceptance of responsibility for actions and consequences • Cooperates in treatment planning and treatment activities • Family/caregiver support and participation in treatment activities		

Reviewer's Assessment of the Person's General Level of Functioning

*Rate the person's general level of functioning over the **LAST 30 DAYS** using the DSM-IV-R Axis V, Global Assessment of Functioning scale. Rate actual current functioning, regardless of treatment or prognosis. Rely on interview results obtained from the person, caregiver, job coach, service coordinator, therapist, and/or service providers and on recent assessments presented in the case record. The levels reported below represent the **REVIEWER'S ASSESSMENT**, based on interviews, records, and direct observation, when possible.*

Level	Levels of Functioning to be Used by the Reviewer in Determining the Person's General Level of Functioning
91-100	Superior functioning in all areas (at home, at school/work, with peers, in the community); involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group); likable, confident; "everyday" worries never get out of hand; doing well in daily activities; getting along with others; behaving appropriately; no symptoms.
81-90	Good functioning in all areas: secure in family, in school/work, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important life event; occasional "blow-ups" with friends, family, or peers).
71-80	No more than slight impairment in functioning at home, at school/work, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a child, loss of job), but these are brief and interference with functioning is transient; such persons are only minimally disturbing to others and are not considered deviant by those who know them.
61-70	Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally smoking pot or minor difficulties with rule/law breaking; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the person well would not consider him/her deviant but those who know him/her well might express concern.
51-60	Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the person in a dysfunctional setting or time but not to those who see the person in other settings.
41-50	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school/work refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, isolation, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
31-40	Major impairment in functioning in several areas and unable to function in one of these areas; i.e., disturbed at home, at school/work, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such persons are likely to require intensive supports and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).
21-30	Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
11-20	Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts, self-injurious behavior), failure to maintain self-care routines, refusal to eat or maintain one's health, or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, isolation).
1-10	Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or self-care.
0	Inadequate information.

Notes	Present Level - Today
	Overall Level: _____

Case Manager/Care Coordinator Information

- How long have you been employed with this mental health agency? _____
- What is you current position/job title? _____
- How long have you been in your current position? _____
- How long have you been assigned to this case? _____
- Do you serve this person only as his/her care coordinator? Or, do you serve as this person's therapist or life coach also?_____

  _____
- How many care coordinators have been assigned to this case before you (if any)? _____
- How many open cases do you currently have? _____
- In your perspective, are there any barriers or limitations that prevent you from providing good service coordination in this case? Please explain your answer in the space provided below.

  _____

  _____

  _____

  _____

  _____

Reviewer Notes

Inquiry Interests and Scope of Review

For Conducting a Community Services Review for an Adult Receiving Mental Health Services

Areas of Inquiry Interest

- How well is this adult participant doing now in life areas
- Quality of services as seen through his/her life and status
- Service system integrity, continuity, and capacity
- Consistency of decisions and actions with good practice
- Results and benefits achieved for this adult

Review Objectives

- Determine the current status of the adult participant
- Appraise adequacy of services/practices being provided
- Examine life change adjustments and progress made
- Compare practices and results with Dixon exit criteria
- Build local capacity for quality management/improvement

Status Indicators

Community Living

- 1. SAFETY* (Free of Abuse/Neglect) pg 14
- 2. Economic Security (Income) pg 16
- 3. Living Arrangements pg 18
- 4. Social Network pg 20
- 5. Satisfaction with Services pg 22

Physical/Emotional Status & Access to Care

- 6. Health/Physical Well-being pg 24
- 7. Mental Health Status/Care Benefit pg 26

Meaningful Life Activities

- 8. Education/Career Preparation pg 28
- 9. Work pg 30
- 10. Recovery Activities pg 32

- 11. **PERSON'S OVERALL STATUS** pg 34

(SAFETY is the "trump" status area)*

Progress Indicators

- 1. Personal Mgt./Troubling Symptoms pg 36
- 2. Improved Self-Management pg 37
- 3. Education/Work Progress pg 38
- 4. Progress toward Recovery Goals pg 39
- 5. Risk Reduction pg 40
- 6. Successful Life Adjustments pg 41
- 7. Social Group Affiliations pg 42
- 8. Meaningful Personal Relationships pg 43
- 9. **OVERALL PROGRESS PATTERN** pg 44

Association between current adult status, progress made, and service system performance for this person

Performance Indicators

Planning Treatment & Support

- 1. Participation/Engagement of the Person pg 46
- 2. Culturally Appropriate Practice pg 48
- 3. Service Team Formation pg 50
- 4. Service Team Functioning pg 52
- 5. Assessment & Understanding pg 54
- 6. Personal Recovery Goals pg 56
- 7. Individualized Recovery Plan (IRP) pg 58
- 8. Goodness-of-Service Fit pg 60

Providing Treatment & Support

- 9. Resource Availability pg 62
- 10. Treatment & Service Implementation pg 64
- 11. Emergent/Urgent Response Capability pg 66
- 12. Medication Management pg 68
- 13. Special Procedures pg 70
- 14. Practical Supports pg 72

Managing Treatment & Support

- 15. Service Coordination & Continuity pg 74
- 16. Recovery Plan Adjustment pg 76

- 17. **OVERALL PRACTICE PERFORMANCE** pg 78

(Overall performance shows current service system capacities in an actual case)

Status Review 1: Safety

SAFETY: • Is this person safe from manageable risks of harm caused by him/herself or others in living, learning, working, and recreational environments? • Are others in the person's environments safe from this person and is the person safe from retribution of others? • Is this person free of abuse, neglect, or exploitation in his/her home or current living arrangement? • Is substance use creating harm or significant risk?

Personal safety is central to one's well-being. The person should be free from known and manageable risks of harm in his/her daily environments. Safety from harm extends to freedom from unreasonable intimidations and fears that may be induced by others, care staff, treatment professionals, or fellow residents. A person who is unsafe from actual injury or who lives in constant fear of assault, exploitation, humiliation, isolation, or deprivation is at risk of injury or death, co-dependent behavior patterns, low self-esteem, and perpetrating similar harm on others. Safety and good health provide the foundation for normal daily living, especially for persons with emotional or behavioral health problems. Safety applies to settings in the person's natural community as well as to any special care or treatment setting in which the person may be served on a temporary basis. Persons in a special care or treatment setting must be free from abuse, neglect, and sexual exploitation. Safety, as used here, refers to adequate management of known risks to the person's physical safety and to the safety of others in all settings. **Safety is relative to known risks**, not an absolute protection from all possible risks to life or physical well-being. All adult supporters and professional interveners in the person's life bear a responsibility for maintaining safety of the person and for others who interact with the person. Protection of a person with self-injurious behaviors and protection of others from a person with assaultive behavior may require special safety precautions.

Determine from Informants, Plans, and Records

Has the treatment team completed a risk assessment of this person to determine any safety risks due to: [based on relevant aspects of case history]

- ☐ **1. Domestic violence?**
- ☐ **2. Physical abuse?**
- ☐ **3. Substance abuse?**
- ☐ **4. Sexual abuse?**
- ☐ **5. Emotional abuse?**
- ☐ **6. Mental illness?**
- ☐ **7. Dangerousness (self-injury, aggression, danger to others)?**
- ☐ **8. Neglect of any physically dependent person in the home?**
- ☐ **9. Other factors?: _____**

If current safety risks require immediate intervention, identify steps taken.

1. Has the person been a victim of abuse, neglect, or exploitation (12 months)?
2. Does the person come from a family that has a history of domestic violence?
3. Does the person have a history of emotional/behavioral problems that have resulted in injury to self or others?
4. Is the person now presenting self-injury or aggression toward others?
5. Has the person exhibited sexually offending behavior?
6. Does the person have a pattern of frequent injuries or victimization?
7. Does the person have any co-occurring conditions?
8. Does substance abuse or addiction place this person at risk?
9. Does the person share needles? Have unprotected sex?
10. Does the person require a high level of support? Does he/she get it?
11. What supports and safety plans are in place to protect this person?

Facts Used in Rating Status

NOTE:

Consider patterns reported in records and by informants over the past 12 months to form a risk context for the person. But, rate the person's current safety status over the past 30 days, based on the information gathered. If safety plans exist for this person, are those plans working in prevention of injury or harm?

Status Review 1: Safety

Determine from Informants, Plans, and Records

12. Has the person required special intervention due to behavior/law violations? Does the person engage in high risk activities?

13. Has there been an allegation of abuse, neglect, or exploitation of this person in the past 12 months? Was a referral made to the police or Adult Protective Services?

14. Are family caregivers, if present for this person, aware of risks to the person? Are known risks being managed effectively for this person?

Facts Used in Rating Status

Consider the steps that DMH staff have made in addressing any of these concerns.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- Situation indicates **optimal safety** for all persons in all of this person's daily settings. The person has a very safe living situation, with highly reliable and competent service providers as necessary, and is safe in the major daytime activity setting, is free from intimidation, and presents no safety risks to self or others. The person is considered very safe from known and manageable risks of harm and is fully free of unreasonable intimidation or fears at home and school/work/daytime activity.

6 | Person | Others

- Situation indicates **good safety** for the person in his/her daily settings and for others near this person. The person has a generally safe living situation, with substantially reliable and competent caregivers as necessary, and is substantially safe in the major daytime activity setting, is free from intimidation, and presents no safety risks to self or others. The person is considered generally safe from known and manageable risks of harm and is substantially free of unreasonable intimidation or fears at home and school/work/daytime activity.

5 | Person | Others

- Situation indicates **fair safety** from imminent risk of physical harm for the person in his/her living and learning settings and for others who interact with this person. The person has a minimally safe living arrangement, with any present caregivers, is usually safe in the major daytime activity setting, has limited exposure to intimidation, and presents no more than a minimal safety risk to self or others. The person is considered minimally safe from known and manageable risks of harm at home and school/work/daytime activity.

4 | Person | Others

- Situation indicates **a minor safety issue present in at least one setting** that poses an elevated risk of physical harm for the person in his/her living and daily activity settings and for others who interact with this person. The person's living arrangement may require active intervention or supportive services. **- OR -** The person may mildly injure self or others rarely. **- OR -** Persons at home or in the person's major daytime setting may pose a safety problem for this person.

3 | Person | Others

- Situation indicates **substantial and continuing safety problems** that pose elevated risks of physical harm for this person in his/her living and daytime activity settings and for others who interact with this person. The person's living arrangement may require protective intervention or specialized services. **- OR -** The person may injure self or others occasionally. **- OR -** Persons at home or in the person's major daytime setting may pose a serious safety problem for this person.

2 | Person | Others

- Situation indicates **adverse and worsening safety problems** that pose high risks of physical harm for the person in his/her daily settings and for others. The person may require protective intervention or intensive services to prevent injury to self or others. **- OR -** The person may seriously injure self or others. **- OR -** Persons in his/her current daily settings may have abused, neglected, or exploited this person.

1 | Person | Others

Scoring Rule: *Insert the lower of the two ratings ("person" and "others") in calculating the Overall Status Rating on page 34.*

Status Review 2: Economic Security

ECONOMIC SECURITY: • Is this person accessing, receiving, and controlling the economic benefits to which he/she is entitled? • Are his/her income and economic supports sufficient to cover basic living requirements (i.e., shelter, food, clothing, transportation, health care/ medicine, leisure, child care)? • Does the person have economic security sufficient for maintaining stability and for effective future life planning?

A person with a serious and persistent mental illness may be entitled to a variety of economic benefits and sources of income. Among these are Supplemental Security Income (SSI), Medicaid, HUD housing subsidy, food stamps, subsidized child care, Temporary Assistance to Needy Families (TANF), and possibly other economic supports, depending on eligibility and need. These economic supports are intended to cover **basic living requirements and other necessities for daily living**, child care (as appropriate), and employment. Together, these sources of income and support should provide a level of economic security that enables a person to achieve and maintain a reasonable degree of stability in his/her living situation. Stability in income, housing, nutrition, and health care provides a foundation for effective future life planning for the person.

A person living with mental illness may require assistance from knowledgeable persons in securing benefits to which he/she is entitled. Such assistance may be provided by a case manager or social worker via a helping agency serving the person. General expectations in this review concerning the status of the person and practice in his/her case are that: (1) the person has been/is being assisted in accessing all sources of income and economic security to which the person is entitled, (2) follow-up activities are conducted to ensure that the person is continuing to access the full array of benefits to which the person is entitled, (3) assessments are made to determine that economic supports are adequate to cover the person's basic living requirements, (4) advocacy is undertaken to address any important unmet needs, and (5) the person has a reasonable degree of economic security sufficient to achieve and maintain stability in conditions of daily living. The focus in this review is placed on the person's current status in economic security.

Determine from Informants, Plans, and Records

1. What are this person's basic living requirements (e.g., shelter, food, clothing, health care, medications) and other necessities of daily living (e.g., transportation, child care, education, or employment-related necessities)?

2. Does this person have dependent children in his/her care? For what types of economic assistance is this person/family eligible? What other agencies are involved in providing services and supports to this person/family? What economic assistance is being provided by other agencies?

3. To what extent are the person's basic living requirements, medications, and other necessities known and understood by the caseworker, therapist, or counselor who is coordinating services for this person? What assessment, follow-up, and advocacy has the staff done on behalf of this person?

4. How effective are current efforts in securing the economic and support resources for meeting this person's basic living requirements and other necessities of daily living? Does this person have what he/she needs to get by?

5. Does this person have a degree of economic security sufficient to achieve and maintain stability in conditions of daily living for him/herself and for any minor children in his/her care?

Facts Used in Rating Status

Does this person have a GUARDIAN? If so, is it a full or limited guardianship? Who is the principal payee for SSI or other cash assistance? Does the person know how much is received? Who accounts for these funds? Is the person moving toward a greater degree of self-management of funds?

Status Review 2: Economic Security

Determine from Informants, Plans, and Records	Facts Used in Rating Status
6. Has this person lost housing, child custody, or employment due to the lack of income or the ability to meet basic living requirements or other necessities of daily living?	
7. What steps are being taken, if necessary, to prevent future disruptions (e.g., eviction) and/or to achieve stable living conditions for this person/family?	
8. If continued instability is present, is it caused by unresolved income and economic security issues? If so, what steps are being taken to resolve these matters (e.g., creative assistance in managing limited funds)?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Economic Security**. The adult is accessing and receiving all economic benefits to which he/she is entitled. Income and economic supports are sufficient to cover basic living requirements and other necessities of daily living. The level of economic security is excellent when the amount and source of funds are considered. There is no recent history of loss of income or benefits. The person may control funds. — **6** ☐

- **Good Economic Security**. The adult is accessing and receiving most economic benefits to which he/she is entitled. Income and economic supports are generally sufficient to cover basic living requirements and other necessities of daily living for the most part or except in extreme emergencies. The level of economic security is sufficient for maintaining stability. There is no recent history of loss of income or benefits. The person may control most of the funds most of the time. — **5** ☐

- **Fair Economic Security.** The adult is accessing and receiving some economic benefits to which he/she is entitled. Income and economic supports are minimally sufficient to cover basic living requirements and other necessities of daily living. The level of economic security is minimal for maintaining stability. The person may control much of the funds at least some of the time. — **4** ☐

- **Marginal Economic Security.** The adult is accessing and receiving limited economic benefits to which he/she is entitled. Income and economic supports are marginal and inconsistent in meeting basic living requirements and other necessities of daily living. The level of economic security is not sufficient for maintaining stability. Economic inadequacies causing disruptions may have occurred in the past and the risk of future disruption may be present. Causes of economic disruption are known, but solutions have not been found. The person may have limited or inconsistent control over some of the funds. — **3** ☐

- **Poor Economic Situation.** The adult has substantial problems of economic security and is not receiving the range of economic benefits to which he/she is entitled. Current economic security is insufficient for maintaining stability. Causes of economic disruption are known and present but are not adequately or realistically addressed in current plans or remedial actions are not being implemented on a timely and competent basis. The person may have little, if any, control over even a small portion of the funds. — **2** ☐

- **Adverse Economic Situation.** The adult has serious and worsening problems of economic security. Because he/she is not receiving entitled benefits, the person is experiencing serious but avoidable hardships and life disruptions (e.g., eviction, loss of children, unemployment). Life disruptions may be continuing. Causes of economic disruption may be complex or not adequately understood or not realistically addressed with current casework or supportive services at this time. The person has no control over any of the funds. — **1** ☐

Status Review 3: Living Arrangements

LIVING ARRANGEMENTS: • Is this person living in a home that he/she chose, with supports that are necessary and sufficient for safe and successful pursuit of recovery? • If not, is this person residing in a community living arrangement that is necessary to meet the person's therapeutic and recovery needs? • Are the person's culture, language, and living and housemate preferences addressed in an appropriate and supportive manner, consistent with his/her recovery goals?

The adult should be living in an adequate home of his/her choice and with persons of his/her choice. This may be a personal home, a supported living arrangement (three or fewer beds), or the home of a significant other. Any needed supports in the home should provide for safe and successful daily living for the person. Because of particular treatment or support needs, some persons may be residing temporarily in a group living setting. The group residential situation should be consistent with the person's language and culture and provide any supports and services necessary for success in that setting. When in a group residential setting, the following matters should be taken into account when reviewing living arrangements. Whether the group living arrangement affords the person: (1) safe and sanitary living and activity areas; (2) adequate living space; (3) appropriate grouping patterns; (4) balanced and nutritionally adequate meals; (5) hygiene (including personal hygiene articles, bathing schedule that promotes privacy, opportunity to bathe daily or more often if needed); (6) privacy, as appropriate to safety; (7) personal possessions, as appropriate to safety; (8) dignity and respect from staff; and (9) freedom of movement (coming and going), as appropriate to safety.

Determine from Informants, Plans, and Records

1. What is the person's current living arrangement? Is the person living in a home of his/her choice and with persons of his/her choice? Who else is living in the person's current home? Can the person's friends visit the person in the home?

2. Does the person's home provide necessary supports and services for safe and successful living? How long has the person lived there? Is it a stable placement?

3. How well does the person's current living arrangement fit his/her language, culture, and personal preferences?

4. Is the person presently residing in a group setting? If so, consider whether the group living arrangements provide:

   - Safe and sanitary living and activity areas?
   - Adequate living space (versus overcrowding)?
   - Appropriate grouping patterns (age, gender, functional level, language)?
   - Balanced and nutritionally adequate meals?
   - Adequate hygiene opportunities and supports (including personal hygiene articles, bathing schedule that promotes privacy, opportunity to bathe daily or more often if needed)?
   - Privacy, as appropriate to safety?
   - Personal possessions, as appropriate to safety?
   - Dignity and respect from staff?
   - Freedom of movement?

5. Does the counselor/caseworker/therapist recognize whether current living arrangements are appropriate and adequate for this person?

6. If the person is homeless and without shelter, what outreach, engagement, and assertive community treatment strategies are being used to get the person into appropriate housing or treatment?

Facts Used in Rating Status

Person's current living setting:

- ☐ *Personal home, with supports as needed*
- ☐ *Home of family or friend*
- ☐ *Supported living arrangement*
- ☐ *Adult boarding home*
- ☐ *Group home/step-down home*
- ☐ *Residential treatment facility*
- ☐ *Hospital/inpatient facility*
- ☐ *Secure facility/jail*
- ☐ *Shelter (homeless/DV shelter)*
- ☐ *Homeless/street life*

Status Review 3: Living Arrangements

Determine from Informants, Plans, and Records	Facts Used in Rating Status
7. If the person is in jail, what services are being offered?	
8. If the person is in a hospital, are staff assisting with discharge planning?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with excellent supports that are necessary and fully sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small community living arrangement that is consistent with the adult's culture, language, and living preferences and provides excellent supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is the least restrictive, most appropriate setting to meet the person's treatment needs or life situation requirements. This residential facility meets all criteria (see probe 5) at an optimal, consistent level for this person. **6** ☐

- **Good Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with good supports that are necessary and generally sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small, generally appropriate community living arrangement that is substantially consistent with the adult's culture, language, and living preferences and provides good supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is the least restrictive, generally appropriate setting to meet the person's treatment needs or life situation requirements. This facility substantially meets the criteria (see probe 5) for this person. **5** ☐

- **Fair Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with fair supports that are minimally sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small, minimally appropriate community living arrangement that is fairly consistent with the adult's culture, language, and living preferences and provides minimally adequate supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is a less restrictive, fairly appropriate setting to meet the person's treatment needs or life situation requirements. This facility minimally meets criteria (see probe 5) for this person. **4** ☐

- **Marginal Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with limited or inconsistent supports that are marginally sufficient for the pursuit of recovery. **- OR -** This person is currently residing in a small, marginally appropriate community living arrangement that is limited in consistency with the adult's culture, language, and living preferences and provides inconsistent supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is a somewhat more restrictive, less appropriate setting for the person's treatment needs or life situation requirements. This facility marginally meets some criteria (see probe 5). Some risks of harm may be present. **3** ☐

- **Poor Living Arrangement.** This person is living in a situation that is not sufficient for safe and successful daily living. The situation could be jail, shelter, or homelessness. **- OR -** The person is temporarily living in a group facility that is unnecessarily restrictive or inappropriate for the person's treatment needs or life situation requirements. This facility meets few criteria (see probe 5) for this person. Risks of harm for this person are substantial. **2** ☐

- **Adverse Living Arrangement.** This person is living in a situation that is unsafe and detrimental to the person's functioning and well-being. The situation could be jail, a crackhouse, or homeless street life. **- OR -** The person is temporarily living in a group facility that is highly restrictive and/or grossly inappropriate for the person's treatment needs or life situation requirements. Conditions in this facility are adverse for care, dignity, and recovery. Risks of harm for this person are high or worsening. **1** ☐

Status Review 4: Social Network

SOCIAL NETWORK: • Is this adult connected to a natural support network of family, friends, and peers, consistent with his/her choices and preferences? • Is this adult provided access to peer support and community activities? • Does this adult have opportunities to meet people outside of the service provider organization and to spend time with them?

As a social species, human beings seek, value, and maintain relationships with others, often for a lifetime. Affiliation gives one's life identity, purpose, and connections. Community is the place where we meet and join with others in life's meaningful activities. Interactions with others provides a sense of belonging and social participation. The focus here is placed upon the person's social connections and natural supports and the extent to which he/she is provided access to peer support and community activities. Because a person with a mental illness may rely on service providers for assistance necessary to maintain existing positive social connections and develop new ones, concern is placed on having opportunities to meet and get to know people outside the service provider organization. Where the person may require encouragement, supports, and structured opportunities to form and maintain social connections with friends, family, and others in the community, how well is the service provider meeting the support requirements?

Determine from Informants, Plans, and Records

1. How well is this person connected to a natural support network consisting of family, friends, and peers?

    - Which family members are part of this person's support network?
    - Which friends (outside the provider agency and service population) are part of this person's support network?
    - Which peers does this person see on a regular basis?

2. Does this person have friends and opportunities to interact with other members of the community in positive ways, subject to his/her preferences?

3. Is this person connected with a local faith community (e.g., church, synagogue, mosque) or with other ways of meeting his/her spiritual needs? Does the person have transportation to and from church-related activities?

4. What kinds of peer support and community activities are provided to this person? To what degree does this person accept and use the peer support and community activities that are currently provided?

5. What specific goals and strategies contained within the person's individualized recovery plan (IRP) are directed toward improving social connections and supports for this person?

6. What effect are any goals and strategies directed toward improving the person's social connections and supports having? What strategies or activities have worked in the past for this person?

7. Does this person have an informal support person who helps in times of crisis? Does this person have an advance directive to guide helpers in times of crisis?

8. Does this person experience negative influences or effects from persons in his/her social network? What steps are being taken to minimize any problems?

Facts Used in Rating Status

Status Review 4: Social Network

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Social Network.** This person has a wide, substantial, and continuing social support network. It may consist of many friends, family, and/or positive peers. Forming and maintaining this social network may be the result of excellent access to peer support and community activities offered by provider agencies. He/she may have many ongoing opportunities to meet positive people outside of the service provider organization and to spend time with them. — **6** ☐

- **Good Social Network.** This person has a meaningful and dependable social support network. It may consist of friends, family, and/or positive peers. Forming and maintaining this social network may be the result of good access to peer support and community activities offered by provider agencies. He/she may have regular ongoing opportunities to meet positive people outside of the service provider organization and to spend time with them. — **5** ☐

- **Fair Social Network.** This person has a small or minimal social support network. It may consist of some friends, family, and/or positive peers. Forming and maintaining this social network may be the result of minimally adequate access to peer support and community activities offered by provider agencies. He/she may have occasional opportunities to meet positive people outside of the service provider organization and to spend time with them. — **4** ☐

- **Marginal Social Network.** This person has a limited social support network. It may consist of a few friends, family, and/or positive acquaintances. Forming and maintaining this social network may reflect marginal access to peer support and community activities offered by provider agencies or to limited interest by the person. He/she may have few opportunities to meet positive people outside of the service provider organization and to spend time with them. — **3** ☐

- **Poor Social Network.** This person has a poor social support network. It may consist of limited or inconsistent contact with friends, family, and/or positive acquaintances. Forming and maintaining this social network may reflect poor access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have rare opportunities to meet positive people outside of the service provider organization and to spend time with them. **- OR -** He/she may occasionally form acquaintances around risky or harmful activities. — **2** ☐

- **Absent or Adverse Social Network.** This person has no social support network. The person may have acquaintances who engage or join the person in risky or harmful activities. Absence of a positive social network may reflect lack of access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have no opportunities to meet positive people outside of the service provider organization and to spend time with them. **- OR -** He/she may have ongoing acquaintance patterns established around risky, harmful, or illegal activities. — **1** ☐

Status Review 5: Satisfaction with Services

SATISFACTION WITH SERVICES: To what extent is the person satisfied with the treatment, support services, respect, and recovery progress that he/she is presently experiencing?

Satisfaction is a concern of the person who is the focus of review. If the person lives with a family member or others who provide assistance to the person and who may receive support services in the home, then that person's views are solicited also. If the person is being served temporarily in a residential treatment setting or hospital and will be returning home, then the views of any spouse, family member, or significant other with whom the person will be residing is solicited. Satisfaction is concerned with the degree to which the person receiving services believes that those services are appropriate for his/her needs; respectful of his/her views and privacy; convenient to receive; tolerable (if imposed by court order); pleasing (if voluntarily chosen); and, ultimately, beneficial in effect. Satisfaction extends to:

- **Participation** in decisions and plans made for the benefit of the person.
- Having **trust-based relationships** with persons involved in the person's care, treatment, and support services.
- Feelings of **respect** for his/her views, ambitions, preferences, and culture in the planning and delivery of services.
- Belief that a **good mix and match** of supports and services is offered that well fits his/her situation.
- Appreciation for the **quality/dependability** of assistance and support provided.
- Feelings that circumstances are better now than before or are **getting better** because of the supports and services.

The person should be generally satisfied with services, taking into account that services may not always be voluntary.

Determine from Informants, Plans, and Records	Facts Used in Rating Status
1. Does the person now reside with his/her family or a domestic partner?	
2. Is the person living at home? Or living with family members?	
3. Is the person involved with the criminal justice system or homeless system?	
4. Are any of the current services required for conditional release or probation?	
5. Does the person agree with the purpose and type of services received?	
6. Does the person believe that services reflect his/her ambitions, preferences, and culture?	
7. Where appropriate, does any home caregiver (e.g., parent, family member, spouse, domestic partner) agree with the purposes and types of support services received in the home?	
8. Does the home caregiver believe that services reflect his/her views?	
9. Do services received really match the needs of this person? Were these needs determined by the person rather than by others? Are these needs addressed?	
10. Are services provided at convenient times and places?	
11. Does the person believe that he/she is benefiting from these services?	

Status Review 5: Satisfaction with Services

Determine from Informants, Plans, and Records	Facts Used in Rating Status
12. To what degree is the person satisfied with current and recent services?	
13. To what degree is any family caregiver, spouse, or domestic partner satisfied with supportive services provided for successful living arrangements?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person and Possible Caregiver in the Home — Rating Level

- The respondent reports **optimal satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved presently exceed a high level of consumer expectation. The respondent "couldn't be more pleased" with the service situation and his/her recent experiences and interactions with service personnel.

  6 Person | Caregiver

- The respondent reports **substantial satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved generally meet a moderate level of consumer expectation. The respondent is "generally satisfied" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are minimal.

  5 Person | Caregiver

- The respondent reports **minimal-to-fair satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved minimally meet a low-to-moderate level of consumer expectation. The respondent is "more satisfied than disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are occasional and/or minor.

  4 Person | Caregiver

- The respondent reports **mild dissatisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved barely meet a low-to-moderate level of consumer expectation. The respondent is "a little more disappointed than pleased" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are recent and substantive.

  3 Person | Caregiver

- The respondent reports **moderate and continuing dissatisfaction** with current supports and services. Service quality, fit, dependability, and results achieved seldom, if ever, meet a low-to-moderate level of consumer expectation. The respondent is "consistently disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are substantial and continuing over time.

  2 Person | Caregiver

- The respondent reports **substantial and growing dissatisfaction** with current supports and services. Service quality, fit, dependability, and results fail to meet any reasonable level of consumer expectation. The respondent is "greatly and increasingly disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Complaints and disappointments may be longstanding, significant, and may be increasing in their scope and intensity.

  1 Person | Caregiver

- **This examination does not apply** to this person. Or, the person declined to offer an opinion.

  NA Person | Caregiver

Scoring Rule: *Use the rating for the "person" for the Overall Status Rating on page 34. Where appropriate, report satisfaction of the caregiver/partner in the case presentations.*

Status Review 6: Health/Physical Well-being

HEALTH/PHYSICAL WELL-BEING: • Is this person in the best attainable health? • Are the person's basic physical needs being met? • Does the person have health care services, as needed?

Persons should achieve and maintain their best attainable health status, consistent with their age and general physical condition. Health maintenance requires that **basic physical needs** for proper nutrition, clothing, shelter, and personal care are met on a daily basis. Proper **medical and dental care** (preventive, acute, chronic) are necessary for maintaining good health. Preventive health care should include immunizations, dental hygiene, and screening for possible physical problems (e.g., PSA, PAP, TB, mammogram). Physical well-being encompasses both the person's physical health status and access to timely health services.

Persons who are elderly or who have chronic or progressive conditions requiring special care or treatment should have a level of attention commensurate with that required to maintain their best attainable health status. Special care requirements may include nursing, physical therapy, adaptive equipment, therapeutic devices, and treatments (e.g., medications, respiratory treatment). Delivery of these services may be necessary in the person's daily settings. The **central concern** here is that the person's physical needs are met and that special care requirements are provided as necessary to achieve and maintain good health status. Family members, home providers, and professional interveners in the person's life bear a responsibility for ensuring that basic physical needs are being met and that health risks, chronic health conditions (e.g., COPD, HIV, diabetes) and acute illnesses are adequately addressed in a timely manner. Health concerns expressed by the person should be taken seriously and evaluated.

Determine from Informants, Plans, and Records

1. Are the person's needs for food, shelter, clothing, and health care met?
2. Is the person a victim of neglect, abuse, or exploitation?
3. Is the person diagnosed with a life-threatening disease (e.g., diabetes, HIV, TB, or hepatitis C)?
4. Does the person have a developmental or physical disability?
5. Does the person appear to have adequate nutrition and physical care?
6. Is the person underweight or overweight?
7. Does the person have frequent colds, infections, or injuries?
8. Does the person have a history of major recurrent health problems?
9. Does the person have a PCP and regular medical check-ups and screenings?
10. Does the person have regular dental care?
11. Are the person's immunizations up to date (e.g., tetanus, flu, hepatitis A-B)?
12. Does the person have prompt access to acute care when needed?
13. Does the person have continuous access to care and treatment of chronic conditions, if needed?
14. If the person requires special care or treatment for a health condition, are the required services and equipment provided where it is needed by the person?
15. Are health care professionals available to provide education and skills for managing a disease or chronic conditions (e.g., diabetes)?

Facts Used in Rating Status

NOTE:

Consider whether the person presents risk factors for disease, disability, or premature death. Such factors may include: heavy tobacco use, substance abuse, tardive dyskinesia, medication side effects, obesity, unsafe sex, lack of family planning, and other high risk behaviors (e.g., sharing needles).

Consider whether the person has access to "wellness" choices (e.g., good diet and exercise) for a positive and healthful lifestyle.

Take the person's age and existing health conditions into account when conducting this review.

Status Review 6: Health/Physical Well-being

Determine from Informants, Plans, and Records	Facts Used in Rating Status
16. If the person takes medications for chronic health problems, seizures, or behavior control: Does the person self-medicate? Are medications monitored for safety and effectiveness at least quarterly by the prescribing physician?	
17. Does the person reside in a treatment facility or secure facility?	
18. Does the person have a health condition requiring monitoring?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Health Status.** All of the person's physical needs for food, shelter, and clothing are reliably met on a daily basis. Routine preventive medical (e.g., immunizations, check-ups, and health screening) and dental care are provided on a timely basis. Any acute or chronic health care needs are met on a timely and adequate basis, including necessary follow-ups and required treatments. Height and weight are within normal ranges. The person has no recurrent colds, infections, or injuries. The person's health status is the best attainable. **6** ☐

- **Good Health Status.** The person's physical needs are generally met on a daily basis. The person's status is good. Routine health and dental care are generally provided but not always on schedule. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed occasionally. Height and weight are within normal ranges. The person may have occasional colds, infections, or non-suspicious minor injuries that respond quickly to treatment. **5** ☐

- **Fair Health Status.** The person's physical needs are minimally met on a daily basis. The person's health status is good. Routine health and dental care are minimally provided but not always on schedule. Some immunizations may not have occurred. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed but are not life threatening. Height and weight are within 20% of normal ranges. The person may have frequent colds, infections, or non-suspicious minor injuries that respond adequately to treatment. **4** ☐

- **Marginal Health Status.** The person's physical needs for food, shelter, hygiene, or clothing may not be consistently met. The person's nutritional or physical status is problematic. Routine health and dental care may not be adequately provided. Immunizations may not have occurred. Acute or chronic health care may be inadequate and/or follow-ups or required treatments may be missed or delayed but are not immediately life threatening. A serious chronic health problem may not be adequately managed. The person may be underweight or overweight. The person may have frequent colds, infections, or suspicious minor injuries. **3** ☐

- **Poor Health Status.** The person's physical or health care needs are chronically or consistently unmet resulting in ongoing hygiene, nutrition, or health problems that cause the person to suffer from poor health status that is affecting the person's ability to function and perform activities of daily living. Further neglect could lead to physical deterioration or disability. **2** ☐

- **Adverse Health Status.** The person's physical or health care needs are unmet, resulting in ongoing and worsening health problems. These problems are causing the person to suffer from poor and declining health status that is adversely affecting the person's daily functioning. Further neglect could lead to serious physical deterioration, disability, or death. **1** ☐

Status Review 7: Mental Health Status/Care Benefit

MENTAL HEALTH STATUS/CARE BENEFIT: • Is the adult's mental health status currently adequate or improving? • If symptoms of mental illness are present, does the adult have access to mental health care, necessary and sufficient, to reduce symptoms and improve daily functioning? • Is the person benefiting from continuity of care provided across mental health and health care providers?

Mental health status and emotional well-being are essential for adequate functioning in a person's daily life settings. To do well in life, a person should:

- Present an affect pattern appropriate to time, place, person, and situation.
- Have a sense of belonging and affiliation with others rather than being isolated or alienated.
- Socialize with others in various group situations as appropriate to age and ability.
- Be capable of participating in major life activities and decisions that affect him/her.
- Be free of or reducing major clinical symptoms of emotional/behavioral/thought disorders that interfere with daily activities.
- Benefit from continuity of care between health care and mental health service providers, especially when the person has chronic health needs that must be managed concurrent with psychiatric needs.

For a person with mental health needs who requires special care, treatment, rehabilitation, or support in order to make progress toward stable and adequate functioning in daily settings, the person should be receiving necessary services and demonstrating progress toward adequate functioning in most aspects of life. Some persons may require well-coordinated health care and mental health services to be successful. Others may require income assistance or support services. Timely and adequate provision and coordination of supports and services should enable the person to benefit from treatment and make progress toward recovery.

Determine from Informants, Plans, and Service Records

1. Is the person currently presenting psychiatric symptoms or behavioral problems in daily settings? If so, which settings and what are the problems?
2. Does the person receive treatment and rehabilitation services? If so, are symptoms being reduced or managed? Is the person's level of functioning improving? Is the person learning how to cope with troublesome symptoms?
3. Does the person have a serious behavior problem? If so, are maladaptive or high risk behaviors being reduced and replaced with functional behaviors?
4. Does the person present an affect pattern appropriate to time, place, person, and situation? If not, how are mood and/or anxiety problems being addressed?
5. Is the person receiving supportive counseling and, where necessary, special assistance in daily settings consistent with his/her needs for success?
6. Does the person receive medication education? Is this person managing his/her own medications? If so, how reliably?
7. Does this person resist medications? Does he/she present any adverse side effects of medications?
8. Is the person making progress toward recovery? Is the person receiving insight-oriented therapy to build coping skills and life management understandings?
9. Does the person receive services, as necessary, to prevent relapse?
10. Does the person enjoy life and feel connected with others?

Facts Used in Rating Status

NOTE:

Consider whether the person is receiving entitled health and mental health benefits necessary to manage symptoms of mental illness.

Consider whether the person is experiencing distress from symptoms and, if so, whether such symptoms are interfering with the person's work or social situations.

Status Review 7: Mental Health Status/Care Benefit

Determine from Informants, Plans, and Service Records	Facts Used in Rating Status
11. Is there continuity in the coordination of treatment and support modalities across health care and mental health providers for this person? Is the person benefiting from continuity of care across care providers?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Mental Health Status/Care Benefit.** The person is stable and functioning very well across settings. The person may enjoy many positive and enduring supports from a variety of people. He/she may socialize well with others in various group situations, as appropriate, to ability and preferences. He/she may be participating at a high and consistent level in major life activities and decisions that affect him/her. The person may be benefiting from an excellent level of coordination of treatment/rehabilitation modalities and continuity of care across health and mental health providers. **6** ☐

- **Good Mental Health Status/Care Benefit.** The person is stable and functioning adequately across settings. The person may have some positive and enduring supports from a variety of people. He/she may socialize in generally acceptable ways with others in various group situations, as appropriate to ability and preferences. He/she may be participating at a substantial level in major life activities and decisions that affect him/her. The person may be benefiting from a good level of coordination of treatment/rehabilitation modalities and continuity of care across health and mental health providers. **5** ☐

- **Fair Mental Health Status/Care Benefit.** The person is functioning with no more than expectable reactions to social stressors and no more than slight impairment. The person may have a few positive and enduring supports, mostly from staff or family. He/she may socialize occasionally in at least minimal ways with others in group situations, as appropriate to ability and preferences. He/she may participate at a minimal level in major life activities and decisions that affect him/her. The person may be benefiting from a fair level of coordination of treatment modalities and continuity of care across health and mental health providers. **4** ☐

- **Marginal Mental Health Status/Care Benefit.** The person is functioning with some symptoms or some difficulties in social situations. The person may have a few positive and enduring relationships. He/she may socialize occasionally or marginally with others in group situations, as appropriate to ability and preferences. He/she may be participating at a marginal level in major life activities and decisions that affect him/her. At this level, staff may be working diligently, but may be doing things that don't work for this person. **- OR -** The person has co-occurring alcohol or substance abuse issues that are not well addressed. **3** ☐

- **Poor Mental Health Status/Care Benefit.** The person is functioning with moderate-to-serious symptoms or substantial difficulties in social situations. The person may have a few relationships with rare or unpleasant contacts. He/she may not socialize with others in group situations. He/she may not be participating in major life activities and decisions that affect him/her. At this level, staff may be working, but may be doing things that don't work for this person. **- OR -** Efforts may be substantially inconsistent across health and mental health providers. **- OR -** The person has a serious co-occurring alcohol or substance abuse problem that is poorly understood or addressed. **2** ☐

- **Adverse Mental Health Status/Care Benefit.** The person is functioning with serious-to-severe impairments and with potentially dangerous symptoms. The person may be socially isolated or withdrawn. He/she may not be capable of participating in major life activities and decisions that affect him/her. The person may be experiencing an absence of appropriate treatment or breakdown in coordination of treatment modalities with no continuity in care by health and mental health providers. **- OR -** The person has a serious co-occurring addiction that undermines other treatment efforts. **1** ☐

Status Review 8: Education/Career Preparation

EDUCATION/CAREER PREPARATION: • Is this adult actively engaged in educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training programs? • Is the person receiving information about work benefits, loss of financial benefits, access to work supports, rights, responsibilities, and advocacy? • If not, does this person have access to such opportunities, subject to the person's needs and preferences?

Opportunities to improve one's skills, knowledge, and life potential are important for all adults. Education and training are ways that people use to promote life-long learning, enhance life opportunities, and advance career possibilities. Subject to ability, choice, and support, a person with mental illness should be able to access learning activities available within the community. Learning activities include adult basic education, GED classes, post-secondary education (via community college, university, online courses) and vocational training programs for career preparation or advancement. Under provisions of Section 504, Rehabilitation Act, 1973, persons with disabilities may request and receive special accommodations from educational institutions that enable them to participate in and benefit from educational opportunities. Educational advocacy by a case manager, social worker, or counselor may be necessary to secure opportunities and accommodations for an adult with mental illness who meets enrollment criteria and who chooses to advance his/her education or career skill status. The focus of this review is placed upon the person's participation in adult learning opportunities available within the community and/or treatment setting. Concerns in this review include whether the person: (1) is aware of learning opportunities; (2) is assisted in enrollment and securing accommodations (including GED club houses; tutoring services; access to computers; consumer education about benefits, losses, access, rights, responsibilities, advocacy, and mental health programs), if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for persons who, by choice, are not currently participating in such activities.

Determine from Informants, Plans, and Records	Facts Used in Rating Status
1. Is the person aware of the learning activities and opportunities currently available in his/her community and/or treatment setting?	
2. Does the person meet enrollment requirements to participate in and benefit from learning activities in the community?	
3. Is the person currently accessing and participating in a community learning activity? If so, what advocacy, support, or special accommodations are being provided to this person?	
4. Is the person receiving consumer education information and advice on the financial and social benefits gained from employment, possible losses of SSI or Medicaid benefits, rights and responsibilities related to employment, and information about sources of advocacy and assistance?	
5 If given assistance or support, would this person be interested and willing to continue his/her education?	
6. Does this person need educational advocacy to gain access to learning activities, with special accommodations as necessary for participation and success? If so, has educational advocacy been offered or provided to this person?	
7. Does this person's life situation (e.g., parent of a newborn infant, hospitalized, or elderly) or current work schedule prevent the person from pursuing learning opportunities at this time?	
8. Has this person been offered educational opportunities recently but declined participation? If so, why?	

Status Review 8: Education/Career Preparation

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Education/Career Preparation.** The person has high aspirations and goals to pursue learning activities in the community. The person is actively and successfully engaged in formal educational activities (e.g., adult basic education, tutorial assistance, GED course work, or post-secondary education/bachelor's degree) or vocational training. The person may have needed, requested, and received excellent educational advocacy (including financial assistance), support, and/or special accommodations to access and benefit from learning opportunities. The person may be making excellent progress. — **6** ☐

- **Good Education/Career Preparation.** The person has many aspirations and goals to pursue learning activities in the community. The person is actively and substantially engaged in formal educational activities (e.g., adult basic education, GED course work, tutorial assistance, or post-secondary education) or vocational training. The person may have needed, requested, and received good educational advocacy (including financial assistance), support, and/or special accommodations to access and benefit from learning opportunities. The person may be making good progress. — **5** ☐

- **Fair Education/Career Preparation.** The person has some aspirations and goals to pursue learning activities in the community. The person is somewhat engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training. The person may have needed, requested, and received some educational advocacy, support, and/or special accommodations to access and benefit from learning opportunities. The person may be making fair progress. — **4** ☐

- **Marginal Education/Career Preparation.** The person has some aspirations and goals to pursue learning activities in the community. The person is marginally engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training. The person may have needed, requested, and received limited or inconsistent educational advocacy, support, and/or special accommodations to access and benefit from learning opportunities. The person may be making little progress. — **3** ☐

- **Poor Education/Career Preparation.** The person has some aspirations and goals to pursue learning activities in the community. The person is poorly or inconsistently engaged in formal educational activities or vocational training. The person may have needed, requested, and received inadequate educational advocacy, support, and/or special accommodations necessary to access and benefit from learning opportunities. The person may be making poor or no progress. — **2** ☐

- **Absent Education/Career Preparation.** The person has some aspirations and goals to pursue learning activities in the community. The person is not engaged in formal educational activities or vocational training. The person may have needed, requested, but received no educational advocacy, support, and/or special accommodations necessary to access and benefit from learning opportunities. The person is lacking the opportunity to make progress. — **1** ☐

- **Not Applicable.** The person may lack any aspirations and goals to pursue active learning, education, or training opportunities at this time. Or, the person may be elderly or retired. — **NA** ☐

Status Review 9: Work

WORK: • Is this person actively engaged in employment (competitive, supported, transitional) or in an individual placement with support in a productive situation? • If not, does this person have access to productive opportunities (e.g., consumer-operated services, community center, or library)?

Productive activity (work or volunteer efforts) gives meaning and value to one's life. Work provides a respected social role and a way to participate in and interact with others in the community. Work provides natural forms of affiliation and a way to develop friends via meaningful social contribution. Opportunities to offer one's skills, knowledge, and time for good purpose and personal benefit are important for adults. Subject to choice, a person with mental illness should be able to access and participate in productive activities available within the community. Productive activities may include various forms of work (competitive, supported, or transitional—full or part-time), job-training-related productive activities, or volunteer service activities. Under provisions of Section 504, Rehabilitation Act, 1973, and the Americans with Disabilities Act (ADA), persons with disabilities may request and receive special accommodations from employers that enable them to participate in and benefit from employment opportunities. Advocacy and assistance by a case manager, social worker, or counselor may be necessary to secure work or volunteer opportunities and accommodations for an adult with mental illness who meets employment criteria and who seeks employment. Some persons with disabilities may require special supports to which they may be entitled through various government programs, such as Vocational Rehabilitation, Ticket to Work, or Temporary Assistance to Needy Families (TANF). The focus of this review is placed upon the person's participation in opportunities for work and other productive activities available within the community. Concerns in this review include whether the person: (1) is aware of productive opportunities and supports; (2) is assisted in work applications and securing accommodations, if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for a person who, by choice, is not currently participating in work or other productive activities.

Determine from Informants, Plans, and Records

1. Is the person aware of productive activities and opportunities currently available in his/her community? Ticket to Work? Career Opportunity Network?

2. Does the person meet requirements and/or have requisite supports to participate in productive activities in the community?

3. Is the person currently accessing and participating in community employment services and supports? If so, what advocacy, support, or special accommodations are being provided to this person?

4 If given encouragement, assistance or support, would this person be interested and willing to try/return to work or volunteer his/her time and services?

5. Does this person need assistance or advocacy to gain access to productive activities, with special accommodations as necessary for participation and success? If so, has advocacy been offered or provided to this person?

6. Does this person's life situation or current educational schedule prevent the person from pursuing productive opportunities at this time? What is being done to help? What choice of job, schedule, work site, and supports was the person offered?

7. Did the person get to see options of his/her choice or were options limited to jobs available in a particular program or service?

8. Has educational information about impact of salary and gain of benefits been discussed with this person? Has assistance been offered to offset any benefit losses? Has the person been counseled on the gains, risks, and hopes?

Facts Used in Rating Status

Status Review 9: Work

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. And, the person is successfully engaged in productive activities (e.g., work or volunteer services). The person may have needed, requested, and received excellent assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing excellent success in and significant benefits from current work or voluntary activities. **6** ☐

- **Good Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. And, the person is actively and substantially engaged in productive activities. The person may have needed, requested, and received good levels of assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing good success and substantial benefits in his/her work or voluntary activities. **5** ☐

- **Fair Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. And, the person is frequently engaged in productive activities. The person may have needed, requested, and received minimally adequate levels of assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing a fair degree of success and some benefits in his/her productive activities. **4** ☐

- **Marginal Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. But, the person is seldom engaged in productive activities. The person may have needed, requested, and received limited or inconsistent assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing minor problems with and limited benefits in his/her productive activities. **3** ☐

- **Poor Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. But, the person is poorly or inconsistently engaged in productive activities. The person may have needed, requested, and received little or poor quality assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing significant problems with and few, if any, benefits in his/her productive activities. **2** ☐

- **Absent Productive Activities/Opportunities.** The person has aspirations and goals to pursue productive activities in the community. But, the person is not engaged in productive activities. The person may have needed and requested, but not received assistance, advocacy, support, and/or special accommodations necessary to access and benefit from productive opportunities. The person is lacking the opportunity to be productive. **1** ☐

- **Not Applicable.** The person may lack the aspirations and goals to pursue employment or voluntary service opportunities at this time. Or, the person may be elderly or retired. **NA** ☐

Status Review 10: Recovery Activities

RECOVERY ACTIVITIES: • Is this person actively engaged in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? • If not, does this person have access to recovery and relapse prevention opportunities, subject to his/her needs, life ambitions, and personal preferences?

Recovery activities may involve use of various forms of medical care along with psychosocial adjustment and vocational training/retraining in an effort to maximize functioning, adjustment, and recovery for a person having serious and persistent mental illness. Recovery aims to prepare the person physically, mentally, socially, and vocationally for the fullest possible life, consistent with his/her abilities, ambitions, and choices. It is an individualized, dynamic, and purposeful process built around skills training and support modalities, as well as directed socialization complementing therapy and retraining. Recovery activities and services aim to help a person make the best use of his/her capacities within as normal as possible social context. For a person with a serious and persistent mental illness, rehabilitation usually aims to: (1) prevent relapse and rehospitalization by achieving successful community support and services, (2) improve the person's quality of life by assisting the person manage his/her life, and (3) achieve valued social roles in the community. Recovery efforts focus on strengthening the person's skills and developing the environmental supports necessary to sustain the person in the community. Successful recovery depends on a network of community services. The focus in this review is placed on access to and use of recovery and relapse prevention support opportunities. Recovery support activities are oriented toward successful community living and self-directed life management. This review may be deemed not applicable for a person who is functioning independently and successfully in the community or who declines recovery opportunities after reasonable, ongoing efforts to engage the person via outreach with attractive offers of supports and services.

Determine from Informants, Plans, and Records

1. What outreach and engagement efforts are being used to develop this person's interests in recovery and relapse prevention opportunities?

2. Is this person currently participating in recovery activities? If not, why not?

3. What recovery/relapse prevention opportunities have been offered to this person? If the person declined participation, what efforts were made to engage the person? Were reasonable and attractive choices (to the person) offered? What supports or incentives were offered?

4. What is the nature of recovery activities in which the person is now participating: a general program for a group of participants or individually tailored services and activities designed to meet specific needs and personally selected goals?

5. Do recovery activities offered or used include skills development, social networking, hope, coping, self-agency, self-management, relapse prevention/support, restarting recovery, and choices about where and how to work the process?

6. Given current recovery services, is the person making progress toward achievement of personally selected recovery goals? Does the person see them as meaningful?

7. Has this person progressed to the self-management and sustainability stage of recovery?

8. Are any of the available recovery activities peer operated?

Facts Used in Rating Status

Status Review 10: Recovery Activities

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is highly motivated to participate in rehabilitative activities. The person may have been engaged via an excellent outreach effort and/or a change in his/her mental health status. The person may have needed, requested, and received excellent assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing excellent progress toward accomplishing personally chosen life goals and recovery. **6** ☐

- **Good Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is substantially motivated to participate in rehabilitative activities. The person may have been engaged via a positive outreach effort. The person may have needed, requested, and received good assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing good and substantial progress toward accomplishing personally chosen life goals and recovery. **5** ☐

- **Fair Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is somewhat motivated to participate in rehabilitative activities. The person may have been engaged via a modest outreach effort. The person may have needed, requested, and received minimally adequate assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing fair progress toward accomplishing personally chosen life goals and recovery. **4** ☐

- **Marginal Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person has difficulty in sustaining motivation to participate in rehabilitative activities. The person may have been engaged via a limited outreach effort. The person may have needed, requested, and received limited or inconsistent assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing limited progress toward accomplishing goals possibly set by others. **3** ☐

- **Poor Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person has not been able to sustain motivation to participate in rehabilitative activities. The person may not have been engaged via outreach efforts for a variety of current reasons or may have had a previous negative experience. The person may have needed, requested, and received inadequate assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing little, if any, progress toward accomplishing goals. **2** ☐

- **Absent Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person cannot agree to participate in rehabilitative activities. The person may not have been engaged via outreach efforts for a variety of long-standing reasons or may have had previous negative experiences. The person may have needed or requested, but not received any assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing no progress toward life goals or could be becoming increasingly isolated or disabled. **1** ☐

- **Not Applicable.** The person chooses not to pursue recovery opportunities at this time. Or, the person may be elderly or in declining health. **NA** ☐

Status Review 11: Person's Overall Status

PERSON'S OVERALL STATUS SCORING RUBRIC

There are 10 reviews to be conducted in the area of the Person's Status. Each review produces a finding reported on a 6-point rating scale with scale values of 1-3 being in the unacceptable range and values 4-6 being in the acceptable range. An "overall rating" of the Person's Status is based on the findings determined for the Person's Status Reviews, using the following scoring procedure to produce an "overall rating value" on a 1-6 scale. **Safety is a "trump" review meaning that the Overall Person's Status is ACCEPTABLE only when SAFETY is rated in the 4-6 range**. This procedure is performed after rating results are produced for all 10 reviews: (1) Begin by transferring the rating value for each review item from the protocol page to the calculation table below; (2) Next, multiply the rating value for each review by the weighting value in the table to produce a weighted score for the review; (3) Then, sum the weighted values of all review scores to produce a total score; (4) Note whether the **SAFETY** review was rated as "acceptable," having a rating score in the 4-6 range; (5) Follow the instructions that appear below the calculation table to assign the OVERALL STATUS RATING for this person. If one or more reviews are deemed not applicable, then follow the procedures on page 35.

Rating	Weight	Score	Status Reviews
			Community Living
_____	**x 3**	_____	**1. SAFETY of the person** (trump item)
_____	x 2	_____	2. Economic security (income)
_____	**x 3**	_____	**3. Living arrangements**
_____	x 2	_____	4. Social network
_____	x 1	_____	5. Satisfaction with services (if NA use page 35)
			Health & Well-being
_____	x 2	_____	6. Health/physical well-being
_____	**x 3**	_____	**7. Mental health status/care benefit**
			Developing Life Skills
_____	x 1	_____	8. Education/career preparation (if NA use page 35)
_____	x 1	_____	9. Work (if NA use page 35)
_____	**x 3**	_____	**10. Recovery activities (if NA use page 35)**

TOTAL SCORE:_____ **SUM of the Weights of all Not Applicable (NA) Review Items = _____**

Note:
Use the rating scale ranges below when all review items are deemed applicable to this case. If one or more review items are deemed not applicable, use the modified scoring ranges presented on page 35, as directed.

Rating of the Person's Overall Status if all Indicators are Applicable	Action Zone
◆ **Optimal Status**. Assign an overall status rating of "6" when the TOTAL SCORE is in the 110-126 range AND when SAFETY is rated in the 4-6 range. If SAFETY is less than 4, then the OVERALL RATING equals the SAFETY rating. ◆ **Good Status**. Assign an overall status rating of "5" when the TOTAL SCORE is in the 92-109 range AND when SAFETY is rated in the 4-6 range. If SAFETY is less than 4, then the OVERALL RATING equals the SAFETY rating.	6 ☐ Maintenance 5 ☐
◆ **Fair Status**. Assign an overall status rating of "4" when the TOTAL SCORE is in the 75-91 range AND when SAFETY is rated in the 4-6 range. If SAFETY is less than 4, then the OVERALL RATING equals the SAFETY rating. ◆ **Marginal Status**. Assign an overall status rating of "3" when the TOTAL SCORE is in the 57-74 range. If SAFETY is less than 3, then the OVERALL RATING equals the SAFETY rating.	4 ☐ Refinement 3 ☐
◆ **Poor Status.** Assign an overall status rating of "2" when the TOTAL SCORE is in the 40-56 range. If SAFETY is rated "1," then lower the OVERALL RATING to "1." ◆ **Adverse Status.** Assign an OVERALL STATUS RATING of "1" when the TOTAL SCORE is in the 21-39 range, regardless of the SAFETY rating.	2 ☐ Improvement 1 ☐

[Alternative] Status Review 11: Person's Overall Status

ALTERNATIVE PERSON'S OVERALL STATUS SCORING PROCEDURE

WHEN EITHER Status Review 5—Satisfaction with services/results, OR Status Review 8—Education/career preparation, OR Status Review 9—Work, OR Status Review 10—Recovery Activities, OR if any of Status Reviews 5, 8, 9, or 10 are deemed "not applicable" OR if all of the Status Reviews 5, 8, 9, and 10 are deemed "not applicable" in a case, use this alternative scoring procedure.

First, complete the rating and weighting table on page 34 using a **ZERO (0)** value for each review deemed not applicable to produce TOTAL SCORE for the Person's Overall Status. Add the weights for each NA item to obtain a Total Sum of the NA item weights. Once a total score and sum of NA weights are produced, the reviewer should select and use the appropriate alternative scoring procedure provided in the table below. Identify the scoring situation present in this case and then locate the scoring range interval that matches the TOTAL SCORE in this case. Then, mark the rating value and zone corresponding to the scoring interval. Use the alternate rating value for the Person's Overall Status Rating on the "roll-up" sheet.

SCORING SITUATION DETERMINED IN THIS CASE						
NA weight = 1	**NA** weights = 2	**NA** weights = 3	**NA** weights = 4	**NA** weights = 5	**NA** weights = 6	**Overall Rating and Zone**
☐ 104-120 range	☐ 99-114 range	☐ 94-108 range	☐ 89-102 range	☐ 84-96 range	☐ 79-90 range	**6** ☐ Maintenance
☐ 88-103 range	☐ 83-98 range	☐ 79-93 range	☐ 75-87 range	☐ 70-83 range	☐ 66-78 range	**5** ☐
☐ 71-87 range	☐ 67-82 range	☐ 64-78 range	☐ 60-74 range	☐ 57-69 range	☐ 54-65 range	**4** ☐ Refinement
☐ 54-70 range	☐ 52-66 range	☐ 49-63 range	☐ 46-59 range	☐ 44-56 range	☐ 41-53 range	**3** ☐
☐ 38-53 range	☐ 36-51 range	☐ 34-48 range	☐ 32-45 range	☐ 30-43 range	☐ 29-40 range	**2** ☐ Improvement
☐ 20-37 range	☐ 19-35 range	☐ 18-33 range	☐ 17-31 range	☐ 16-29 range	☐ 15-28 range	**1** ☐

Progess Review 1: Personal Management of Troubling Symptoms

SYMPTOM MANAGEMENT: To what extent are troublesome symptoms of mental illness being reduced, coped with, and personally managed by this individual?

A person receiving treatment for mental illness has one or more diagnoses based on psychiatric symptoms and other conditions. As a result of treatment intervention and recovery support, symptoms of disorders are expected to diminish over time. Effective treatment response is accompanied by reduction in symptoms and, hopefully, restoration of the person to adequate functioning. Persons receiving appropriate treatment are expected to experience reduction in symptoms over the course of treatment and recovery. Medications alone, however, are seldom sufficient to eliminate or prevent the recurrence of some troubling symptoms. For this reason, recovery efforts are aimed at helping the person develop coping strategies that promote the person's self-management and tolerance of those symptoms without accompanying losses in daily functioning.

The purpose of this review is to determine the person's progress in the reduction and self-management of bothersome symptoms associated with the disorder or condition being treated. The reviewer should use the scale provided below to report the degree of progress in symptom reduction reported by informants and records in this case.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Progress.** The person is making excellent progress in symptom reduction, coping, and self-management at a level well above expectation. The disorder maybe in partial-to-full remission. There no longer may be any symptoms or signs of disorder or the person is coping exceptionally well with persisting symptoms of a troublesome nature. Functioning is now similar to previous favorable levels.	**6** ☐
◆ **Good Progress.** The person is making good progress in symptom reduction, coping, and self-management at a level somewhat above expectation. Coping and self-management are at a good and consistent level. Symptoms do not interfere with the person's life and pursuit of happiness.	**5** ☐
◆ **Fair Progress.** The illness is now at a mild-to-moderate level with some symptoms or functional impairments still present in social or work settings. Coping and self-management are at a fair level. Symptoms may sometimes minimally interfere with the person's life and pursuit of happiness.	**4** ☐
◆ **Marginal Progress.** The person is making limited or inconsistent progress in symptom reduction, coping, and self-management at a level that is uncomfortable and that reduces or impairs some life functions. Coping and self-management are at a limited or inconsistent level. The illness is now at a moderate level with substantial symptoms or functional impairments present in social or work settings.	**3** ☐
◆ **No Progress.** The illness is now at a moderate-to-severe level with many symptoms and marked functional impairments present in social or work settings. Coping and self-management are presently at an impaired level. Risks of restriction, isolation, increased disability, or injury may be present.	**2** ☐
◆ **Decline.** The person's symptoms are increasing. Serious symptoms and increasing functional limitations may be present across settings. Overwhelming symptoms are out-running the person's coping capacity and self-management capabilities at the present time. Risks of increased restriction, isolation, disability, or injury are high.	**1** ☐

Progress Review 2: Improved Self-Management

IMPROVED FUNCTIONING/SELF-MANAGEMENT: • To what extent is the person making progress in key life areas, including self-management in the community, where appropriate?

Adults with serious and persistent mental illness may encounter more difficulties functioning in daily settings and activities than other persons. Building appropriate functional behavior patterns and reducing behaviors that may cause problems in social and work settings may be addressed through positive behavioral supports, rehabilitative services developed uniquely by and with the person, use of medications, or a combination of these modalities. Where appropriate, an individualized recovery plan (IRP) should be evaluated on the basis of the person's improvement over time. The person either should be presenting functional behavior patterns in daily settings or should be demonstrating substantial progress toward improved functioning, problem solving, and self-management. Persons with mental illness may require specialized or intensive supports and services for a period of time to participate in community settings, consistent with the person's preferences. The person should be learning how to understand and meet daily life challenges encountered at home, at work, and in the community as a part of recovery and increasing self-management. This may include a step-by-step process of meeting short-term goals that increases hope for recovery and demonstrates practical progress in self-management. The reviewer should rate the person's progress in acquiring and using social and self-management skills in community settings, according to the person's culture, ambitions, and present opportunities for improvement. [Staff should always be asking: What am I doing for this person that the person might do?]

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Improvement.** The person is performing **above expectation,** based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she takes full responsibility for his/her life and asks for assistance when needed. There is evidence of excellent progress toward IRP goals related to community functioning and independent self-management. **6** ☐

- **Good Improvement.** The person is performing **at expectation,** based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she takes some responsibility consistently for his/her life and occasionally asks for assistance when needed. There is evidence of good progress toward IRP goals related to community functioning and independent self-management. **5** ☐

- **Fair Improvement.** The person is performing **near expectation,** based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she takes some responsibility intermittently for his/her life and still relies on staff for assistance in many aspects of his/her life. There is evidence of minimally adequate to fair progress toward IRP goals related to community functioning and independent self-management. **4** ☐

- **Marginal Improvement.** The person is performing **below expectation,** based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she rarely or intermittently takes responsibility for his/her life and has not reduced reliance on staff assistance. There is evidence of limited or inconsistent progress toward IRP goals related to community functioning and independent self-management. **3** ☐

- **Poor Improvement.** The person is performing **well below expectation,** based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she continues to use staff assistance to a large degree for task support and decisions. There is little, if any, evidence of progress toward IRP goals related to community functioning and independent self-management. **2** ☐

- **No Improvement or Decline.** The person is **not improving or may be declining** in daily functioning in the settings where he/she lives, works, and plays, based on reports from informants, progress notes, and other evidence. **1** ☐

- **Not Applicable.** The person may be elderly or in physical decline. **Improvement is not expected** at this time. **NA** ☐

Progress Review 3: Education/Work Progress

EDUCATION/WORK PROGRESS: To what extent is this person presently making progress toward educational course completion - OR - making progress toward getting and keeping a job?

Consistent with the person's ambitions and choices, the person may be actively engaged in educational, vocational, or employment processes that are enabling the person to build skills and functional capabilities necessary for a productive life in the community. The person may be participating in educational activities (e.g., adult basic education, GED course work, or post-secondary education), vocational training programs, and/or employment (competitive, supported, transitional; either paid or voluntary). The expectation is that the person, consistent with his/her personal ambitions and preferences, is making goal-related progress while making use of any supports that may be required for the person's participation and success. If the person has completed or dropped out of school and is working, then progress in satisfying expectations of the employer and making career advancement is the focus of rating progress in this review. If the person is not in school and/or is not working, then this review does not apply to this person at this time.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Education/Work Progress.** The person is working **above expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	6 ☐
◆ **Good Education/Work Progress.** The person is working **at expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	5 ☐
◆ **Fair Education/Work Progress.** The person is working **near expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	4 ☐
◆ **Marginal Education/Work Progress.** The person is working **below expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	3 ☐
◆ **Poor Education/Work Progress.** The person is working **well below expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	2 ☐
◆ **No Education/Work Progress.** The person is **showing no progress or no longer works** in his/her educational classes, vocational program, or job situation.	1 ☐
◆ **Not Applicable.** This person, by choice, is not participating in an education or work-related opportunity at this time.	NA ☐

Progress Review 4: Progress Toward Recovery Goals

PROGRESS TOWARD RECOVERY GOALS: To what degree is the person making progress toward attainment of personally selected recovery goals in the individualized recovery plan (IRP)?

To achieve and maintain good health, reduce psychiatric symptoms, and/or to make recovery progress in key life areas (e.g., communications, self-care, mobility in the community, coping, self-management, capacity for independent living), a person with mental illness may choose *[subject to medical necessity]* clinical services (e.g., nursing, physical therapy, speech therapy, occupational therapy, psychiatric services) or psycho-social rehabilitative services or supportive services to improve his/her life situation. Such services may be necessary in order for a person to participate in and benefit from other life opportunities, such as education, work, or social integration in the community. Recovery-related services should be supportive of the person's self-selected life goals expressed in his/her IRP. Depending on the person's needs, support may be required to master a broad range of potential goals, from basic functional behaviors (e.g., mobility following an injury) to sophisticated social behaviors (e.g., respectful social interactions in group situations) to self-management of troublesome symptoms. Recovery goals in the IRP should define competencies to be achieved with clinical, psychosocial, or supportive services targeting skill acquisition and life management. Progress may be assessed via a variety of procedures including, but not limited to, observation, functional data collection, self-report, and formal or informal assessments. The focus in this review is on the person's progress made toward the achievement of personally selected goals contained in the person's IRP. The expectation is that the person is or should be receiving active treatment/support related to those goals. If the person does not wish to pursue recovery goals at the present time, this review is not applicable.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is **above expectation** based on the person's hopes, goals, and short-term steps in achieving IRP goals. The person is making excellent progress.	**6** ☐
◆ **Good Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is **at expectation,** based on the person's hopes, goals, and short-term steps, in achieving IRP goals. The person is making good progress.	**5** ☐
◆ **Fair Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is **near expectation,** based on the person's hopes, goals, and short-term steps, in achieving IRP goals. The person is making minimally adequate to fair progress.	**4** ☐
◆ **Marginal Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is somewhat willing to actively participate in those services at this time. The person is **below expectation,** based on the person's hopes, goals, and short-term steps, in achieving IRP goals. The person is making limited or inconsistent progress.	**3** ☐
◆ **Poor Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is somewhat willing to actively participate in those services at this time. The person is **far below expectation,** based on the person's hopes, goals, and short-term steps, in achieving IRP goals. The person is making slight or erratic progress.	**2** ☐
◆ **No Progress or Decline.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is somewhat willing to actively participate in those services at this time. The person is **not progressing** or may be **declining** in IRP goal areas.	**1** ☐
◆ **Not Applicable.** The person does not wish to pursue life goals in areas that may require clinical services and/or psychosocial supports at this time. Or, the person may be elderly, retired, or in declining health.	**NA** ☐

Progress Review 5: Risk Reduction

RISK REDUCTION: To what extent is reduction of risks of harm, use of chemical substances, and/or utilization of coercive techniques being accomplished with and for this person?

Due to a combination of life circumstances and/or functional limitations, some persons with mental illness may be at risk of physical harm, poor outcomes, or high utilization of restrictive services and coercive techniques. If the person is at elevated risk of harm (e.g., health crisis, physical abuse, substance use, or self-injury) or at elevated risk of an undesirable outcome (e.g., disease, addiction, arrest, acute inpatient hospitalization, homelessness), then such risks and their reduction should be addressed in the IRP. Identification of risks for a person should include case history of past harmful events, present risk factors, life stressors, and service utilization patterns. Due diligence in practice requires that clinicians, service coordinators, and support providers spot and respond to serious risks. Recognized risks (e.g., physical abuse via domestic violence in the home) should be reduced and potentially harmful events (e.g., self-injurious behavior) should be prevented or managed over time via interventions and supports. History is the best predictor of risk and persons should be involved in describing their risks and managing them. Not all persons with mental illness present such risks. In a case where diligent assessment is made and no risks are identified, this review is deemed not applicable.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Risk Reduction.** Excellent identification of and protective responses to detected risks are present at this time for this person. Known risks are very well managed and the likelihood of harm or poor outcomes is minimized.	**6** ☐
◆ **Good Risk Reduction.** Good and consistent identification of risks is evident in this case. Commensurate responses to detected risks are present at this time for this person. Known risks are substantially well managed and the likelihood of harm or poor outcomes is low.	**5** ☐
◆ **Fair Risk Reduction.** Minimally adequate to fair identification of risks is evident in this case. Responses to detected risks appear to be minimally adequate at this time for this person. Known risks are somewhat managed and the likelihood of harm or poor outcomes is being reduced.	**4** ☐
◆ **Marginal Risk Reduction.** Identification of risks may be spotty, shallow, or inconsistent, leading to a confusing picture. Responses to identified or suspected risks may be off target or not well coordinated. Risks are managed in a limited or inconsistent manner and the likelihood of harm or poor outcomes is present at a somewhat lowered level of probability.	**3** ☐
◆ **Poor Risk Reduction.** Identification of risk is poor, e.g., incomplete, conflictual, or questionable. Responses to identified or suspected risks may be delayed, misdirected, ineffective, or uncoordinated. Risks may be misunderstood or undetected. The likelihood of harm or poor outcomes may be present at a moderate-to-high level of probability.	**2** ☐
◆ **Adverse Risk Reduction.** Identification of risk is erroneous, is obsolete, or may be missing. Responses to identified or suspected risks may be missing, contrary to good practice, ineffective, or not performed when needed. Risks for the person may be high and increasing.	**1** ☐
◆ **Not Applicable.** No evidence of risk is revealed after appropriate review of the person and his/her circumstances. This review is deemed not applicable to the person at this time.	**NA** ☐

Progress Review 6: Successful Life Adjustments

SUCCESSFUL LIFE ADJUSTMENTS: Consistent with this person's needs and goals, to what extent is the person making successful transitions and life adjustments between living settings, service providers, levels of care, and from dependency to personal control and direction?

Transitions and life adjustments are a part of life. For most people, transitions and life adjustments are always important but difficult, as are most changes. This is because new learning, special arrangements, accommodations, supports, or services may be necessary to accomplish a smooth and successful transition from one setting, program level, service provider, and set of relationships to another. Many different kinds of transitions and adjustments may play out in a person's life. Some may involve personal losses or changing life stages that are natural and unavoidable aspects of life. For a person with mental illness, more immediate transitions and adjustments may involve changes in living settings, service providers, levels of care, and natural progression from dependency to personal control and direction of one's life.

For a person requiring support or assistance, transitions may require diligent identification and planning of special transition goals and tasks as part of the person's IRP. Progress is assessed in the context of the person's support requirements and the timely provision of necessary supports and services in advance of the transition, during the transition, and for a 30-day period following the transition to assess adjustment success. In a case where diligent identification assessments are made but no transition-related needs and life adjustments are identified, this review is deemed not applicable.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Life Adjustments.** The person is making optimal progress toward achievement of an excellent and successful transition and life adjustment according to an appropriate sequencing of related events (i.e., advance planning, making near-term arrangements, facilitating transition activities, following along in the new setting, and following up for a 30-day adjustment period, as appropriate to the transition situation).	**6** ☐
◆ **Good Life Adjustments.** The person is making good progress toward achievement of a smooth and successful transition and life adjustment according to an appropriate sequencing of related events and support activities. No significant problems have been encountered.	**5** ☐
◆ **Fair Life Adjustments.** The person is making minimally adequate progress toward achievement of a fair transition and life adjustment according to a minimally adequate sequencing of related events and support activities. A few minor difficulties might be encountered but are being or have been resolved.	**4** ☐
◆ **Marginal Life Adjustments.** The person is making limited and inconsistent progress toward achievement of transition and life adjustment according to a marginal sequencing of related events and support activities. Delays or difficulties might be encountered that are limiting transition supports and progress.	**3** ☐
◆ **Poor Life Adjustments.** The person is making poor and inadequate progress toward a difficult transition and life adjustment according to inadequate sequencing of related events and support activities. Inadequate transition planning or breakdowns are present that are hindering transition efforts.	**2** ☐
◆ **Adverse Life Adjustments.** The person should be in a structured and coordinated transition process but is not being supported and/or is encountering foreseeable and preventable difficulties. The person is experiencing unnecessary hardship, adjustment difficulties, or loss of prospective opportunities due to unacceptable transition planning and consequential life adjustment difficulties.	**1** ☐
◆ **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed via transition and life adjustment, supports, or services for this person at this time. This review exam is deemed not applicable.	**NA** ☐

Progress Review 7: Improvement in Social Group Affiliations

IMPROVEMENT IN SOCIAL GROUP AFFILIATIONS: • To what degree is this person increasing his/her social affiliation among a variety of social groups (outside of his/her immediate social group) in the community, consistent with IRP goals? • Does the person access services and participate in social group activities available to all citizens? • Does this person affiliate with community groups, with special accommodations and supports, consistent with the person's desires? • Is the person benefiting from social group affiliation in the community?

As a person with mental illness progressively recovers from serious psychiatric symptoms and social impairments to reach higher levels of functioning, a major thrust of recovery becomes the social integration of the person into his/her community. Restoring the person to the community becomes a major focus of recovery. A person with mental illness should have access to the same community services and activities as do other citizens of the community. The person should have the opportunity, freedom, and support to determine the degree of contact he/she wants to have with social groups in the community. And, the person should be able to decide his/her degree of participation in community life, based on his/her interests and preferences. As interests change, the person may choose to increase the range and frequency of contacts and activities in community life. Benefits of social integration include belonging to social groups, performing social roles, interacting with other members of the community, and enjoying community activities and events. The focus of this review is on recent progress made by the person in improving his/her degree of social integration. This review may not apply to a person who is behaving in ways that are not socially acceptable, who may be in a restrictive setting, or who may choose to remain isolated from others in the community even after diligent efforts have been made to engage the person by repeatedly offering him/her a variety of attractive social integration opportunities.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Social Group Affiliations.** The person has access to and/or participates to a high degree in a wide variety of available social group opportunities appropriate for his/her situation and interests (with accommodations and supports, as needed) and is demonstrating optimal improvement (consistent with IRP goals) and experiencing social benefit from such participation. — **6** ☐

- **Good Social Group Affiliations.** The person has access to and/or participates to a substantial degree in several available social integration opportunities appropriate for his/her situation and interests (with accommodations and supports, as needed) and is demonstrating substantially good improvement and good social benefits from such participation. Participation and benefits are likely to continue if present supports remain. — **5** ☐

- **Fair Social Group Affiliations.** The person has access to and/or participates to a fair degree in at least one available social integration appropriate for his/her situation and interests (with accommodations and supports, as needed) and is demonstrating minimally adequate to fair improvement and some social benefits from such participation. Participation and benefits may be linked to certain persons and supports that may be somewhat limited in time availability or consistency. — **4** ☐

- **Marginal Social Group Affiliations.** The person occasionally has access to and/or participates to a limited degree in one social integration opportunity showing limited or inconsistent improvement or limited social benefits from such participation. Social integration activities may be limited in number or scope. Special accommodations and supports may be substantially limited in availability, consistency, or effectiveness. — **3** ☐

- **Poor Social Group Affiliations.** The person has access to and/or participates inconsistently in social integration opportunities for his/her situation and interests with generally poor results and questionable social benefits from such participation. Social integration activities may be limited in number or scope. Special accommodations and supports may be severely limited in availability, consistency, or effectiveness. — **2** ☐

- **Adverse Social Group Affiliations.** The person does not have access to and/or does not participate in social integration opportunities or may be adversely affected by participation. — **1** ☐

- **Not Applicable.** The person is unable or unwilling to participate in social integration opportunities at the present time. Or, the person may be elderly, retired, or in declining health. — **NA** ☐

Progress Review 8: Improved Meaningful Personal Relationships

IMPROVED MEANINGFUL PERSONAL RELATIONSHIPS: • To what degree is the person improving meaningful personal relationships with peers, friends, and family members, consistent with the person's preferences?

As a person with mental illness progressively recovers from serious psychiatric symptoms and social impairments to reach higher levels of functioning, a major thrust of recovery becomes the connection or reconnection of the person to a circle of supporters consisting of friends, peers, and family members. The person should have the opportunity, freedom, and support to determine the degree of contact he/she wants to have with peers, friends, and family members. As interests change, the person may choose to increase the circle of support and frequency of contacts and activities with persons involved in his/her life. The focus of this review is on recent progress made by the person in improving his/her degree of connection with a circle of supporters. This review may not apply to a person who presently is presenting serious psychiatric symptoms and impairments in functioning, who may be in a restrictive setting, or who may choose to remain isolated from others in the community even after diligent efforts have been made to engage the person by repeatedly offering him/her a variety of attractive social connection/reconnection opportunities.

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Personal Relationships.** The person is actively developing or extending his/her circle of supporters (with accommodations and supports, as needed). He/she is demonstrating excellent improvement in and benefits from these personal relationships.	**6** ☐
◆ **Good Personal Relationships.** The person is currently developing or extending his/her circle of supporters (with accommodations and supports, as needed). He/she is demonstrating substantial improvement in and good benefits from these personal relationships.	**5** ☐
◆ **Fair Personal Relationships.** The person is minimally developing or extending his/her circle of supporters (with accommodations and supports, as needed). He/she is demonstrating fair-to-minimal improvement in and some benefits from these personal relationships.	**4** ☐
◆ **Marginal Personal Relationships.** The person is marginally developing or extending his/her circle of supporters (with some accommodations and supports). He/she is demonstrating limited or inconsistent improvement in and occasional benefits from these personal relationships.	**3** ☐
◆ **Poor Personal Relationships.** The person is poorly developing or extending his/her circle of supporters (with possibly limited accommodations and supports). He/she is demonstrating slight or erratic improvement in and few benefits from any social connections.	**2** ☐
◆ **No Personal Relationships.** The person is not developing or extending his/her circle of supporters (with possibly little or no accommodations and supports). He/she is not demonstrating improvement in or any benefit from any social connections.	**1** ☐
◆ **Not Applicable.** The person is unable or unwilling to participate in social integration opportunities at the present time.	**NA** ☐

Progress Review 7: Overall Progress Pattern

OVERALL PROGRESS PATTERN SCORING PROCEDURE

There are 8 possible reviews to be conducted in the area of the Person's Progress. Each review produces a finding reported on a 6-point rating scale. An overall estimate of the Person's Progress is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE PERSON'S RECENT CHANGES ON APPLICABLE PROGRESS INDICATORS. (1) Begin by transferring the rating value for each progress review item from the protocol page to the summation table below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this person. (4) Focusing on those applicable indicators having the greatest importance to the person at this time, determine an "overall progress pattern" based on your general impression of the person's recent progress. (5) Mark the box indicating your overall rating on item #9 below. Report this rating value on the roll-up sheet prepared for this person.

Person's Progress Pattern

Progress Indicator	Improve		Refine		Maint.		NA
CHANGE OVER TIME	1	2	3	4	5	6	
1. Personal management of troubling symptoms	☐	☐	☐	☐	☐	☐	
2. Improved self-management	☐	☐	☐	☐	☐	☐	☐
3. Education/work progress	☐	☐	☐	☐	☐	☐	☐
4. Progress toward recovery goals	☐	☐	☐	☐	☐	☐	☐
5. Risk reduction	☐	☐	☐	☐	☐	☐	☐
6. Successful life adjustments	☐	☐	☐	☐	☐	☐	☐
7. Social group affiliations	☐	☐	☐	☐	☐	☐	☐
8. Meaningful personal relationships	☐	☐	☐	☐	☐	☐	☐
9. OVERALL PROGRESS PATTERN	☐	☐	☐	☐	☐	☐	

Six-Month Prognosis

ESTIMATING THE TRAJECTORY OF THIS PERSON'S EXPECTED COURSE OF CHANGE

Determination of the person's current status and service system performance is based on the observed current patterns as they emerge from the recent past. This method provides a factual basis for determination of current status and service system performance. Forming a six-month prognosis or forecast is based on predicable future events and informed predictions about the expected course of change over the next six months, grounded on known current status and system performance as well as knowledge of tendency patterns found in case history.

If a case were being reviewed in April, then the trajectory point for consideration would be October. Suppose that the person being reviewed has demonstrated a pattern of serious, complex, and recurrent behavior problems that were just being brought under control in April [Overall Status = 4, meaning person's status is minimally and temporarily acceptable; a fact]. Suppose that this person got into trouble with the law last summer [a fact] while homeless [a fact] and lacked adequate support provided via home [a fact]. Suppose this person is to be discharged from the hospital at the end of May [a fact], but has no transition plan for returning to home with supportive services [a fact] following discharge, no planned daytime program or work situation to keep the person engaged [a fact], continuing health problems [a fact], and no current contact or planning with any residential provider expected to admit and serve the person upon discharge [a fact]. Based on what is now known about this person, what is the probability that the person's status in six months (October) will: (1) Improve from a 4 to a higher level? (2) Stay about the same at level 4? or (3) Decline or deteriorate to a level lower than 4? Given this set of case facts plus the person's tendency patterns described in recent history, most reviewers would make an informed prediction that the case trajectory would be downward and that the person's status is likely to decline or deteriorate. One may "hope" for a different trajectory and a more optimistic situation, but "hope " is not a strategy to change the conditions that are likely to cause a decline. Based on the reviewer's six-month prognosis or forecast for this case, the reviewer offers practical "next step" recommendations to alter an expected decline or to maintain a currently favorable situation over the next six months.

Based on what is known about this case and what is likely to occur in the near-term future, the reviewer makes an informed prediction of the prognosis in this case. Mark the appropriate alternative future statement in the space provided below. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer's recommendations. Insert your determination in the appropriate space on the roll-up sheet.

Six-Month Prognosis

Based on the person's current status on key indicators, recent progress, the current level of service system performance, and events expected to occur over the next six months, is this person's status expected to improve, remain about the same, or decline or deteriorate in the next six months? (check only one)

☐ **Improve status**

☐ **Continue—status quo**

☐ **Decline/deteriorate**

Explain the rationale for your determination in the oral and written reports presented for this case. Offer practical "next step" suggestions for maintaining positive status or preventing avoidable decline or deterioration.

Service Review 1: Participation/Engagement of the Person

PARTICIPATION/ENGAGEMENT: • Is this person actively engaged in service decisions? • Does participation enable the person to express to the service team: (1) preferences about where and with whom to live and where to work, (2) choice of daily routines, (3) wishes about how to spend his/her time and money, (4) choice of service providers, and (5) satisfaction/dissatisfaction with services? • If the person is resistant to participation, are reasonable efforts being made to engage him/her and to support his/her participation?

Whose individualized recovery plan (IRP) and process is it—the service consumer's, the funders', or the providers' plan? The **person should have a sense of personal ownership** in the IRP and decision process. If not, the likelihood of its success is small. Service arrangements are made to benefit the person by helping to create conditions under which he/she can promote personal recovery and succeed in life. Service arrangements should build on the strengths of the person and should reflect his/her strengths, needs, culture, and preferences. If arrangements are not seen as helpful and dependable by the person, services offered are not likely to be beneficial. The socially valued life dreams, ambitions, and peer group interests of the person should be reflected in the IRP and supported by providers. The **central concern** of this review is that the person be an **active participant in shaping and directing service arrangements** that impact his/her life. Emphasis is placed on direct and ongoing involvement in all phases of service: assessment, planning, selection of providers, monitoring, modifications, and evaluation. Allowance should be made when services are imposed by court order for the person rather than being voluntary. The person's satisfaction with services may be a useful indicator of participation and ownership. *["Nothing about us without us!"]* If the person is resistant, diligent and appropriate ongoing efforts should be made to encourage participation.

Determine from Informants, Plans, and Records

1. Does the person know service providers by name? How to contact them?
2. Does the person know and agree with the IRP's personal recovery goals?
3. Are the person's strengths and preferences reflected in assessments, plans, and the mix and fit of the services provided? Does the person "own" his/her IRP?
4. Does the person demonstrate enthusiasm about his/her interactions with service providers?
5. Are service providers comfortable working with the person as a partner?
6. Is the person comfortable expressing dissatisfaction to service providers? Does the person know what to do if his/her rights are violated?
7. Does the person routinely participate in the monitoring/modification of the IRP, arrangements, and providers? Does the person routinely participate in the evaluation of results?
8. Has the person invited friends, neighbors, mentors, and other supporters to participate in the service process? Is the service process person directed and responsive to this person's particular cultural values?
9. If the person resists participation, what diligent and ongoing efforts have been and are being made to engage the person in the service process?

Facts Used in Rating Performance

Service Review 1: Participation/Engagement of the Person

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Engagement & Participation.** (A) Participation: The person is a full, effective, and ongoing participant in all major aspects of assessment, planning, making service arrangements, selecting providers, monitoring, and evaluating services and results. Special accommodations or supports are offered as needed to assist participation. The person assists in planning personal recovery goals, deciding on services, and shaping the service process to support and achieve life ambitions. (B) Engagement: Excellent counselor/caseworker efforts (i.e., early, continued, varied, and appropriate actions) have been made and are continuing to be made to engage a resistant or difficult-to-reach person and to promote his/her participation via outreach or re-engagement during and after relapse.

  6
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

- **Good Engagement & Participation.** (A) Participation: The person is a regular, ongoing participant in most aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. Meetings are scheduled at times convenient for the person, when needed. The person participates in planning life goals, major activities, and service arrangements. (B) Engagement: Good, substantial counselor/caseworker efforts are being made to engage a resistant person and to promote participation. Reasonable outreach efforts and engagement supports to facilitate participation are repeatedly being offered.

  5
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

- **Fair Engagement & Participation.** (A) Participation: The person selectively participates in offering assessment information, planning services, and providing feedback about service satisfaction. The person usually participates in planning personal recovery goals and deciding between attractive and appropriate service options offered. (B) Engagement: Minimally adequate to fair counselor/caseworker efforts are being made to engage a resistant person and to promote participation. Special accommodations to facilitate participation may be made on some occasions to encourage participation. Outreach and re-engagement efforts may be minimal.

  4
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

- **Marginal Engagement & Participation.** (A) Participation: The person is notified of IRP team meetings. The person is allowed to attend service planning meetings and offer comments. Meetings are held at the convenience of DMH staff or provider agencies. Participation is limited to planning activities and annual evaluation activities. (B) Engagement: Inconsistent or limited counselor/caseworker efforts are being made to engage a resistant person and to promote participation. Some accommodations to facilitate participation would be made, but only if requested by the person or family.

  3
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

- **Poor Engagement & Participation.** (A) Participation: The person may be notified late about the IRP team meetings with few, if any, supports offered to facilitate participation. The person is occasionally allowed to attend service planning meetings. Meetings are held at the convenience of DMH staff or provider agencies. Plans are made before the meetings and the person is expected to accept what is offered. (B) Engagement: Occasional-to-rare counselor/caseworker efforts have been made to engage a resistant person, but with little effect.

  2
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

- **Not Engaged or Participating.** (A) Participation: Service planning and decision-making activities are conducted at times and places or in ways that prevent effective consumer participation. Decisions are made without the knowledge or consent of the person. Services are denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services are not offered. Important information may be withheld. Procedural safeguards may be violated. (B) Engagement: After initial and possibly unsuccessful efforts by the counselor/caseworker to engage the family, further efforts to engage resistant family members were either not attempted or soon abandoned. Outreach and re-engagement efforts are not occurring.

  1
  ☐ a. Person's participation
  ☐ b. Engagement efforts by staff

Service Review 2: Culturally Appropriate Practice

CULTURALLY APPROPRIATE PRACTICE: • Are any significant cultural issues for the person being identified and addressed in practice? • Are the behavioral health services provided being made culturally appropriate via special accommodations in the person's engagement, assessment, planning, and service delivery processes?

Behavioral health service systems serve an increasing proportion of consumers from underserved minority populations. If such systems are to effectively serve these persons, the impact of culture and diversity must be recognized and accommodated. Cultural accommodations enable practitioners to serve individuals of diverse cultural backgrounds effectively. Such accommodations include valuing cultural diversity, understanding how it impacts on functioning and problems during the course of disease/disorder, and adapting service processes to meet the needs of culturally diverse consumers and their informal supporters. Properly applied in practice, cultural accommodations reduce the likelihood that matters of language, culture, custom, or belief will prevent or reduce the effectiveness of treatment/rehabilitation efforts. The focus of this examination is placed on the person in which significant cultural issues are present in the case that must be understood and accommodated in order for desired treatment results to be achieved. This review does not apply in a case in which matters of native language, culture, custom, or belief are not potential barriers or present impediments in the attainment of desired treatment results. Careful judgment of the reviewer is required in distinguishing the case in which this review applies. The reviewer does not have to be of the same culture as the person but does have to have necessary language skills or interpreter assistance when communicating with the person and his/her family and significant others in making a determination.

Determine from Informants, Plans, and Records

1. Are the person's cultural identity and related needs identified?
2. Are assessments performed appropriate for the person's background?
3. Do the service providers know and respect the person's beliefs and customs?
4. Is the service provider of the same cultural background as this person or does the service provider have adequate knowledge of cultural issues relevant to service delivery for this person and his/her informal supporters?
5. If the person has a primary language that is other than English, are interpreter services provided?
6. Has the service team explored natural, cultural, or community supports appropriate for this person?
7. Has the person expressed any cultural preferences and desires for accommodations? Specific cultural issues identified and addressed are:

   ☐ None
   ☐ Racial:_____
   ☐ Ethnic:_____
   ☐ Religious:_____
   ☐ Other:_____

8. Are cultural differences impeding working relationships or service results with this person and his/her informal supporters? What do they say?
9. If necessary, is the facility able to decide when the rights and preferences of an individual will be limited by the rights and preferences of other individuals in the setting?

Facts Used in Rating Performance

NOTE:

A person's group identity may shape his/her world view and life goals in ways that have to be understood and accommodated in practice. Pentecostals, orthodox Jews, elders, gang members, sexual minorities, deaf, and homeless persons may have their own unique identities, values, beliefs, and world views that shape their ambitions and life choices.

Aspects of Cultural Competence are:

- *Values and attitudes that promote mutual respect.*
- *Communication styles that show sensitivity.*
- *Community/consumer participation in developing policies, practices, and interventions that build on cultural understandings.*
- *Physical environment including settings, materials, and resources that are culturally and linguistically responsive.*
- *Policies and procedures that incorporate cultural/linguistic principles and multi-cultural practices.*
- *Population-based clinical practice that avoids misapplication of scientific knowledge and stereotyping groups.*
- *Training and professional development in culturally competent practice.*

Service Review 2: Culturally Appropriate Practice

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person	Rating Level
◆ **Optimal Practice.** The person's cultural identity is recognized, is well understood, and services are tailored to meet related needs. Cultural beliefs and customs are fully respected and well accommodated in service processes. All assessments are culturally appropriate and limitations or potential cultural biases are recognized. Service providers are fully knowledgeable about issues related to the person's identified culture and shape treatment planning and delivery appropriately. Other individuals important to the person's culture are included in service planning and delivery at the invitation of the person. As needed, interpreter services are provided in a culturally appropriate manner.	**6** ☐
◆ **Good Practice.** The person's cultural identity is recognized and services generally address related needs. Cultural beliefs and customs are generally respected and taken into consideration for planning services. Most assessments are culturally appropriate and limitations or potential cultural bias is recognized. Service providers attempt to gain knowledge about issues related to the person's identified culture and arrange for knowledgeable assistance in treatment planning and service delivery. Other individuals important to the person's culture are acknowledged and information is obtained from them with the agreement of the person. If needed, interpreter services are available.	**5** ☐
◆ **Fair Practice.** The person's cultural identity is recognized and the provider acknowledges this in the assessment, treatment planning, and service delivery process. Cultural beliefs and customs are usually acknowledged and services are planned in an effort to be supportive. For example, the provider might acknowledge other natural community helpers important to the person's culture and works with the person to integrate those supports. If needed, interpreter services are available most of the time.	**4** ☐
◆ **Marginal Practice.** The person's cultural identity is recognized and the provider acknowledges that assessment, treatment planning, or services are <u>not</u> a good fit but is seeking to improve these processes for this person. There may be evidence of cultural accommodations by this behavioral health provider/agency in some cases, although it is limited or inconsistent for this person. Cultural beliefs and customs are not viewed as relevant to the assessment, treatment planning, or service delivery process. If needed, interpreter services are only sporadically available.	**3** ☐
◆ **Poor Practice.** The person's cultural identity is not recognized in the service process. Inappropriate assessment, treatment planning, or service delivery processes ignore the person's cultural beliefs and customs. If needed, interpreter services may be limited or difficult to secure through the behavioral health system. Few, if any, provisions are made for cultural accommodations.	**2** ☐
◆ **Adverse Practice.** There is no evidence of cultural recognition or accommodation by behavioral health service providers in this case. The person's cultural identity may be treated with disrespect and his/her customs and beliefs may be ignored or treated as irrelevant. Inappropriate assessment, treatment planning, or service delivery processes ignore or violate the person's cultural beliefs and customs. If needed, interpreter services are not provided by the behavioral health system.	**1** ☐
◆ **Not Applicable.** The person does not see him/herself of a member of a particular group. **- OR -** The person does not identify any cultural issues or needs relevant for service system performance. **- OR -** The person has not needed or attempted to obtain any behavioral health services in the past six months.	**NA** ☐

Service Review 3: Service Team Formation

SERVICE TEAM FORMATION: • Do the individuals who compose the service team for this person collectively possess the technical skills, knowledge of the person, authority, and access to the resources necessary to organize effective services for a person of this complexity and cultural background? • Did the person select any members of this team?

Professionals, paid service providers, employers, and other friends and supporters selected by the person may comprise a service/support team for the person. [The person should always assist in identifying members of his/her service team.] Such team representation may be required to assure that a **necessary combination** of technical skills, cultural knowledge, and personal interests and contributions are formed and maintained for the person and his/her informal supporters. Collectively, the team should have the technical and cultural competence, knowledge of the person, authority to act in behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person. **Team competence, authority, and opportunity of members to perform as a team are essential**. The focus of this review is placed upon the formation and composition of the service team. In reviewing the formation of the service team, the reviewer should remember that there is **no fixed formula** for team composition. Rather, consideration is based on what is necessary to provide effective intervention, treatment, and support for this person. A service team should be the "**right people**." This includes any mandated interveners (e.g., probation officer), paid service providers, and informal supporters involved in the person's life. The performance and effectiveness of the service team is addressed in Service Review 4: Service Team Functioning, not in this review item.

Determine from Informants, Plans, and Records

1. Is the person satisfied with the membership of the service team? Which members of the team did the person identify or select for him/herself? Are there any unpaid supporters on the person's team? Does the person know the name and function of each person on his/her service team?
2. Has the person invited friends, family members, or a partner to be on the team? Are these members satisfied with the composition of the team?
3. Are all team members give due notice of team meetings to encourage their participation? Do team members participate on a regular basis?
4. Do team members have the authority to commit resources for serving the person?
5. Are all service agencies involved with the person represented on the team?
6. Does the team demonstrate effective ability to develop, implement, and monitor the person's IRP?
7. Do members of the team demonstrate an understanding of best practice principles in the design of the plan and uses of formal and informal resources for this person?
8. Are the person and his/her informal supporters partners with professionals, funders, and others in planning and guiding services?
9. Are all members of the team kept fully informed of the person's status, placement situation, implementation of services, progress made, and changes?
10. Is the membership of this team likely to remain stable over the next six months? If not, what impact are the expected changes likely to have?

Facts Used in Rating Performance

Service Review 3: Service Team Formation

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Service Team Formation.** The person identified and selected key members of the service team, which contains non-professional supporters who share perspectives important to the person that are used in service planning. Members of the person's service team collectively demonstrate the technical skills, knowledge of the person, and authority necessary to effectively serve a person of this complexity and culture. The service team demonstrates willingness to supply necessary resources as well as a commitment of the time and effort required to produce effective services that support optimal recovery for this person. The full service team has been formed for at least six months (if the case has been open this long) and is expected to remain intact for at least another six months (if needed for this person). **6** ☐

- **Good Service Team Formation.** The person identified and selected some members of the service team, which contains non-professional supporters who share perspectives important to the person that are used in service planning. Members of the person's service team generally have the technical skills, knowledge of the person, authority and willingness to supply necessary resources, and adequate opportunity to produce effective services that support good recovery for this person. All members of the team have been together since the creation of the current IRP for this person and are expected to remain intact for at least another three months, if needed. **5** ☐

- **Fair Service Team Formation.** The person identified at least one member of the service team, which contains a non-professional supporter who shares perspectives important to the person that are used in service planning. Members of the person's service team minimally have the technical skills, knowledge of the person, authority and willingness to supply necessary resources, and time committed to produce adequate services that support fair recovery for this person. Key team members have been together since the creation of the current IRP and are expected to remain involved for at least another three months, if needed. **4** ☐

- **Marginal Service Team Formation.** The person identified at least one member of the service team, who may participate on a limited basis to share perspectives important to the person that may be useful in service planning. Some, but not all, members of the person's service team have the technical skills, knowledge of the person, authority and willingness to supply necessary resources, and adequate time availability to meet the needs of a person of this complexity and culture. Some team members have been together since the creation of the current IRP. Composition of the service team may be unstable or have incomplete membership at this time. **3** ☐

- **Poor Service Team Formation.** The person may have suggested possible members of the service team, who may not have been invited or who may not participate on the team. Collectively, members of the person's service team lack the technical skills, knowledge of the person, authority to supply necessary resources, and opportunity to meet the needs of a person of this complexity and culture. Few team members have been together since the creation of the current IRP. Composition of the service team has been unstable or had incomplete membership for a substantial period of recent service planning and implementation activities. **2** ☐

- **Absent Service Team.** The individuals involved with the person do not constitute a unified team, nor have these persons formed or convened a working team for conducting service assessment, planning, or implementation activities. **1** ☐

Service Review 4: Service Team Functioning

SERVICE TEAM FUNCTIONING: • Do members of the person's service team collectively function as a unified team in planning services and evaluating results? • Do actions of the service team reflect a pattern of effective teamwork and collaborative problem solving that benefits the person in a manner consistent with the person's choices and personal life goals? • Is there a shared philosophy among team members about the importance of recovery to the person?

This review focuses on the **functional performance** of the service team in providing effective services for the person's recovery. Team functioning and decision-making processes should be consistent with good and accepted practice. **Evidence of effective team functioning lies in its performance over time and in the recovery results it achieves for the person served.** The focus and fit of services, authenticity of relationships and commitments, unity of effort, dependability of service system performance, and connectedness of the person served to critical resources all derive from the functioning of the service team. The person's overall status (see page 34), his/her engagement, participation, satisfaction, and achievement of effective recovery results are important indicators of the functionality of the service team and should be taken into account when making this review. Service team functioning is dependent, in part, on the composition and stability of the service team (see Service Review 3: Service Team Formation).

Determine from Informants, Plans, and Records

1. Who convenes team meetings? Who chairs team meetings? Is there a usual and known agenda for team meetings? Is this known to the person?
2. Can the team effectively negotiate with the person when there are differences in views about the person's capabilities and needs? Is the person satisfied with the functioning of the team? Do service actions reflect team recommendations?
3. Are individuals with similar backgrounds to the person functioning as advisors in shaping service team decisions? Are their opinions respectfully considered?
4. What accommodations have been made to assure the person is not overwhelmed by providers and mandated interveners?
5. How much "say so" does the person have in setting goals and planning interventions in the IRP? What role does the person have in team meetings?
6. Does the team demonstrate effective ability to develop, implement, and monitor the person's IRP?
7. Do members of the team demonstrate consistency with principles of good and accepted practice in the design of the IRP and uses of formal and informal resources for this person?
8. Are the person and his/her friends or family members active partners with professionals, funders, and others in planning and guiding services?
9. Are all members of the team kept fully informed of the person's status, changes in service settings, and implementation of planned services?
10. Does the team have and use flexible funding, informal resources, and generic services as appropriate to IRP goals, strategies, and activities?
11. Do service team actions and decisions reveal a pattern of consistent and effective problem solving for this person?
12. Are service team decisions leading to improved functioning and recovery for the person served?

Facts Used in Rating Performance

NOTE:

Other considerations of team function include:

- *Team orientation toward recovery principles, involvement of the person, and due regard for the person's personal goals and preferences*
- *Awareness of the person's life/recovery goals*
- *Responsiveness of the team to the person*
- *The person's "trust" of the team and its members*
- *Use of evidence-based practices and state-of-the-art medications recommended by the team*
- *Commitments made and follow-through by mandated agencies and their representatives on the person's team*

Service Review 4: Service Team Functioning

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Service Team Functioning.** The person and service team work exceptionally well together as a team, with members negotiating effectively to overcome any differences in current understandings or future directions for recovery. Highly effective accommodations help prevent the person from being overwhelmed by providers or any mandated interveners. The person's views and preferences are well reflected in team decisions. The person may convene the team at any time. Actions of the service team demonstrate an excellent, well-established pattern of highly effective teamwork and collaborative problem solving that is benefiting the person in a manner fully consistent with his/her recovery goals and with principles of good practice. The person's participation and satisfaction may be excellent. **6** ☐

- **Good Service Team Functioning.** The person and service team work substantially well together as a team, with members negotiating earnestly to overcome any differences in current understandings or future directions for recovery. Generally effective accommodations help prevent the person from being overwhelmed by providers or any mandated interveners. The person's views and preferences are generally reflected in team decisions. The person may convene the team under certain conditions. Actions of the service team demonstrate a good and consistent pattern of generally effective teamwork and collaborative problem solving that is benefiting the person in a manner consistent with his/her recovery goals and with principles of good practice. The person's participation and satisfaction may be good. **5** ☐

- **Fair Service Team Functioning.** The person and service team work fairly well together as a team, with members negotiating occasionally to overcome differences in current understandings or future directions for recovery. Fair accommodations may help to prevent the person from being overwhelmed by providers or any mandated interveners. The person's views and preferences are somewhat reflected in team decisions. The person may convene the team under exceptional circumstances. Actions of the service team demonstrate a fair pattern of satisfactory teamwork and collaborative problem solving that may be benefiting the person in a manner fairly consistent with his/her recovery goals and with principles of good practice. The person's participation and satisfaction may be fair. **4** ☐

- **Marginal Service Team Functioning.** The person and service team work inconsistently together as a team, with members sometimes negotiating to overcome differences in current understandings or future directions for recovery. Limited or inconsistent accommodations occasionally may help to prevent the person from being overwhelmed by providers or any mandated interveners, but problems are occurring. The person's views and preferences are inconsistently reflected in team decisions. The person may not know how to convene the team. Actions of the service team demonstrate a spotty pattern of limited teamwork and inconsistent problem solving that may not be benefiting the person in a manner consistent with his/her recovery goals or may at times conflict with principles of good practice. The person's participation and satisfaction may be marginal to poor. **3** ☐

- **Poor Service Team Functioning.** The person and service team work poorly together as a team, with members in conflict over differences in current understandings or future directions for recovery. Few, if any, accommodations prevent the person from being overwhelmed by providers or any mandated interveners. Breakdowns and conflicts are substantial. The person's views and preferences are seldom reflected in team decisions. The team may be unstable or missing members. Actions of the service team demonstrate poor teamwork and problem solving. Team actions or decisions are in conflict with principles of good practice. The person's participation and satisfaction may be poor or adverse. **2** ☐

- **Absent or Adverse Service Team Functioning.** Either there is no functional service team for this person. **- OR -** The actions and decisions made by the team are inappropriate, adverse, and/or antithetical to principles of good and accepted practice. **1** ☐

Service Review 5: Assessment & Understanding

ASSESSMENT & UNDERSTANDING: • Are the diagnoses used for the person's treatment consistent with current understandings among providers? • Is the relationship between the diagnosis and the person's bio/psycho/social functioning in daily activities well established? • Does the service team have a working understanding of the person's strengths and needs in the context of the person's recovery goals as well as underlying issues that must change for the person to have a safe and satisfying life and to fulfill desired adult roles? • Are any co-occurring conditions identified, including substance abuse? • Does the team understand the person's aspirations for personal power and control in his/her life?

As appropriate to the situation, a combination of clinical, functional, and informal assessment techniques should be used to determine the capabilities, needs, risks, underlying issues, and social ecology of the person. Once gathered, the information should be analyzed and synthesized (along with diagnostic results) to form a comprehensive therapeutic impression or "big picture understanding" of the person. This view includes the person's behavioral symptoms and daily functioning within the environmental context and current social support networks. Assessment techniques, both formal and informal, should be appropriate for the person's age, ability, culture, language or system of communication, and social ecology. New assessments should be performed promptly when IRP goals are met, when emergent needs or problems arise, or when changes are necessary. New assessment findings should stimulate and direct modifications in strategies, services, and supports for the person. Recent monitoring and evaluation results should be used to update the big picture view of the person's situation. Members of the person's service team, working together, should synthesize their assessment knowledge to form a **common big picture view that provides a shared understanding of the person's situation and what must be done to get positive results.** This provides a common core of team intelligence for unifying efforts, planning joint strategies, sharing resources, finding what works, and achieving a good mix and match of supports and services. Developing and maintaining a useful functional assessment and big picture view is a dynamic, ongoing process performed by the person's service team.

Determine from Informants, Plans, and Records

1. What diagnoses are used as the basis of treatment, particularly medications, for this person? On what observations, assessments, or evaluations are they based? Are assessments based on the person's goals and aspirations? Are assessments conducted in a variety of settings? Has there been a recent change in diagnoses? What is the common understanding held among team members?

2. Do assessments cover the person's functional status and level of impairment?

3. Are risks of harm assessed (e.g., suicidal/homicidal impulses; physically/sexually aggressive behavior; ability to maintain physical safety; risk of victimization, abuse, or neglect; high risk behaviors; self-injurious behaviors)?

4. Are co-occurring conditions or co-morbidities present (e.g., physical illness or disability; developmental disability; substance use or abuse; other psychiatric conditions; recent transient, stress-related, psychiatric symptoms)?

5. Are life stressors present (e.g., traumatic or enduring disturbing circumstances; recent life transitions; grief or losses of consequence; transient but serious illness or injury; expectations that create discomfort; danger or threat in daily settings; incarceration; extreme poverty; social isolation; language barrier)?

6. How are the person's symptoms linked to his/her daily functioning? Are supports adequate for this person? Is the person responsive to treatment?

7. Does the person know the results of assessments and does he/she believe that the results are accurate?

Facts Used in Rating Performance

Service Review 5: Assessment & Understanding

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
8. How well do the team and person demonstrate an understanding of what things have to change to reduce symptoms and achieve recovery goals?	

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Assessment & Understanding**. The diagnoses used as a basis of treatment and recovery are well justified with history, symptom observations, assessments, and evaluations fully documented. Clearly delineated relationships exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are comprehensively understood by the person and staff/others involved in his/her supports and services. The full scope of things that must be changed in order for the person's psychiatric symptoms to be reduced and for him/her to function adequately in normal daily settings are fully defined in the pursuit of recovery and thoroughly understood by the service team. **6** ☐

- **Good Assessment & Understanding.** The diagnoses used as a basis of treatment and recovery are generally supported with history, symptom observations, assessments, and evaluations documented. Demonstrated relationships exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are generally understood by the person and staff/others involved in his/her supports and services. Most of the things that must be changed in order for the person's psychiatric symptoms to be reduced and for him/her to function adequately in normal daily settings are generally defined in the pursuit of recovery and understood by the service team. **5** ☐

- **Fair Assessment & Understanding.** The diagnoses used as a basis of treatment and recovery are minimally supported with history, symptom observations, assessments, and evaluations fully documented. Some reported relationships exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are somewhat understood by the person and staff/others involved in his/her supports and services. Some of the things that must be changed in order for the person's psychiatric symptoms to be reduced and for him/her to begin the recovery journey are somewhat defined and minimally understood by the service team. **4** ☐

- **Marginal Assessment & Understanding.** The diagnoses used for treatment and recovery are limited or inconsistent. Relationships are assumed to exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and ambitions by the service team. Some confusion exists about things that must be changed in order for symptoms to be reduced, and there are some questions about whether recovery is possible for the person. Dynamic conditions may be present that limit the usefulness of present understandings. **3** ☐

- **Poor Assessment & Understanding.** The diagnoses used for treatment and recovery are obsolete, erroneous, or inadequate. Limited associations between the treatment diagnosis, the person's functioning, social contexts, and ambitions have been made. Uncertainties exist about things that must be changed for symptoms to be reduced, and there is almost no hope for recovery. Dynamic conditions may be present that could require a fundamental reassessment of the situation. **2** ☐

- **Absent, Incorrect, or Adverse Assessment & Understanding.** Current diagnoses used for treatment and recovery are absent or incorrect. Some adverse associations between the treatment diagnosis, the person's functioning, daily social contexts, and life ambitions may have been made. Glaring uncertainties and conflicting opinions exist about things that must be changed for symptoms to be reduced, and recovery is not seen as possible. A new and complete functional assessment should be made and used now to move planning forward for this person. **1** ☐

Service Review 6: Personal Recovery Goals

PERSONAL RECOVERY GOALS (PRGs): • Are there personal recovery goals used for service planning that reflect the person's life and career aspirations? • If met, will these goals lead to the person managing successfully at home, at work, and in the community, with supports and services as necessary, to achieve ongoing recovery?

Where is this person headed and how can the service team assist the person fulfill aspirations and achieve recovery? Will this direction lead to this person being successful and being a part of the community? Are there personal recovery goals for guiding services that will lead to this person's recovery?

Personal recovery goals form a **guiding strategic vision** used to set the purpose and path of recovery and support. It is used to focus a coherent IRP and process for the person. PRGs **focus and unify service planning efforts**, especially when multiple interveners are involved. PRGs anticipate and define what the person must have, know, and be able to do in the recovery process leading to achievement of the person's ambitions and life goals. Smooth and effective transitions require such a strategic vision and its fulfillment through the service process. To be acceptable, the PRGs should "fit" the person's situation and establish a strategic course to be followed in a service process that will lead to achievement of recovery goals. Collectively, the PRGs should answer the questions of where is the case headed and why. The long-term view should answer the question: How, where, and with whom will this person be living, learning, working, and playing in the next 6-18 months? Meaningful answers to this question will support recovery for the person.

Determine from Informants, Plans, and Records

1. Are there PRGs for this person? If yes, are they explicitly written in the person's IRP? - OR - Are the PRGs implicitly understood as well as clearly and consistently articulated by members of the service team? Are they expressed in the person's own words?

2. Do the PRGs anticipate the next expected transition or life change for this person? If yes, does it set strategic goals aimed at enabling the person's successful life adjustment after crossing the transition threshold?

3. Do the PRGs cover functional areas: living, learning, working, playing? How much "say so" does the person have in setting PRGs in these areas?

4. Do the PRGs reflect the person's ambitions, goals, and preferences?

5. Do the PRGs reflect strengths, capabilities, risks, barriers, and needs?

6. If the strategic goals in the PRGs are met, is the person likely to succeed in the recovery process, including making smooth and successful transitions or life adjustments, as necessary?

7. Are the person's PRGs updated as circumstances change? When important recovery thresholds are crossed, is the next one anticipated in the PRGs?

8. Will the person's current PRGs likely lead to greater independence, self-management, productivity, social integration, and community participation?

Facts Used in Rating Performance

NOTE:

Recovery goals focus on restorative change efforts aimed at returning the person to a previous state of higher functioning and well-being having lower risks of hardship or harm. For an elderly person who is becoming increasingly frail or for a person with a degenerative disease, the goals may focus on conservation of existing functioning and well-being in the near term. For a person at life's end, the goals may focus on care and comfort until the person expires. In such cases, recovery is not possible. Therefore, goals appropriate to age and circumstance should be used to guide services. Any such alternative goals should be accepted by the reviewer and used as the basis for conducting a review in this area.

Service Review 6: Personal Recovery Goals

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Personal Recovery Goals.** The person has explicitly expressed PRGs that are clearly guiding recovery and that are fully understood among service team members. Where appropriate, the PRGs fully envision the person's next major life changes/adjustments and articulate what the person must have, know, and be able to do to be successful when those recovery thresholds are crossed. The PRGs fully reflect the person's strengths, ambitions, preferences, barriers, and needs. The PRGs build upon knowledge of recent recovery milestones and are modified continuously as experience is gained and circumstances change. **6** ☐

- **Good Personal Recovery Goals.** The person has understood PRGs that are substantially guiding recovery and that are generally understood among service team members. Where appropriate, the PRGs substantially anticipate the person's next major life changes/adjustments and articulate what the person must have, know, and be able to do to be successful when that recovery threshold is crossed. The PRGs substantially reflect the person's strengths, ambitions, preferences, barriers, and needs. The PRGs track recent recovery milestones and are modified frequently as experience is gained and circumstances change. **5** ☐

- **Fair Personal Recovery Goals.** The person has a written set of treatment/rehabilitation goals that creates implicit PRGs used by service team members. Where appropriate, the PRGs minimally anticipate the person's next major life changes/adjustments and identify some key elements that the person must have, know, and be able to do to be successful when that recovery threshold is crossed. The PRGs minimally reflect the person's ambitions, preferences, and needs. The PRGs periodically note recovery milestones and are updated as major circumstances change. **4** ☐

- **Marginal Personal Recovery Goals.** The person may have some long-term goals set by one or more funding agencies that create a limited planning direction for recovery. Set by others rather than by the person, these goals inconsistently anticipate the person's next recovery stage, providing a few simple steps and provisions that may increase the likelihood of a successful future recovery. Existing goals only marginally reflect the person's ambitions or preferences. Existing goals occasionally reflect expected recovery milestones. **3** ☐

- **Poor Personal Recovery Goals.** The person may have a few IRP goals set by one or more funding agencies, but they do not form a useful direction for recovery nor reflect the person's ambitions and life aims. The goals provide some simple steps or provisions but are not necessarily linked to the person's recovery. **2** ☐

- **Absent, Ambiguous, or Adverse Personal Recovery Goals.** There is no common future planning direction that is desired by the person and used by service team members to guide the person's recovery. Goals do not address the requirements that would increase the likelihood of successful recovery. Conflicting goals may be present and, if implemented, could lead to adverse consequences for the person. **1** ☐

Service Review 7: Individualized Recovery Plan

INDIVIDUALIZED RECOVERY PLAN: • Is there an IRP for this person that integrates treatment, support strategies, and services across providers and funders? • Is the IRP designed to meet personal recovery goals? • Does the IRP reflect small steps in the right direction toward recovery? • Is the IRP coherent in the assembly of strategies, supports, and services? • Does the IRP state what the person wants in his/her own words?

An IRP unifies the efforts of providers/supporters in the person's life into a common, coherent set of purposes and processes designed to help the person achieve personally selected, socially valued goals on the way to recovery. The IRP specifies the goals, roles, strategies, resources, and schedules for coordinated, comprehensive provision of assistance, supports, supervision, and services for the person and his/her service providers. For the person to be successful at home and in the community, special supports may be necessary, especially in the home and on the job. To be workable, an IRP should: (1) be based on the big picture assessment; (2) reflect the ambitions and preferences of the person; (3) be directed toward the achievement of strategic goals and successful recovery; (4) be sensible in design; (5) be prudent in the use of natural and professional resources; (6) be culturally appropriate; and (7) be modified frequently, based on changing circumstances, experience gained, and progress made. It is the **vitality, unity, and intelligence of the planning process** that is of essence here, not the elegance of a written document. The IRP is the collective intentions of the person and his/her service team that organizes the path and process to be followed.

Determine from Informants, Plans, and Records

1. Are all obvious and substantial needs addressed in the IRP, according to the person's priorities? If the person poses a safety risk to self or others, does the plan provide protective strategies and necessary supports?
2. Are most services received by the person addressed in the IRP?
3. Do planned services follow the purpose and path of recovery?
4. Does the IRP reflect assessed capabilities, risks, barriers, and needs—especially those needs perceived by the person?
5. Does the IRP focus on success after the person's next life change/adjustment?
6. Does the IRP reflect the person's goals and choices in his/her own words?
7. Does the IRP unify the efforts/integrate actions of the person and providers?
8. Are planned services appropriate for the person's PRGs and culture?
9. Will planned services include use of restrictive or intrusive procedures?
10. Is the strategic path and service process realistic? That is, does the combination and sequence of strategies, interventions, accommodations, supports, and services planned for this person make sense? Will it pass Utilization Review?
11. Is the IRP capable of being implemented? Did the key funders authorize or approve the IRP? Does the IRP say what the person will do?
12. Is the IRP updated and the service process modified as goals are met, life change/adjustment milestones are crossed, and circumstances change?
13. Does the IRP support any unpaid individuals (e.g., friends, family, partner, minister) in their efforts to assist this person?

Facts Used in Rating Performance

If planned treatment or support services are not available, report the reasons given.

Service Review 7: Individualized Recovery Plan

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal IRP.** The person has an IRP that fully and artfully integrates treatment, support strategies, and services. The IRP fully acknowledges and builds well upon the person's actions. It is fully approved (e.g., by Utilization Management, UM) and funded by the agencies involved. The IRP firmly builds upon the person's strengths, needs, ambitions, choices, and PRGs. The plan uses the person's own words and may be written in his/her native language. The IRP is fully coherent and highly practical in its strategy, sequence, assembly, and use of formal and informal resources. The IRP is designed in an excellent and creative way to drive practice and to foster recovery for the person. **6** ☐

- **Good IRP.** The person has an IRP that substantially integrates treatment, support strategies, and services. The IRP acknowledges and builds on the person's actions. It is generally approved (UM) and funded by the agencies involved. The IRP generally reflects the person's strengths, needs, ambitions, choices, and PRGs. The plan may reflect the person's own words. The IRP is generally coherent and substantially practical in its strategy, sequence, assembly, and use of formal and informal resources. The IRP is designed in a thoughtful way to drive practice and to foster recovery for the person. **5** ☐

- **Fair IRP.** The person has an IRP that integrates treatment, support strategies, and services from minimally to fairly well. The IRP includes some actions for the person. It is at least minimally approved and funded by the agencies involved. The IRP usually reflects the person's strengths, needs, ambitions, choices, and PRGs. The plan may reflect some of the person's own words. The IRP is minimally coherent and basically practical in its strategy, sequence, assembly, and use of formal and informal resources. The IRP is designed in a very basic way to drive practice. **4** ☐

- **Marginal IRP.** The person has an IRP that inconsistently links treatment, support strategies, and services. Some parts of the IRP may not be approved and funded by the agencies, providers, or indirect staff involved. The IRP may not reflect various aspects of the person's strengths, needs, ambitions, choices, and PRGs. Differing plans of various agencies may work toward divergent or conflicting goals. The IRP is limited or inconsistent in its strategy, sequence, assembly, and use of formal and informal resources. The IRP is not adequately designed to drive practice. **3** ☐

- **Poor IRP.** The person's plan has some elements that could be used to create an IRP. There is little, if any, collaboration among agencies planning services for this person. UM may not approve elements of the plan as presented. Plans may not reflect a common understanding of the person or may work toward divergent or conflicting goals, incompatible with recovery or the person's choices. Service plans may focus on immediate concerns only, without a guiding vision, thus, creating future problems. The service process may not respond quickly to changes in life circumstances and local services. Separate plans from different staff or providers serving the person may be creating gaps in services or conflicting demands on the person. The residential providers and/or employer may lack adequate information and supports. **2** ☐

- **Absent IRP.** The person has no IRP. No effective collaboration exists among key agencies and providers serving this person. Some separate-agency plans may not be functional or adequately funded. The separate staff or provider plans may not have common or accurate assessment knowledge and may have divergent or conflicting goals. The person's voice may be silent in the planning process. The narrow focus of any services may be restricted upon immediate issues without a view toward recovery. **1** ☐

Service Review 8: Goodness-of-Service Fit

GOODNESS-OF-SERVICE FIT: • Are treatment, rehabilitation, and support services assembled into a holistic and coherent mix of services uniquely matched to the person's particular situation and personal recovery goals? • Does the combination and intensity of supports and services fit the person's situation so as to increase recovery results and benefits while limiting any conflicting strategies and inconveniences?

All planned elements of treatment, rehabilitation, assistance, and support for the person should fit together into a sensible combination and sequence that is individualized to match his/her situation and preferences. The goodness of fit between the mix/match of supports and services and the person's situation is related to the opportunity and ability of the person to participate in and benefit from the service process. A poor service fit wastes participants' goodwill and the public's resources. Goodness of fit requires that programs, services, and supports be integrated and coordinated across providers and funders. Seamless integration requires a holistic approach to services, a coherent weave of supports and services, and continuous delivery of dependable services. Achieving a good fit optimizes the path and flow of services for best results. Optimization of services requires the removal of agency barriers to flexible use of funds and resources, preventing the use of conflicting or contradictory strategies, and the minimization of inconveniences and life disruptions for the person and his/her supporters. Goodness of fit is promoted by expanding the range of choices exercised by the person concerning life goals and selection of supports and services, providers, schedules, and locations.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. To what extent did the person exercise choices in the selection of interventions, service providers, delivery schedules, and locations?	
2. How well does the current mix of services match the person's situation and expressed preferences? What does the person say about convenience/respect?	
3. Is the IRP holistic in scope ("whole person") and coherent in design?	
4. Are all services addressed in an integrated plan for the person?	
5. Are all participating programs, agencies, and individual staff supporting the plan?	
6. Are the efforts of everyone involved coordinated through a unified process?	
7. Are services continuously available and dependable? Can emerging and complementary therapies be accessed and used in the service mix?	
8. Are flexible funding and resources being used for this person?	
9. Have agency barriers to service integration been identified and subsequently removed?	
10. Have scheduling inconveniences and disruptions in services been minimized? Have any contradictory strategies of everyone involved been removed?	

Service Review 8: Goodness-of-Service Fit

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
11. Do the person and supporters report differences in satisfaction with the mix, match, and fit of supports and services? What does the person say is still needed?	
12. Have supports and services been modified over time to yield a workable mix and match for the person?	
13. Does the person believe the current mix is promoting his/her recovery?	

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Service Fit.** All necessary supports and services are assembled into a holistic and coherent service process having an excellent fit between the person's situation and the service mix. The person's preferences are well reflected in the assembly of supports and choice of services. Positive results are being produced and the person reports no conflicting service strategies or inconveniences that cause hardship. — **6** ☐

- **Good Service Fit.** Essential supports and services are assembled into a holistic and sensible service process having a workable fit between the person's situation and the service mix. Many of the person's preferences are accommodated in the assembly of supports and services. Positive results are being produced and the person reports few conflicting service strategies or inconveniences that cause hardship. — **5** ☐

- **Fair Service Fit.** Basic supports and services are assembled into a sensible service process having a minimally acceptable fit between the person's situation and the service mix. Some of the person's preferences are considered in the assembly of supports and services. Some positive results may be produced and the person may report minor conflicting service strategies or inconveniences that cause a minimum degree of hardship. — **4** ☐

- **Marginal Service Fit.** Limited supports and services are partially or inconsistently assembled into the service process. The fit between the person's situation and the service mix is limited or services are insufficient in intensity or dependability. Few of the person's preferences are considered in the assembly of supports and services. Few, if any, positive results may be produced. The person may report some conflicting service strategies or inconveniences that cause a degree of hardship that reduces his/her willingness to participate. — **3** ☐

- **Poor Service Fit.** Any supports and services are poorly assembled into a service process. The fit between the person's situation and the service mix is poor or services are inadequate to meet identified needs. The person's preferences have little, if any, influence in the selection of supports and services. Some coercive strategies may be in use without a plan for reducing or eliminating their use. Few, if any, positive results may be produced. The person may report undependable or conflicting service strategies or inconveniences that cause a substantial degree of hardship that significantly reduces his/her willingness to participate. — **2** ☐

- **Adverse Service Fit.** Few, if any, supports and services may be provided or may not be assembled into a sensible process. The fit between the person's situation and the service mix is adverse or services are grossly inadequate. The person's preferences did not influence the selection of supports and services. Highly coercive strategies may be in use without a plan for reducing or eliminating their use. The person's status may be poor and worsening. The person may report undependable or conflicting service strategies or inconveniences that cause an unacceptable degree of hardship that restricts his/her willingness to participate in or benefit from whatever services may be provided. — **1** ☐

Service Review 9: Resource Availability

RESOURCE AVAILABILITY: • Are the supports, services, and resources (both informal and formal) necessary to meet the identified needs in the IRP available for use by the person, family supporter, and service team? • Are any unavailable but necessary resources or supports identified by the person, team, or plan? • Are reasonable efforts being undertaken by the team to secure or develop any needed but unavailable supports, services, or resources?

An array of informal and formal supports and services may be necessary to fulfill IRP requirements and commitments made to the person. Supports can range from volunteer reading tutors, peer mentors, recreational activities, and supported employment. Supports may be voluntarily provided by friends, neighbors, and churches or secured from provider organizations. Professional treatment services may be donated, offered through health care plans, or funded by government agencies. A combination of supports and services may be necessary to support and assist the person. For clinical or rehabilitative service providers to exercise professional judgment and for the person to exercise choice in the selection of treatment services and supports, an array of appropriate alternatives should be locally available. Such alternatives should present a variety of socially or therapeutically appropriate options that are readily accessible, have the power to produce desired results, be available for use as needed, and be culturally compatible with the needs and values of the person. An adequate array of services includes social, health, mental health, educational, vocational, recreational, peer support, and organizational services, such as service coordination. An adequate array spans supports and services from all sources that may be needed by the person. Selection of basic supports should begin with informal network supports and generic community resources available to all citizens. Specialized and tailor-made supports and services should be developed or purchased only when necessary to supplement rather than supplant readily available supports and services of a satisfactory nature. Unavailable resources should be systematically identified with reasonable efforts made by the service team to secure or develop any needed but unavailable supports, services, or resources.

Determine from Informants, Plans, and Records

1. Are all obvious and substantial needs matched with appropriate supports and services for this person? Will supports shift from formal to informal over time?
2. Have informal supports been developed or uncovered and used at home and in the community as a part of the service process?
3. Are resources matched to needs addressed in the IRP?
4. Are resources provided within the person's home and neighborhood?
5. To what extent are informal resources of the family, extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports for this person?
6. Is each support provided socially and culturally appropriate for the person?
7. Is the service team taking steps to locate or develop or advocate for previously unknown or undeveloped resources?
8. Are there two or more appropriate service options from which to choose when recommending professional services for this person?
9. Did the person have two or more appropriate and attractive options from which to choose when selecting supports and services?
10. Are treatment/rehabilitation services consistent with assessments and PRGs?
11. Is each service and support accessible when needed? At the needed intensity and quality? If not, what is missing and why? Are informal supports being used as a substitute for needed services?
12. Were any of the supports and services tailor-made or assembled uniquely for this person? Are they sustainable as needed over time?
13. Is the combination of informal and formal supports and services used for this person sufficient for the person to make progress toward recovery?

Facts Used in Rating Performance

If IRP treatment or support services are not available, report what is missing and the reasons given.

Resource identification and use patterns tend to reflect what staff know of and know how to access and use. Explore what resources that staff know/don't know about that could benefit this person.

Service Review 9: Resource Availability

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
14. Is the combination of supports and services used for/by this person dependable and satisfactory from the person's point of view?	
15. Have the person and the service team taken steps to identify resource gaps, develop or secure resources, and notify the community of development needs?	

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Resource Availability.** The array of supports and services is helping the person reach optimal levels of functioning necessary for him/her to make excellent progress toward recovery. A highly dependable combination of informal and, where necessary, formal supports and services is available, appropriate, used, and seen as very satisfactory by the person. The array provides a wide range of options that permits use of professional judgment and the person's experience about appropriate treatment and consumer choice of providers. **6** ☐

- **Good Resource Availability.** The array of supports and services is helping the person reach favorable levels of functioning necessary to make good progress toward recovery. A usually dependable combination of informal and formal supports and services is available, appropriate, used, and seen as generally satisfactory by the person. The array provides a narrow range of options that permits use of professional judgment, the person's experience, and consumer choice of providers. Steps are being taken to secure or develop additional resources to give the person greater choice and/or provide resources to meet particular unmet needs. **5** ☐

- **Fair Resource Availability.** The array of supports and services is helping the person reach minimally acceptable levels of functioning necessary for him/her to make fair progress toward recovery. A set of supports and services is usually available, somewhat appropriate, used, and seen as minimally satisfactory by the person. The array provides few options, limiting professional judgment and consumer choice in the selection of providers. Steps are being considered to mobilize additional resources to give the person greater choice and/or provide resources to meet particular unmet needs, but no steps have been undertaken. **4** ☐

- **Marginal Resource Availability.** A limited array of supports and services may not be helping the person reach levels of functioning necessary for him/her to make progress toward recovery. These supports and services may be inconsistently available and may be seen as partially unsatisfactory by the person. The array provides few options, substantially limiting use of professional and consumer judgment and personal choice in the selection of providers. Steps to mobilize additional resources to give the person greater choice and/or provide resources to meet particular unmet needs have not yet been considered. **3** ☐

- **Poor Resource Availability.** The poor array of supports and services is limiting the person's opportunity to make progress toward recovery. Few supports and services may be available and/or used. Available services may be seen as generally unsatisfactory by the person. The sparse array provides very few options, preventing use of professional judgment and personal choice in the selection of providers. No effort to address resource problems has been planned or undertaken by the person or team. The person may not have a functioning service team. **2** ☐

- **Absent or Adverse Resource Availability.** Few, if any, supports and services are provided. They may not fit the actual needs of the person well and may be undependable over time. Because informal supports may not be well developed and/or because local services or funding is limited, any services may be offered on a "take it or leave it" basis. The person may be dissatisfied with or refuse services, and results may present a potential risk to the person and/or community. The person and team may be powerless to alter the service availability situation or the person may lack a functioning service team. **1** ☐

Service Review 10: Treatment & Service Implementation

TREATMENT AND SERVICE IMPLEMENTATION: • Are the planned therapies, services, and supports being implemented with adequate intensity and consistency to achieve stated goals? • Is implementation timely and competent? • Are recovery strategies assigned to the person and the team being implemented? • Is team problem solving any implementation problems that could lead to a failure of efforts to achieve the person's recovery goals?

The processes for implementing supports and services for the person should meet the following conditions:

- The strategies, supports, services, and activities in the IRP are being implemented in a timely, competent, and dependable manner, consistent with principles of good and accepted practice.
- An adequate array of supports and services are being accessed and used at a level of intensity and consistency necessary to meet priority needs, reduce risks, facilitate life change adjustments, achieve adequate daily functioning, and recovery.
- Needs requiring an urgent response are being met to protect health and safety. *[See Service Review 11—Emergent/Urgent Response Capability.]*
- Line workers (e.g., all staff, service coordinators) are receiving supports and supervision for good role performance.
- Implementation problems are quickly detected with timely adjustments made.
- Persistence in problem solving and securing appropriate performance by staff and providers is contributing to a successful pattern of implementation. Experience gained is used to refine implementation.

Accomplishment of these implementation processes should enhance chances for successful recovery while reducing risks for the person and, where appropriate, hardships for the person's support system.

Determine from Informants, Plans, and Records

1. Are the supports and services in the person's IRP being implemented in a timely and competent manner? Is community tenure emphasized?

2. Are small steps being taken toward full participation by the person in services leading, where possible, to self-management?

3. Is an adequate array of supports and services consistently provided at a level of intensity to get desired results? Are transition arrangements being made?

4. Are urgent needs met in ways that protect the health and safety of the person or, where necessary, protect others from the person? *[Service Review 11]*

5. Are all the person's service providers (e.g., staff, tutors, mentors) receiving any supports and supervision necessary for them to adequately perform the roles they play in the person's life so that symptoms and risks are reduced, functioning is improved, and progress toward recovery is achieved?

6. For a person in a staffed service setting, are supports and treatment services being coordinated across shift staff within the facility with implementation problems quickly detected and timely adjustments made? Is the experience gained actually used to refine implementation?

7. Is persistence in solving implementation problems evident? Is diligence in securing appropriate performance by providers and staff contributing to a successful pattern of supports and services for the person?

Facts Used in Rating Performance

If treatment or support services are not available or not adequate, report the reasons (e.g., Utilization Management decisions, program admissions criteria, service gaps, past trials considered unsuccessful, restrictive funding criteria).

Service Review 10: Treatment & Service Implementation

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Implementation.** An excellent pattern of implementing treatment and rehabilitation shows that all planned services are fully implemented in a timely, competent, and coordinated manner. Necessary resources are optimally available. High quality services are being provided at levels of intensity and continuity that are meeting priority needs, managing risks, and yielding desired results. Where appropriate, staff and support system members are receiving excellent guidance and assistance in the performance of their roles. Services are excellent and effective in promoting daily functioning, including social integration, and progress toward recovery. **6** ☐

- **Good Implementation.** A good pattern of of implementing treatment and rehabilitation shows that most planned services are substantially implemented in a timely, competent, and coordinated manner. Substantially available services are being provided at adequate levels of intensity and continuity and are generally meeting priority needs, managing risks, and yielding desired results. Any staff and support system members are receiving satisfactory guidance and assistance in the performance of their roles. All providers and funders are contributing substantially to a successful pattern of results. Services are good and responsive to needs. **5** ☐

- **Fair Implementation.** A minimally acceptable pattern of implementing treatment and rehabilitation shows that most planned strategies, supports, and services are at least minimally implemented in a timely, competent, and coordinated manner. Usually available services are being provided at adequate levels of intensity and continuity and are minimally meeting priority needs, managing risks, and yielding some positive results. Any staff and support system members are receiving minimally satisfactory guidance and assistance in the performance of their roles. Most providers and funders are contributing at least minimally to some positive results. **4** ☐

- **Marginal Implementation.** A somewhat limited pattern of implementing treatment and rehabilitation shows that many planned services are inconsistently implemented in a timely, competent, and coordinated manner. A limited array of services may be provided at varying levels of intensity and continuity and is inconsistently meeting priority needs, managing risks, and yielding results. Any staff and support system members are receiving limited or inconsistent guidance and assistance in the performance of their roles. Minor implementation problems persist or recur. Some providers are inconsistent in their performance or contribution of resources. Results may be mixed or inconsistent. **3** ☐

- **Poor Implementation.** A substantially limited and inconsistent pattern shows that services are not being implemented in a timely, competent, and coordinated manner. An inadequate array of services is being provided at insufficient levels of intensity and continuity and is not meeting priority needs, managing risks, and yielding results. Any staff and support system members are receiving poor guidance and assistance in the performance of their roles. Many implementation problems are ongoing and unaddressed. Some providers are inadequate in fulfilling their performance requirements or contribution of resources. Results may be poor or unknown. **2** ☐

- **Absent or Adverse Implementation.** Services are not being implemented in a timely, competent, and coordinated manner, which may lead to harmful conditions or adverse results. The array of services is unable to meet priority needs, manage risks, or yield results. Any staff and support system members are not receiving guidance or assistance in the performance of their roles. Serious implementation problems are ongoing and unaddressed. The person's situation may be worsening with risks increasing. **1** ☐

Service Review 11: Emergent/Urgent Response Capability

EMERGENT/URGENT RESPONSE CAPABILITY: • Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems, as needed by this person? • Are crisis services accessed and delivered in a manner that respects and does not demean the person?

NOTE: This examination applies only to a person who by history has a demonstrated need for these services.

A person who presents dangerous psychiatric symptoms, severe maladaptive behaviors, or acute episodes of chronic health problems (e.g., seizures, hemophilia, asthma) may require immediate, specific, and possibly intensive services to meet emergent needs and to prevent harm from occurring to the person or to others. For such persons, an urgent response capability is necessary. Providing this capacity requires a health or safety "crisis plan," designed specifically for the person, that can be activated and implemented immediately. An alert procedure and crisis response capability has to be prepared in advance, has to be made a part of the IRP or other appropriate crisis response or safety plan, and has to be prepared to implement the crisis response plan and a follow-along mechanism that tracks the person through the crisis period. The urgency and significance of an emerging need or problem of the person should be met with a timely and commensurate service response (i.e., **emergency** within one hour and **urgent** within 24 hours). The primary concern here is whether the person, members of his/her support system, and service workers have timely access to services necessary to stabilize or resolve emerging problems of an urgent nature. A person living in a home under adult protective supervision may require a safety plan to be followed in the event of domestic violence, abandonment, or some other safety problem that has occurred previously in the home. A crisis plan should be evaluated following every use to ensure that its provisions are effective and that persons responsible for its use know and perform key tasks. This review may not apply to some persons.

Determine from Informants, Plans, and Records

To determine if this review area should be rated, consider the following matters:

- ☐ **Does the person present severe levels of psychiatric symptoms or behavioral challenges? If so, do these symptoms present cyclically? Can crisis episodes be anticipated?**
- ☐ **Does the person have a chronic health condition with frequent acute episodes that needs to be taken into account in planning behavioral health services?**
- ☐ **Is this person's home under adult protective supervision or threat of closure?**
- ☐ **Have special risks* and a pattern of urgent needs been identified for this person?**
- ☐ **Are safety plans indicated and provided to manage special situations?**
- ☐ **Have emergency procedures (including 911 services) been used for this person?**

1. Does this person have a crisis alert and response plan? If so, how is it designed?

2. Are emergent or urgent response services available when and as needed? Have emergent or urgent response services ever been denied? If so, why?

3. Is there an alert procedure and crisis response plan for this person specified in the IRP and/or other appropriate service plan documents? Are the persons who would send the alert and implement the crisis response plan aware of and ready to fulfill their assigned responsibilities? How is it working now?

4. Have the alert and crisis response processes been used in the past six months for this person or caregiver? If yes, did they work effectively? Were such services timely (within one hour, if an emergency, and within 24 hours, if urgent)?

5. Is there an advance directive the person can follow or initiate? Has the plan been developed collaboratively with the person? How current is the plan?

Facts Used in Rating Performance

**Special Risks to Consider:*

- *Recent abuse, trauma, victimization*
- *Recent self-mutilation or self-injury*
- *Recent severe aggression toward others*
- *Conflict or instability in the home*
- *Under adult protective custody or supervision for abuse, neglect, dependency*
- *Resident in a facility with licensing problems*
- *Resident in an unlicensed facility*
- *Recent arrest, hospitalization, or self-endangering*
- *Significant external impact (e.g., loss of a loved one, parental divorce, homelessness)*

Service Review 11: Emergent/Urgent Response Capability

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Urgent Response Capability.** The plan has been developed with the person and he/she has stated preferences for crisis management strategies that are followed/in use to the maximum extent possible. All appropriate supporters in the person's daily living, working, and therapeutic settings are fully prepared and ready to implement the team alert, crisis response, and follow-along provisions of a well-tested, effective, and respectful urgent response capability for the person. The alert and crisis response processes, if used in the past six months, performed in an excellent, reliable, respectful, and effective manner. **6** ☐

- **Good Urgent Response Capability.** The plan has been developed with the person and he/she has stated preferences for crisis management strategies that are followed, to a substantial degree, as circumstances permit. Key supporters in the person's daily living, working, and therapeutic settings are generally prepared and ready to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. Plan provisions have been discussed and are believed to be adequate or, if used in the past six months, worked reliably, respectfully, and acceptably well. **5** ☐

- **Fair Urgent Response Capability.** The plan may have been designed based on the person's ideas and previous experiences. Key supporters in the person's daily living, working, and therapeutic settings are minimally prepared to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. Plan provisions are periodically reviewed with the persons responsible for implementation. If used recently, crisis response was at least minimally successful in managing risks and securing necessary services and was not described by the person as disrespectful. **4** ☐

- **Marginal Urgent Response Capability.** The person was not involved in the development of the plan and may not even know of its existence. Some, but not all, of the key supporters in the person's daily living, working, and therapeutic settings are minimally prepared to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. If used recently, crisis response revealed some minor problems in managing risks at an acceptable level or in securing necessary crisis services in an acceptable and respectful manner. **3** ☐

- **Poor Urgent Response Capability.** The person was not involved in the development of the plan and may not even know of its existence. Key supporters in the person's daily living, working, and therapeutic settings are not adequately prepared to implement a team alert, crisis response, and follow-along plan necessary for the person. If used recently, crisis response revealed substantial problems in managing risks at an acceptable level or in securing crisis services in an acceptable and respectful manner. **2** ☐

- **Absent or Adverse Urgent Response Capability.** A crisis plan and response is necessary for this person but currently may not exist (except to call 911). In any recent crisis, the crisis response effort failed to manage risks adequately or failed to provide crisis supports or services in an acceptable and respectful manner to the person. **1** ☐

- **Not Applicable.** The person has no history of psychiatric or medical crises or emergencies within the past year that would warrant an urgent response plan. **NA** ☐

Service Review 12: Medication Management

MEDICATION MANAGEMENT: • Is the use of psychotropic medications for this person necessary, safe, and effective? • Does the person have a voice in medication decisions and management? • Is the person routinely screened for medication side effects and treated when side effects are detected? • Have new atypical/current generation drugs been tried, used, and/or appropriately ruled out? • Is the use of medication coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma, HIV)?

Use of psychotropic medications is one of many treatment modalities that may be used in treating a person having a serious emotional disorder. When use of such medications is deemed necessary and appropriate, it should conform to standards of good and accepted practice, including informed consent, consultation, most efficacious drug selection, consistency with medication protocols, demonstrated treatment response, and minimal effective dose. Effects and side effects of medication use should be assessed, tracked, and used to inform decision making. Any adverse side effects should be addressed and treated. Use of medications should be coordinated with other modalities of treatment including positive behavioral supports, behavioral interventions, counseling, skill development, and social supports. Continuity in medication regimes should be present across treatment settings. The person should have access to necessary specialized health care services including treatment and care for any co-occurring conditions (e.g., seizures, asthma, diabetes, addiction, HIV). The purpose is to determine whether the person receives and benefits from safe medication practices. This review does not apply to a person who has not taken psychotropic medications within the past 90 days.

Determine from Informants, Plans, and Records

1. Does the person take a psychotropic medication? Is use consistent with current treatment protocols? Has the person given consent for each medication?

2. Is there a DSM-IV-R Axis I diagnosis to support each psychotropic medication? Is the purpose for each medication documented and tracked to target symptoms or maladaptive behaviors? Is each medication consistent with intended use?

3. Has a minimum effective dosage of each medication been determined or are steps being taken to do so? Who is responsible for medication monitoring and screening for side effects?

4. Is there periodic evaluation of the person's response to treatment using data to track target symptoms or behaviors?

5. Is there quarterly screening of the person for adverse effects of medications? If adverse effects have been found, have appropriate countermeasures been implemented?

6. Is medication use coordinated with other treatment modalities? If multiple psychotropic medications are used with the person, is there written justification by the physician? Is there continuity in medications across settings?

7. Does the person have access to specialized health care services? Have coordinating staff consulted with other treating professionals (e.g., neurologists, psychiatrists) for a person having chronic and/or complex health care needs?

8. Is relapse prevention information available to the person? Is educational information about medications, effects/side effects, and self-medication available?

9. Has the person requested medication adjustments? Are the person's significant others trained on medications (e.g., administration, effects, side effects)?

Facts Used in Rating Performance

Service Review 12: Medication Management

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Medication Management.** The person presents symptoms or behaviors that are responding well to current generation medications with no report of bothersome side effects. The person reports good compliance with the prescribed medications and is not requesting any changes at this time. Use of medications is well coordinated with other treatment modalities. The person and physician have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to high quality health care for any serious health co-occurring conditions. **6** ☐

- **Good Medication Management.** The person presents symptoms or behaviors that are responding fairly well to current generation medications but reports some mild side effects. The person reports that sometimes medications are not taken as prescribed. Use of medications is sometimes coordinated with other treatment modalities. The person and physician have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to high quality health care for any serious health co-occurring conditions. **5** ☐

- **Fair Medication Management.** The person is becoming stable on appropriate medication and presents some symptoms or behaviors of concern and complains of side effects. Use of medication is checked conversationally and staff hint at non-compliance. The person may refuse participation in medication education activities. Medication is minimally coordinated with other treatment modalities. The person has minimally adequate access to fair quality health care for any serious health co-occurring conditions, including specialists with a short waiting period. **4** ☐

- **Marginal Medication Management.** The person presents symptoms or behaviors that may be responding somewhat to medications. Medication use may be inconsistent. Consents may not have been obtained. Screening for side effects may not be current or mild side effects may be noted but minimally treated. Use of medication is seldom coordinated with other treatment modalities. The person has somewhat limited access to fair-to-poor quality health care for any serious health co-occurring conditions and may receive most care from emergency rooms. **3** ☐

- **Poor Medication Management.** The person presents symptoms or behaviors that may not be responding to medications. Medication use may not be well documented or justified. Consents may be missing. Screening for side effects may not be current or moderate side effects may be noted. Use of medication is not coordinated with other treatment modalities. The person has inconsistent or very slow access to health care for any serious health co-occurring conditions. The person's physical or psychiatric status may be at risk due to inadequate health care for treating co-occurring conditions. **2** ☐

- **Absent or Adverse Medication Management.** The person presents increasing symptoms or behaviors that may not be responding to medications. Medication use may be undocumented, not justified, or experimental. Consents may be missing. Screening for side effects may not occur or serious side effects may be present and untreated. Use of medication is conflicting with other treatment modalities. The person has poor or no access to needed health care for any serious health co-occurring conditions. The person's physical or psychiatric status may be declining due to inadequate health care. **1** ☐

- **Not applicable:** The person does not now take psychotropic medications, nor has the person used such medications within the past 90 days. Therefore, this review does not apply. **NA** ☐

Service Review 13: Special Procedures

SPECIAL PROCEDURES: • If emergency seclusion or restraint has been used for this person, was each use: (1) Done only in an emergency? (2) Done after less restrictive alternatives were found insufficient or impractical? (3) Ordered by a trained, authorized person? (4) Accomplished with proper techniques that were safely and respectfully performed by qualified staff? (5) Effective in preventing harm? and (6) Properly supervised during use and evaluated afterwards?

Respectful relationships, effective communications, and positive behavior management techniques help to create safe therapeutic environments and reduce the emergence of unsafe situations. Staff training, appropriate placements and transfers, and use of advanced directives also minimize the use of emergency control techniques to prevent harm. Special procedures are permitted only when the person is a danger to him/herself or others and when alternative interventions are impractical or insufficient. Use of these emergency measures must be implemented in the least restrictive manner possible and ended as quickly as possible. During implementation, the person's status and effects of the procedure must be continually assessed, monitored, and evaluated. Seclusion and certain forms of restraint (physical, legal, protective, and medical) may be used under specific conditions, but chemical restraint (medication to immobilize a person) is prohibited. Seclusion is not a treatment modality and is contraindicated for persons who exhibit suicidal or self-injurious behavior. Each use of seclusion or restraint must be ordered on a time-limited basis for a person. Such measures are never authorized by "standing orders" or on an "as needed" (PRN) basis. Certain forms of restraint are prohibited (e.g., restraining nets, ambulatory restraints, face-down restraints, simultaneous use of seclusion and restraint, renewal orders in excess of one hour, use of seclusion or restraints in excess of 24 hours, any restraint around a person's neck or covering the person's face). Restraint may be contraindicated for a person who has experienced sexual trauma or physical abuse or who is deaf and cannot communicate without the use of hands. Staff are to follow specific policies and procedures when using seclusion and restraint. All services, including emergency measures, should be provided with consideration and respect for the person's dignity, autonomy, and privacy. This review applies to a consumer who has experienced the use of an emergency control procedure within the past 90 days.

Determine from Informants, Plans, and Records

1. Has the person experienced the use of any emergency control technique within the past 90 days? If so, what were the circumstances of use? What was the emergency and risk of harm? What antecedent events were present? What alternative interventions were found insufficient or impractical at the time?

2. Were respectful relationships, effective communications, and positive behavior management techniques used at the facility to create safe therapeutic environments and reduce the emergence/recurrence of unsafe situations for the person?

3. Were staff training, appropriate placements and transfers, and use of advanced directives applied to minimize use of emergency control techniques?

4. Were the emergency measures implemented in the least restrictive manner possible and ended as quickly as possible? During implementation, were the person's status and effects of the procedure continually assessed, monitored, and evaluated ? If so, by whom? What do records reflect?

5. Were the forms of seclusion or restraint used with the person consistent with standards of good practice (not using any contraindicated or prohibited techniques) and consistent with the facility's policies and procedures?

6. How has the person's IRP been modified to reduce the use of special procedures, based on experience gained?

7. Has the rate of use of special procedures been reduced or eliminated?

8. Is relapse prevention information available to the person? Have advanced directives been used, evaluated, and modified over time, based on experience?

Facts Used in Rating Performance

Only licensed facilities with trained and well-supervised staff should use emergency control procedures and then only in conformance with policies and procedures. Monitoring of emergency control measures should be done via an internal quality improvement program.

Service Review 13: Special Procedures

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Use of Special Procedures.** The person is served in an excellent therapeutic environment that reduces the emergence of unsafe situations via respectful relationships, effective communications, and positive behavioral supports. Excellent use of advanced directives, appropriate placements, and lesser restrictive techniques by highly trained staff minimizes use of special procedures, which, when used in an emergency, are the least restrictive, most appropriate, and most effective techniques possible. Staff actions are highly consistent with facility policies, procedures, and best practice. Based on experience gained, the person and team have modified the IRP and advanced directives to minimize unsafe situations. An excellent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **6** ☐

- **Good Use of Special Procedures.** The person is served in a generally positive therapeutic environment that reduces the emergence of unsafe situations via respectful relationships, effective communications, and positive behavioral supports. Good use of advanced directives, appropriate placements, and lesser restrictive techniques by well-trained staff minimizes use of special procedures, which, when used in an emergency, are the least restrictive, most appropriate, and most effective techniques possible. Staff actions are generally consistent with facility policies, procedures, and good practice. Based on experience gained, the person and team have modified the IRP and advanced directives to minimize unsafe situations. A good and consistent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **5** ☐

- **Fair Use of Special Procedures.** The person is served in a fairly positive therapeutic environment that helps to reduce the emergence of unsafe situations via respectful relationships, fair communications, and positive behavioral supports. Minimal use of advanced directives, appropriate placements, and lesser restrictive techniques by some trained staff lowers use of special procedures, which, when used in an emergency, may be the least restrictive, most appropriate, and most effective techniques possible. Staff actions are fairly consistent with facility policies, procedures, and accepted practice. Based on experience gained, the person and team may have modified the IRP and advanced directives. A minimal-to-fair level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **4** ☐

- **Marginal Use of Special Procedures.** The person is served in a somewhat problematic environment, having limited or inconsistent relationships, communications, and behavioral supports. Use of advanced directives and lesser restrictive techniques is limited by gaps in staff training. Use of special procedures, which are used only in real emergencies, may not be the least restrictive, most appropriate, and most effective techniques possible. Staff actions are sometimes inconsistent with facility policies, procedures, and accepted practice. Experience gained may have little connection to modifications in the person's IRP or any advanced directives. A marginal and inconsistent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. Risk of harm during use or caused by use of special procedures may be low for this person at this time. **3** ☐

- **Poor Use of Special Procedures.** The environment in which the person receives services may be contributing to the emergence of unsafe situations and higher usage of special procedures. Advanced directives and lesser restrictive procedures may not be used due to a poor level of staff training. Special procedures may be over-used or used as a substitute for appropriate treatment. Use of special procedures may be contrary to policies, procedures, and standards of good practice. Respect by staff for the person's dignity, autonomy, and privacy is lacking. Risk of harm during use of special procedures may be moderate. **2** ☐

- **Adverse or Dangerous Use of Special Procedures.** There are serious and dangerous breakdowns in the treatment environment for this person. Respectful relationships and good communications are lacking. Special procedures are being used unnecessarily, inappropriately, unsafely, and without adequate training, authorization, or oversight. Risk of harm during use of special procedures may be high. **1** ☐

- **Not Applicable:** The person has not experienced use of any emergency control measures within the past 90 days. Therefore, this review does not apply. **NA** ☐

Service Review 14: Practical Supports

PRACTICAL SUPPORTS: • Is the array of in-home and community-based supports provided to this person sufficient [in design, intensity, and dependability] to meet the person's preferences and assist him/her to achieve recovery goals? • Are supports effective during life change adjustments and in maintaining the person within the home, job, and community? • Where applicable, is individually assigned staff (job coach, respite/crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship and support arrangement for the person?

Practical supports consist of agents and/or environmental arrangements that help mediate a gap between a person's capacities and the performance requirements of an environment so that the person can operate successfully in that environment (home, job, or other social setting) under a range of typical conditions. Persons with mental illness may require such supports to function successfully in daily settings. An array of supports may be required for a person with a serious mental illness to function within the community. To be effective, arrangements for supports have to be designed specifically for the person and setting and then must operate at a level of consistency, intensity, and dependability. Special supports should be thought of as transitional and as having to be acceptable to the person.

In-home supports for adults with a serious mental illness are usually focused on: (1) crisis situations, i.e., the live-in associate or family member feels overwhelmed by the severity of the symptoms of the illness; (2) respite, i.e., the adults need time away from each other for a variety of reasons; and (3) the person has a skills or social deficit or needs that exceed the capacity of the helper in the home. Live-in associates or family members must receive education and training increases their effectiveness as helpers. Extra supports may be required for other reasons; i.e., a new job, temporary child care support, attempts at sobriety, or starting a class at college. The person should have as many choices as possible in selecting the provider, in deciding the intensity of supports, and in defining the nature of support. In general, the use of in-home/extra supports should be addressed in the IRP and access may be controlled by Utilization Management.

Determine from Informants, Plans, and Records

1. Is this person receiving practical supports in his/her daily settings? If so, how are these designed? How well do current support arrangements enable the person to function successfully in his/her daily settings?

2. Are current supports consistent with the IRP? Consistent with the person's preferences and culture? Dependable from day to day and from setting to setting? Adjusted to meet changing circumstances?

3. Are in-home support services appropriate for the situation, accessible when needed, effective when used, and dependable? Have support services ever been denied? If so, why?

4. Given these supports, is the provider able to meet the needs of the person? Is the provider able to maintain the stability of the home and capacity of the person to function adequately over time? Is the person satisfied with the supports provided? Have hardships and disruptions been minimized?

5. If this person presently is residing in a group home or residential treatment facility, does the direct care staff have the capacity to meet the support needs of this person on a daily basis?

6. Has special training, assistance, or support been provided for direct care staff serving this person in the group home/residential treatment facility?

Facts Used in Rating Performance

Practical supports may include:

- *Personal assistant services*
- *Friend and family assistance*
- *Peer support*
- *Community support worker*
- *Job coach*
- *Homemaker services*
- *Assistive technology*
- *Internet access*

Informal supports from partners, friends, peers, and family members [where appropriate and available] should be sought and used before paid supports are arranged. In some instances, informal supports may not be available or appropriate.

Service Review 14: Practical Supports

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person and Home Provider — Rating Level

- **Optimal Practical Supports.** An optimal array of supports and services is planned with and for the person and covered in the IRP. These services are immediately and consistently accessible as needed, dependable in use, and truly supportive in nature. The person is benefiting from excellent support arrangements in daily settings, fully consistent with his/her needs and choices. Any home provider is receiving an excellent level of training, assistance, in-home support, and periodic relief necessary for the provider to fully meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose all support providers to assure cultural compatibility and quality performance over time. **6** ☐

- **Good Practical Supports.** A good and substantial array of supports and services is planned with and for the person and covered in the IRP. These services are generally accessible as needed, dependable in use, and supportive in nature. The person is benefiting from good support arrangements in daily settings, fully consistent with his/her needs and choices. Any home provider is receiving a good level of training, assistance, in-home support, and periodic relief necessary for the provider to meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose most support providers to assure cultural compatibility and quality performance over time. **5** ☐

- **Fair Practical Supports.** A minimally adequate to fair array of supports and services is accessible as needed, adequate in use, and minimally supportive in nature. The person and home provider had minimal involvement in planning supports that are documented in the IRP. The person is benefiting from fair support arrangements, at least minimally consistent with his/her needs and choices. Any home provider is receiving a minimally adequate to fair level of training, assistance, in-home support, and periodic relief necessary for the provider to meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose some support providers to assure cultural compatibility and quality performance over time. **4** ☐

- **Marginal Practical Supports.** There is little evidence that the person or home provider participated in planning of supports. A limited or inconsistent array of supports and services is being provided. The person is receiving marginal support arrangements, somewhat inconsistent with the person's needs and choices. Any home provider is receiving a limited level of training, assistance, in-home support, and periodic relief limiting his/her ability to meet the needs of the person and maintain the stability of the living arrangement. The person and home provider had little, if any, choice in selecting support providers. Cultural compatibility and performance quality of support providers may be somewhat problematic at this time. **3** ☐

- **Poor Practical Supports.** There is little evidence that the person or home provider participated in planning of supports. A poor set of supports and services is being provided. The person is receiving inadequate support arrangements, substantially inconsistent with the person's needs and choices. Any home provider is receiving a poor and inadequate level of training, assistance, in-home support, and periodic relief, thus, undermining his/her ability to meet the needs of the person and maintain the stability of the living arrangement. Neither the person nor home provider had a choice in selecting support providers. Cultural compatibility and performance quality of support providers may be seriously problematic at this time. **2** ☐

- **Absent or Adverse Practical Supports.** There is no evidence that the person or home provider participated in planning of supports. Necessary supports and services are either absent or adverse in effect. The person is receiving either no or harmful support arrangements in daily settings, grossly inconsistent with the person's needs and choices. Any home provider is receiving either no or inappropriate training, assistance, in-home support, and no periodic relief. This situation is seriously reducing the home provider's ability to meet the needs of the person while putting the stability of the home living arrangement at risk. **1** ☐

- **Not Applicable.** Neither the person nor home provider needs or receives supports at this time. **NA** ☐

Service Review 15: Service Coordination & Continuity

SERVICE COORDINATION & CONTINUITY: • Is there a single point of coordination, accountability, and continuity in the organization, delivery, and results of treatment, supports, and services for this person? • Are IRP-specified services well coordinated across providers, funding agencies, and service settings for this person, especially when entering and leaving intensive service settings?

A **single point of coordination, integration, and accountability** is necessary to plan, implement, monitor, modify, and evaluate essential service functions and outcomes for the person, regardless of the number of public funders involved. The single-point person may be referred to as the service coordinator, case manager, or other similar title. Regardless of the title, the person filling this role should have the **competence** necessary to perform essential functions for a person of the complexity of the case being reviewed. This person should have the **authority to convene and communicate with the service team** for purposes of planning, assembling supports and services, monitoring implementation and results, and modifying supports and services. This person should be able to **advocate** on behalf of the person without conflicts of interest that may be associated with a particular funder or provider. The coordinator's caseload size should afford the **opportunity** to adequately coordinate services and provide **continuity of care** for every individual assigned. In a case where several agencies and providers are involved, collaboration is necessary to achieve and sustain a coordinated and effective service process. The primary concern is whether all necessary functions performed by service planners, providers, supporters, and any home provider are organized and integrated to achieve the person's recovery goals.

Determine from Informants, Plans, and Records

1. Does the person require multiple providers to meet his/her needs?
2. Is there a single point of coordination and accountability for implementing the IRP and for linking the public funders, paid providers, and voluntary resource persons involved in the process?
3. Is there evidence of the integration of services and continuity of effort in the implementation of the person's IRP? Is there a mechanism for identifying emerging problems and developing appropriate responses and adjustments in the planning and service process?
4. Is there adequate communication so that all parties know the current status and location of the person?
5. Is the service coordinator sufficiently competent to handle the complexities of this person? Are services well coordinated across settings, providers, levels of care—especially during transitions in/out of intensive services?
6. Can the service coordinator convene the service team as needed?
7. What is available to assist the coordinator in gaining the cooperation and participation of multiple providers to meet the requirements and commitments of the IRP?
8. Can the service coordinator access and use flexible funding if needed?
9. Does the service coordinator and service team collectively share a sense of accountability for helping the person meet recovery goals stated in the IRP?

Facts Used in Rating Performance

NOTE:

The accountable agent could be a clinical manager, therapist, case manager, or other designated person.

Service Review 15: Service Coordination & Continuity

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Service Coordination.** There is a highly effective single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) fully demonstrates the skills, influence, and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services to achieve desired results for this person. Services are fully integrated across settings and providers and are consistently timely, appropriate, effective, and satisfying to the person. Continuity of care is excellent across providers and settings. **6** ☐

- **Good Service Coordination.** There is a generally effective single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) usually demonstrates the skills, influence, and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services to achieve desired results for this person. Services are generally integrated across settings and providers and are usually timely, appropriate, effective, and satisfying to the person/family. Continuity of care is good. **5** ☐

- **Fair Service Coordination.** There is a minimally adequate single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) minimally demonstrates the skills and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are minimally integrated across settings and providers and are at least minimally timely, appropriate, and satisfying. Continuity of care is fair. **4** ☐

- **Marginal Service Coordination.** There is limited coordination of services with little accountability for service delivery and results. The service coordinator (possibly working independently of the person or in the absence of a service team) may lack the skills necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are somewhat fragmented across settings and providers. Breakdowns in services may occur occasionally. Providers may have their own agendas that are inconsistent with the IRP. **3** ☐

- **Poor Service Coordination.** There is substantially inadequate coordination of services. The service coordinator (working independently of the person or in the absence of a service team) may lack the skills to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are substantially fragmented across settings. Breakdowns may be frequent and risks may not be adequately managed. Inconsistency in approach and service may be obvious among providers. **2** ☐

- **Absent or Adverse Service Coordination.** There is no single point of coordination and accountability for services or results. Providers and funders may operate independently, placing unreasonable or conflicting demands on the person. Needed services may be absent or fragmented. Inappropriate or potentially harmful services may be inadvertently provided. The person may "get lost in the system" for periods of time, leaving him/her at elevated risk of harm or poor outcomes. **1** ☐

Service Review 16: Recovery Plan Adjustment

RECOVERY PLAN ADJUSTMENT: • Is the service coordinator using monitoring activities to follow this person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? • Does the service coordinator keep all providers informed and discuss IRP implementation fidelity, barriers encountered, and progress being made? • Are services adjusted in response to problems encountered, progress made, changing needs, and knowledge gained to create a process that supports recovery?

What's working now for this person and, where appropriate, the providers? Are desired treatment results being produced? What things need changing? Continued-stay reviews can serve to monitor service implementation, outcomes, and modify services. **These reviews can provide the "learning" and "change" processes that make the treatment process "smart" and, ultimately, effective for the person.**

The IRP should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The service coordinator, along with the service team for the person, should play a central role in tracking and adjusting planned treatment strategies, services, and supports. Members of the service team (including the person and providers) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. The frequency and intensity of the continued-stay review process should reflect the pace, urgency, and complexity of the person's needs and unfolding case events. This learning and change process is necessary to find what works for the person. Learning what works is a continuing process. Getting successful results depends on a "smart" service process.

Determine from Informants, Plans, and Records

1. How often is the status of the person monitored/reviewed? How does this person participate in the review? How is treatment progress and the person's well-being monitored by the service coordinator and team (e.g., face-to-face contacts, telephone contacts, and meetings with the person and service providers; reviewing reports from providers)?

2. How is implementation of treatment and service processes being tracked? Is progress or lack of progress being identified and noted?

3. Are identified needs and problems being acted on?

4. Is there a clear and consistent pattern of successful adaptive service changes that have been made in response to use of short-term results?

5. Is the IRP and treatment process modified as goals are met? Is the service process modified if no progress is observed? If not, why not?

6. How does the service coordinator and service team update and modify the IRP?

Facts Used in Rating Performance

Service Review 16: Recovery Plan Adjustment

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Adjustment Process.** Treatment strategies, supports, and services being provided to the person are highly responsive and appropriate to changing conditions and recovery needs. Continuous or frequent monitoring, tracking, and communication of the person's status and service results to the service team [person and other involved providers] are occurring. Timely and smart adjustments are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the person. **6** ☐

- **Good Adjustment Process.** Treatment strategies, supports, and services being provided to the person are generally responsive to changing conditions and recovery needs. Frequent monitoring, tracking, and communication of the person's status and service results are occurring. Generally successful adaptations are based on a basic knowledge of what things are working and not working. **5** ☐

- **Fair Adjustment Process.** Treatment strategies, supports, and services being provided to the person are minimally responsive to changing conditions and recovery needs. Periodic monitoring, tracking, and communication of the person's status and service results are occurring. Usually successful adaptations to supports and services are being made. **4** ☐

- **Marginal Adjustment Process.** Treatment strategies, supports, and services being provided to the person are partially responsive to changing conditions and recovery needs. Occasional monitoring and communication of the person's status and service results are occurring. Limited or inconsistent adaptations are based on isolated facts of what is happening. Their status may be adequate in some areas but unacceptable in others. The person and/or caregiver could be at low risk of harm or poor outcomes. **3** ☐

- **Poor Adjustment Process.** Poor treatment strategies, supports, and services may be provided to the person and may not be responsive to changing conditions and recovery needs. Perfunctory monitoring, poor communications, and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Few modifications may be planned or implemented. The person's status may be poor in several areas. The person could be at moderate-to-high risk of harm or poor outcomes. **2** ☐

- **Absent, Nonoperative, or Misdirected Adjustment Process.** Treatment strategies, supports, and services may be limited, undependable, or conflicting for the person. No monitoring or communications may occur and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become nonresponsive to the current needs of the person. The service process may be "out of control" or so limited as to be non-existent. The person's status may be generally poor. The person could be at high risk of harm or poor outcomes. **1** ☐

Service Review 17: Overall Practice Performance

OVERALL PRACTICE PERFORMANCE SCORING RUBRIC

There are 16 reviews to be conducted in the area of Practice Performance. Each review produces a finding reported on a 6-point rating scale with scale values of 1-3 being in the unacceptable range and values 4-6 being in the acceptable range. An "overall rating" of Practice Performance is based on the findings determined for the Practice Performance review items, using the following scoring procedure to produce an "overall rating value" on a 1-6 scale. This procedure is performed after rating results are produced for all 16 items: (1) Begin by transferring the rating value for each review item from the protocol page to the calculation table below. (2) Next, multiply the rating value for each item by the weighting value in the table to produce a weighted score for the item. Please note that there are no "trump" review items in the Practice Performance domain. (3) Then, sum the weighted values of all review scores to produce a total score; (4) Follow the instructions that follow the calculation table to assign the OVERALL PRACTICE PERFORMANCE RATING for this person. Follow the alternative scoring procedure (page 79) when one or more reviews are not applicable in this case.

Rating	Weight	Score	Practice Performance Reviews
_____	x **3**	_____	**1a. Participation of the person**
_____	x **3**	_____	**1b. Engagement/Outreach efforts by staff**
_____	x 1	_____	2. Culturally appropriate practice (if NA, use page 79)
_____	x 2	_____	3. Service team formation
_____	x 2	_____	4. Service team functioning
_____	x **3**	_____	**5. Assessment & understanding**
_____	x 2	_____	6. Personal recovery goals
_____	**x 3**	_____	**7. Individualized recovery plan**
_____	x 2	_____	8. Goodness-of-service fit
_____	x 1	_____	9. Resource availability
_____	x **3**	_____	**10. Treatment & service implementation**
_____	x 1	_____	11. Emergent/urgent response capability (if NA, use page 79)
_____	x 1	_____	12. Medication management (if NA, use page 79)
_____	x 1	_____	13. Special procedures (if NA, use page 79)
_____	x 2	_____	14. Practical supports (if NA, use page 79)
_____	x **3**	_____	**15. Service coordination and continuity**
_____	x 2	_____	16. Recovery plan adjustment
	TOTAL SCORE:	_____	**SUM of the Weights of all Not Applicable (NA) Review Items = _____**

Note

Use the rating scale ranges below when all review items are deemed applicable to this case. If one or more review items are deemed not applicable, use the modified scoring ranges presented on page 79, as directed.

Rating of the Overall Practice Performance for the Person — **Action Zone**

- **Optimal Practice Performance**. Assign an overall performance rating of "6" when the total weighted score across the reviews is 182-210 range.
- **Good Practice Performance**. Assign an overall performance rating of "5" when the total weighted score across the reviews is within the 153-181 range.

6 ☐ Maintenance **5** ☐

- **Fair Practice Performance**. Assign an overall performance rating of "4" when the total weighted score across the reviews is within the 123-152 range.
- **Marginal Practice Performance**. Assign an overall performance rating of "3" when the total weighted score across the reviews is within the 94-122 range.

4 ☐ Refinement **3** ☐

- **Poor Practice Performance**. Assign an overall performance rating of "2" when the total weighted score across the reviews is within the 65-93 range.
- **Adverse Practice Performance**. Assign an overall performance rating of "1" when the total weighted score across the reviews is 35-64 range.

2 ☐ Improvement **1** ☐

[Alternative] Service Review 17: Overall Practice Performance

ALTERNATIVE OVERALL PRACTICE PERFORMANCE SCORING RUBRIC

WHEN EITHER Service Review 2—Culturally appropriate practice, OR Service Review 11—Emergent/urgent response capability, OR Service Review 12—Medication management, OR Service Review 13—Special procedures, OR Service Review 14—Practical supports, OR any combination of Service Reviews 2, 11, 12, 13, or 14, OR all five Service Reviews 2, 11, 12, 13, and 14 are deemed "not applicable" in a case, use this alternative scoring procedure.

First, complete the rating and weighting table on page 78 using a ZERO (0) value for each review deemed not applicable to produce a TOTAL SCORE for Overall Practice Performance. Add the weights for each NA item to obtain a Total Sum of the NA items. Once a total score and sum of NA weights are produced, the reviewer should select and use the appropriate alternative scoring procedure provided in the table below. Identify the scoring situation present in this case and then locate the scoring range interval that matches the TOTAL SCORE in this case. Then, mark the rating value and zone corresponding to the scoring interval. Use the alternate rating value for the Overall Practice Performance Rating on the "roll-up" sheet.

SCORING SITUATION DETERMINED IN THIS CASE						
NA weight = 1	**NA** weights = 2	**NA** weights = 3	**NA** weights = 4	**NA** weights = 5	**NA** weights = 6	**Overall Rating and Zone**
☐ 177-204 range	☐ 172-198 range	☐ 166-192 range	☐ 161-186 range	☐ 156-180 range	☐ 151-174 range	**6** ☐ Maintenance
☐ 148-176 range	☐ 144-171 range	☐ 140-165 range	☐ 135-160 range	☐ 131-155 range	☐ 127-150 range	**5** ☐
☐ 120-147 range	☐ 117-143 range	☐ 113-139 range	☐ 109-134 range	☐ 106-130 range	☐ 102-126 range	**4** ☐ Refinement
☐ 92-119 range	☐ 89-116 range	☐ 86-112 range	☐ 84-108 range	☐ 81-105 range	☐ 78-101 range	**3** ☐
☐ 63-91 range	☐ 62-88 range	☐ 60-85 range	☐ 58-83 range	☐ 56-80 range	☐ 54-77 range	**2** ☐ Improvement
☐ 34-62 range	☐ 33-61 range	☐ 32-59 range	☐ 31-57 range	☐ 30-55 range	☐ 29-53 range	**1** ☐

Written Case Review Summary

Person's Status Summary

Facts about the Person Reviewed

- Agency or Office
- Person's Initials
- Reviewer's Name
- Review Date
- Date of Report
- Person's Placement

People Interviewed during this Review

Indicate the number and role (person, home provider, live-in associated, service coordinator, therapist, job coach, etc.) of the persons interviewed.

Facts About the Person and Living Arrangement

[About 100 words]

- Person's situation and living arrangement
- Reasons for mental health services
- Mental health services received
- Services provided by other agencies

Person's Current Status [About 250 words]

Describe the current status of the person and living arrangement based on status review findings. If any unfavorable status result puts the person at risk of harm, explain the situation. Mention relevant historical facts that are necessary for an understanding of the person's current status. Use a flowing narrative to tell the "case story" and make sure that it supports and adequately illuminates the Overall Status rating.

Home Provider's Status [About 100 words]

Because the status of the person often is linked to the status of any home provider, indicate whether the provider is receiving the supports necessary to adequately meet the needs of the person and maintain the stability of the living arrangement.

Factors Contributing to Favorable Status

[About 100 words]

Where status is positive, indicate the contributions that the person's resiliency, provider capacities, and uses of natural supports and generic community services made to the results.

Factors Contributing to Unfavorable Status

[About 100 words]

Describe what local conditions seem to be contributing to the current status and how the person may be adversely affected now or in the near-term future, if status is not improved.

System Performance Appraisal Summary

Describe the current performance of the service system for this person using a concise narrative form. Mention any historical facts or local circumstances that are necessary for understanding the situation.

What's Working Now

[About 250 words]

Identify and describe which service system functions are now working adequately for this person. Briefly explain the factors that are contributing to the current success of these system functions.

What's Not Working Now and Why

[About 150 words]

Identify and describe any service system functions that are <u>not</u> working adequately for this person. Briefly explain the problems that appear to be related to the current failure of these functions.

Six-Month Prognosis/Stability of Findings

[About 75 words]

Based on current service system performance found in this case, is the person's overall status likely to improve, stay about the same, or decline over the next six months? Take into account current service quality and important life change adjustments that may occur over this time period. Explain your answer.

Practical Steps to Sustain Success and Overcome Current Problems

[About 75 words]

Suggest several practical "next steps" that could be taken to sustain and improve successful practice activities over the next six months. Suggest practical steps that could be taken to overcome current problems and to improve poor practices and local working conditions for this person in the next 90 days.

Report Length

The summary should not exceed two-to-four typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.

Review Presentation Outline

Oral Presentation Outline

1. Core Story of the Person **3 minutes**

- Reason for mental health and other services
- Primary treatment and rehabilitation goals
- Personal recovery goals expressed by the person
- Strengths and needs of the person and home provider
- Services provided by participating agencies

2. Person's Status and, where appropriate, Caregiver Status **3 minutes**

- Overall status of the person finding/rating
- Progress made
- Problems

Emphasize any accomplishments or concerns related to community living, life skills, health, and well-being.

3. System Practice and Performance **3 minutes**

- Overall system performance finding/rating
- What's working now for this person
- What's not working and why
- Six-month prognosis

Emphasize any accomplishments or concerns related to engagement of the person, assessment, planning, treatment, functional support, emergent/urgent response, coordination of services, or results.

4. Next Three Steps **1 minutes**

- Recommended important and doable "next steps"
- Any special concerns or follow-up indicated

Total Presentation Time **10 minutes**

Group Questioning of Presenter **3-5 minutes**

Appointments

APPOINTMENT 1

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 1

APPOINTMENT 2

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 2

APPOINTMENT 3

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 3

APPOINTMENT 4

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 4

APPOINTMENT 5

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 5

Help Resources

Review Team Leader: _____ Phone: _____

Local Contact Person: _____ Phone: _____