November
2025

Introduction to essential F/ACT Principles and Practices

Passing on F/ACT history, knowledge and culture Through Storytelling

Ontario Association for ACT & FACT

Acknowledgment

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Slides prepared by Roger Renaud.

Overall Training Outline

- OAAF
- History of the ACT Model
- Differentiating ACT and FACT
- Role of ACT clinicians
- Team Process
- Admission and Retention of Clients
- Team Members
- Support Approaches on ACT
  - Concurrent Disorders
  - Vocation
  - Community Services
  - Safety issues
  - Client Centered
- Role of Stakeholders
- Recovery/Service Planning

Session One Outline

- Intro to OAAF
- History of ACT
- Differentiating ACT from FACT
- Evidence Base
- What Makes ACT Unique
- Model Fidelity and TMACT
- Duties of Primes/Mini Teams
- Can Do Approach
- Do we really do that on ACT?

OAAF
Ontario Association for ACT and FACT

- The Ontario Association for ACT & FACT (OAAF) is a voluntary organization of Assertive Community Treatment (ACT) teams and Flexible Assertive Community Treatment (FACT) teams.
- The OAAF helps identify, develop, and advocate for the collective interests of ACT and FACT teams in the Province of Ontario.

https://www.ontarioactassociation.com/

Brief History of ACT

- First mental health hospitals referred to as asylums
- By the 1960's MH client population explodes, cost increases, development of effective medications (Illness like others)
- Two waves of deinstitutionalization
- Madison, Wisconsin in the 70's (Stein, Test, Marx and Lontz)
- The consumer's environment becomes the therapeutic arena
- Moving the multidisciplinary team from the in-patient unit to the living environment of Mental Health Consumers

What is FACTT

(Flexible Assertive Community Treatment Team)

- FACT is a flexible, recovery-oriented model of care for individuals with complex mental health and addiction needs that can shift based on support needs
- FACT models have been established in the Netherlands and Europe for more than 10 years

What is the difference between ACT and FACT teams?

- Expanded diagnostic eligibility for FACT
- Different team staffing compositions
- Evidence based assessment and treatments (specific to expanded eligibility)
- Staff to client ratio's 1:13 to 1:16
- Fact board and switching system (20% ACTT level care, 80% ICM level of care)

ACT Model - Evidence Based Practice

Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system. ACT is one of the oldest and most widely researched evidence-based practice in behavioral healthcare for people with severe and persistent mental illness.

Moral of the story:
You need to have more than good intentions to have good outcomes

https://www.centerforebp.case.edu/practices/act

ACT Model – Evidence Based Practice

First study to evaluate ACT approach - Madison, Wisconsin in the 1970's found:

- less time spent in psychiatric hospitals
- better independent–living skills
- improved symptomatology
- enhanced work and social functioning
- higher consumer satisfaction.

(Stein & Test, 1980)

- Fewer hospitalizations/Reduced time in hospital
- Improved housing stability
- Better retention in mental health services
- High satisfaction (patients and families)
- Cost effective

https://www.ontarioactassociation.com/act-results/

ACT Model – More Evidence

- **Fewer number of days in hospitals**

Kent County, Michigan (Mulder, 1985), Sydney, Australia (Hoult, Renolds, Charbeonneau – Powis, Weeks & Briggs, 1983), Chicago (Bond, 1990) and Indiana (Bond, Miller, Krumweid & Ward, 1998)

- **Fewer symptoms than their service counterparts**

(Hoult, 1983; Stein & Test, 1980)

- **Additional studies supported the first round of research as well as these results with an expanded range of clients**

(Rosenheck, Neal, Leaf, Milsteind & Frisman, 1995), clients in Great Britain (Marks, 1991), and homeless people with severe mental illness (Morse, Calsyn, Allen, Temelhoff, & Smith, 1992).

Burns & Santos (1995) found strong evidence that ACT reduces the number of psychiatric hospital days.

https://www.ontarioactassociation.com/act-results/

ACT Fast Facts!

Savings

During the period 2005 – 2006, Ontario's first round of ACT teams represented 4,048 clients, who:

- used 70.9 bed days one year pre-ACT.
- But only 27.2 psychiatric hospital days one year post-ACT

This resulted in over 176,500 psychiatric hospital days being freed up, and available for other use.

Estimated to be a savings of $105,000,000

There was also an increase of 36% in ACT clients living in single accommodation

https://www.ontarioactassociation.com/fast-facts/

Evidence Based Best Practices

(CAP, 2005; Dixon et al 2010;. Mueser et al, 2003, NICE, 2009;. SAMHSA, 2011)

Psychoeducational approach and illness self management
Client centered treatment
Peer Support/Counselling
Family Support and active involvement in treatment planning as well as advanced directives
Community based crisis intervention/support in home environment
Intensive monitoring for clients at risk of repeated hospitalization
Promotion of healthy lifestyle and monitoring of physical health issues
Coordinated support (case management) in the home environment
Access to affordable group and leisure activity in the community
Academic support
Support for regular employment (particularly individual Placement Support-IPS)
Priority access to safe affordable housing
Specialized recovery approaches (CBT, Motivational approach, Social Skills training)
Art Therapy
Integrated Mental Health and Addictions services
Specialized services for early intervention (i.e. first episode psychosis programs)

Why do we need a model like F/ACT ?

- Chronic illness requires long term interventions.

- Wide range of help = sustained and satisfactory life in the community.

- Interventions needed for
  - everyday problems (food, shelter and medical care)
  - teaching coping skills (demands of life)

- Enough support needed to:
  - keep clients motivated to persevere and remain involved in life;
  - help families and clients problem solve
  - educate community members who might be involved

When the primary mode of treatment was the hospital, clients learned to use the hospital as their major coping mechanism. It took a great deal of effort to keep early ACT clients out of hospital long enough and to see them through enough episodes of stress for them to learn to use the community system instead.

Stein, L. I., & Santos, A. B. (1998)

ACT Teams Around the World

Australia
England
Ireland
Italy
Spain
Japan
New Zealand
United States

Holland
France
Singapore
Israel
Slovenia
Norway
Poland
Canada
Great Britain

http://www.cnesm.org

ACT Teams in Ontario

LHin 1
Sarnia/Lambton
Chatham/Kent
Windsor (2 teams)

LHIN 2
Owen Sound
Seaforth
St. Thomas (2 teams)
London ACT (2 teams)
Woodstock
Strathroy-Middlesex

LHIN 3
Cambridge
Kitchener
Guelph
Fergus

LHIN 4
Burlington
Brantford
Townsend
Hamilton (2 teams)
Niagara (2 teams)

LHIN 5
Reconnect ACT Team (Toronto)
North Peel ACT (SHiP team I) (Mississauga)
CMHA Peel ACT (Brampton)

LHIN 6
Mississauga (3 teams)

LHIN 7
Toronto (8 teams)

LHIN 8
Toronto
North York
Keswick
Newmarket
Markham
Vaughan

LHIN 9
Scarborough (3 teams)
Ajax
Oshawa
Whitby
Haliburton, Kawartha, Peterborough
Cobourg

ACT Teams in Ontario

LHIN 10
Brockville (2 teams, one for dual diagnosis)
Kingston (4 teams)
Belleville

LHIN 11
Ottawa (4 teams, 2 are bilingual)
Carlington
Pembroke
Cornwall

LHIN 12
Barrie
Orillia
Bracebridge
Parry Sound
Sundrige

LHIN 13
North Bay (2 teams)
Sault Ste. Marie
Sudbury (2 teams)
Timiskaming
Timmins

LHIN 14
Thunder Bay (2 teams)
Kenora Rainy River District

FACT Teams in Ontario

Adult Intensive Services (Kitchener Waterloo, Guelph and Cambridge)

FOCUS team (St Mikes hospital Toronto)

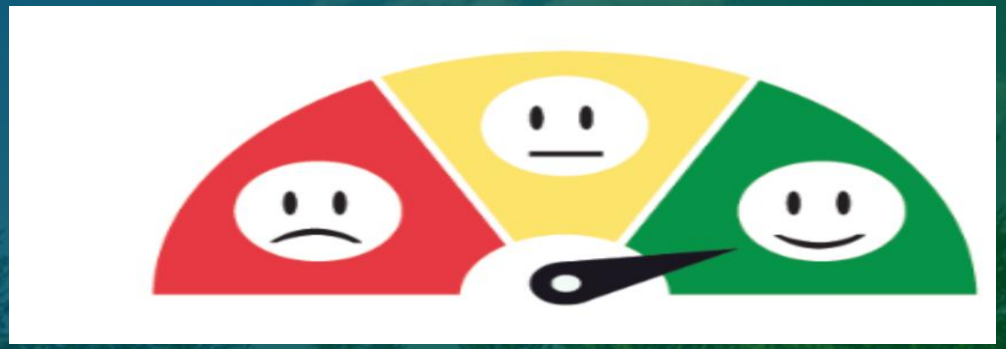
Dual Diagnosis Team (Royal Ottawa Hospital)

FACT (Mississauga/Brampton)

Possible FACT teams to be developed in the near future:

- London,
- CMHA Grey Bruce
- Niagara Regional Health Services
- CAMH

Why Would Clinicians Want to Work on F/ACTT?



- professionally satisfying
- staff get a lot of responsibility and autonomy. The results of what you do are very apparent

- personally satisfying
- get to know your clients very well -- gratifying to see people you have cared for make so much progress

- working within a team
- support/comraderie
- consult mitigate risk/liability

- feel your opinion more valued
- Feel they are integral to decision making

Stein, L. I., & Santos, A. B. (1998)

What Makes ACT Unique

#1 Broad Approach

- Focus on all factors that promote stability
  - finances, Housing , ADL's, socialization, hobbies, work, crisis services, mental health services, medical services

- Forge relationships
  - landlords, family doctors, parole officers, family, employers, friends, neighbors

Stein, L. I., & Santos, A. B. (1998)

#2 Careful Monitoring

- Ensures the team can intervene promptly
- Care issues are effectively communicated with the team
- Ensure clients are actively involved in their stability maintenance
- Ensure that as clients progress they are not unnecessarily held onto by ACT as well as unnecessarily discharged too quickly from ACT

Stein, L. I., & Santos, A. B. (1998)

#3 Time Unlimited Service?

- The big debate
- Recovery takes time
- Mental Health Community Resources are limited/dwindling
- Pressure from sponsoring agencies and referral sources advocating for their clients to access services
- Fact Teams, Stepped Care

Stein, L. I., & Santos, A. B. (1998)

Other Characteristics

- team approach
- in vivo services
- small caseload
- shared caseload
- flexible service delivery
- 24/7 crisis availability

Stein, L. I., & Santos, A. B. (1998)

Model Fidelity Assessment Tools

- F/ACT models are evidence based but only valid if your team is implementing properly
- DACTS (Dartmouth Assertive Community Treatment Scale) original tool changed to TAMCT
- TMACT = Tool for Measuring Assertive Community Treatment
- If a team is not faithful to the ACT model, it can not claim to offer "EBP care“
- Fidelity reviews are being explored as possible ways that the OAAF can support and promote EBP care for teams

http://www.cnesm.org

First winter and now TMACT is coming?

TMACT Categories

- Low ratio of clients to staff
- Team approach
- Daily Team Meeting (frequency and attendance)
- Daily Team Meeting (Quality)
- Program Size
- Priority Service Population
- Active Recruitment of clients
- Gradual Admission Rate
- Transition to less Intensive Services
- Retention Rate of clients
- Involvement in Psychiatric Hospitalization Decisions
- Dedicated office based program assistance
- Team Leader on team
- Team Leader is a practicing clinician
- Psychiatric Care Provider on the team, role in services and within team
- Nurses on the Team, Role of Nurses
- Co-occurring Disorders specialists on the team, role in services and within team
- Employment Specialist on team, role in services and within team
- Peer Specialist on Team, role in services and within team

- Community Based Services
- Assertive Engagement Mechanisms
- Intensity of service
- Frequency of contact
- Frequency of Contact with Natural Supports
- Responsibility for Crisis Services
- Full Responsibility for:
  - Psychiatric Services
  - Recovery Services
  - Integrated Treatment for Co-Occurring Disorders
  - Employment and Educational Services
  - Wellness Management
- Engagement and Psychoeducation with Natural Supports
- Empirically-Supported Psychotherapy
- Supported Housing
- Strengths Informed Treatment Plan
- Person-Centered Planning
- Interventions target Broad Range of Life Domains
- Client Centered Self-Determination and Independence

https://depts.washington.edu/ebpa/sites/default/files/TMACT%20Protocol%20Part%20II.pdf

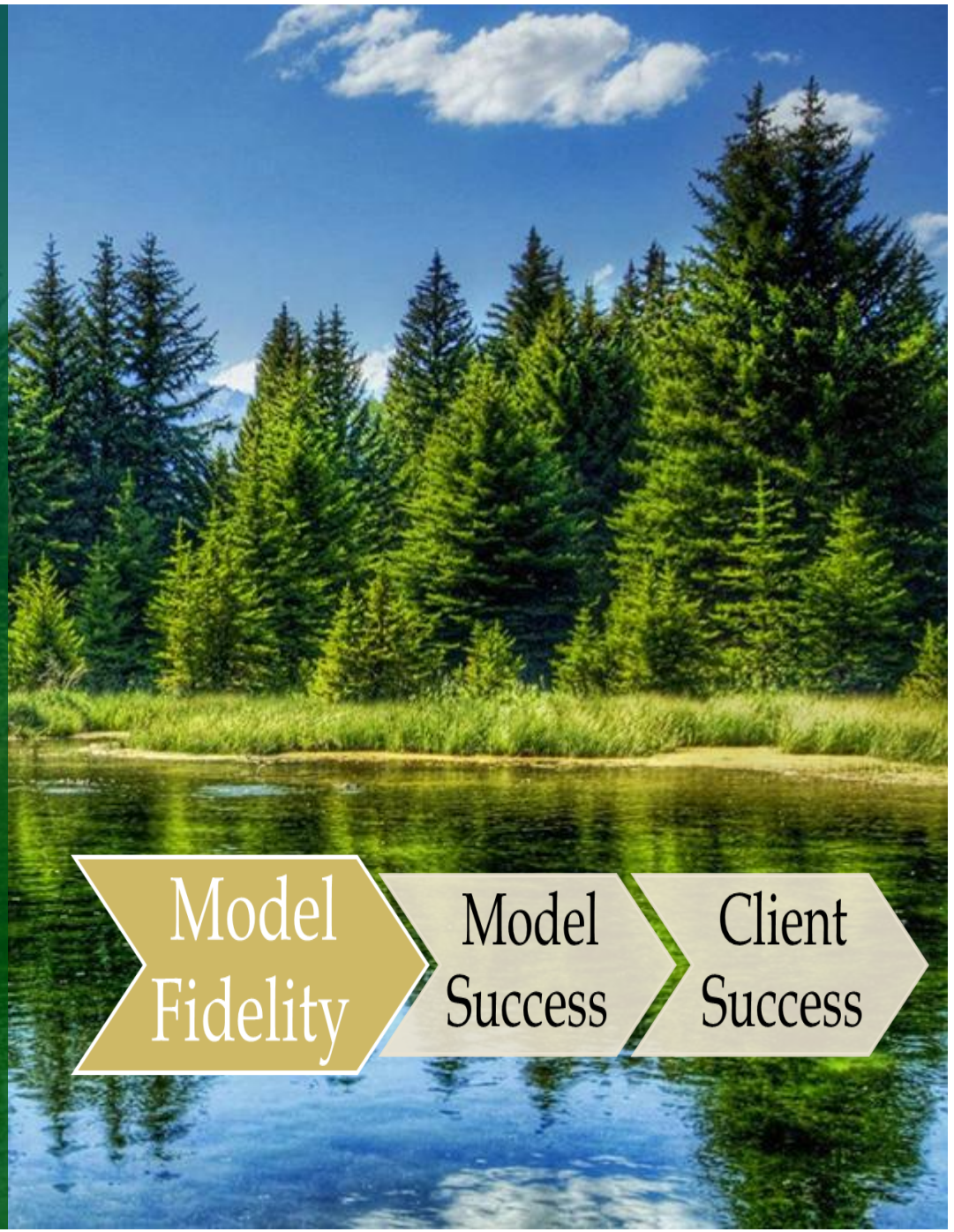
What Does a Fidelity Review Look Like?

- Lasts about two days
- Observe team meetings
- Meeting all stakeholders
- Meeting approximately 10% of clients
- Review documentation, crisis plans, service plans and other clinical tools
- Categories are scored on a maximum of 5/5

The scored elements in the TMACT are used to bring out the strengths and areas for growth of a team. Recommendations are generated but equally important is the opportunity to provide support for teams

Benefits for a team with high fidelity to the ACT model

- Reduced staff turnover
- Decreased burnout
- More job satisfaction
- interdisciplinary approach
- Shared workload
- Commitment and greater harmony
- Community of Practice
- Sharing successes and challenges
- Greater communication (daily meeting)



http://www.cnesm.org Rollins, Salyers et al.
- Staff turnover in statewide implementation of ACT: relationship with ACT fidelity

Primary Clinician

Pros and Cons to Each Approach

- Primes
  - mini-teams
  - Shared responsibility,
  - equitable distribution of work
  - equitable office time etc.

- No Designated Primes
  - All clinician functions are shared by the full team
  - Everyone is responsible for everything

There is one way to be the perfect clinician.
There are a million ways to be a good one.

Stein, L. I., & Santos, A. B. (1998)

Duties of a Prime

- Primary monitor of client functioning
- Primary source of communication to the team
- Ensures clients receive benefits to which they are eligible
- Ensure documentation kept up to date (TP, Ax, Notes etc.)
- Leads/facilitates the treatment plan
- Leads discussion with regards to their client during team meetings
- Locates and collaborates with all necessary services that cannot be provided by the team
- Ensures that client have adequate housing in the most normalized setting possible
- assuring income maintenance (impact of stress!!!)

Stein, L. I., & Santos, A. B. (1998)

Duties of a Prime

- help clients connect with appropriate social networks
- If possible be there for the important stuff (i.e. significant appointments or significant things that might be more of a struggle for your prime)
- other activities necessary to maintain health stability and in community setting

Discussion scenario on sexuality—would your team drive a client so that they could spend intimate time with their partner—how far—how often—do these questions matter?

—what if the team does not support this what could the prime do?

Stein, L. I., & Santos, A. B. (1998)

Mini Teams (you're not alone)

- Collaboration in drafting (and reviews) of the service plan/recovery plan/crisis plan
- Main providers of services
- Develop further knowledge of the client
- mini team meetings beyond the morning meeting/weekly meetings
- The psychiatrist and team leader involved in different mini-teams as needed
- Shared workload = reduced burden, reduced burn out, improved risk mitigation, improved buy in of full team

Do you have a Can Do attitude?

- Ready to take on anything
- No challenge is insurmountable
- Find answers for seemingly difficult problems
- Don’t seem to get frazzled by anything

Often you cannot do anything about negative circumstances (job loss, break up of a romantic relationship or stressful situations at work or home)

These can knock us off balance, but it is how you react that really determines how long you stay down

https://www.arvinddevalia.com/blog/2007/01/16/11-tips-to-develop-a-can-do-attitude/

You always have a choice

You can choose to see the positive side to everything and not the negative

Have you ever met someone who is always positive, and a joy to be around – someone with lots of energy, and who can see the sunny side to everything?

Possitivity and negativity are infectious! **Cultivate a strong belief in your ability to cope with whatever life may bring. You are a role model for your colleagues and clients!**

- ACT clients often live at the edge of poverty

- Every day they deal with:
  - significant, severe and persistent symptoms
  - Homelessness
  - legal issues
  - Signficiant social issues (stigma, isolation)
  - risk issues
  - Significant physical health issues
  - difficulty finding the right meds that work for their unique symptoms/physiology and sticking with them
  - needing an advocate to be a voice for them-- just to name a few

- All of these issues often require
  - complex problem solving
  - Being creative or thinking outside the box
  - persistence (what does the A stand for in ACT?)

F/ACT Clients need you to bring your A game to work every day.

- F/ACT work is rewarding **but** difficult
- F/ACT work requires that you be equally good at being able to work independently **and** effectively with a group of people
- its not for everyone
- A can do attitude can be nurtured and developed but …..

Questions to ask yourself
Is F/ACT the best career fit for me? Does it fit with my core values and strengths or strengths I would like to develop?

“Do we really do that on ACT?”

- Everyday, every staff guarantee that each client receives the needed services and supports detailed in their treatment plan
- regardless of their professional discipline/background they must perform a variety of clinically relevant activities

Yes (left hand)
No (Right hand)
Not Sure (no hands)

Now Let's play everybody's Favorite Game Show
"Do we really do that on ACT?"

1. Phoning a client to prompt them to make a shopping list, then grocery shopping with them 3 hours later during which time the clinician talks to the client about any symptom difficulties, does health teaching about diet and budgeting and gives support around a new job.

2. Assessing a suicidal client at her apartment and developing a plan with her to help her through the evening

3. Going with a client to look at an apartment after first helping him to prepare for the conversation with the rental agent so that the client makes the best possible impression

Yes (left hand)
No (Right hand)
Not Sure (no hands)

4. Making med supervision visits to 5 clients, spending a few minutes to chat with each one and assess mental status and stay longer with the last client to discuss how to deal with a noisy neighbor

5. Meeting with a client and her parents at their home to develop a plan how ACT can increase support visits while the parents take an upcoming vacation for two weeks.

Yes (left hand)
No (Right hand)
Not Sure (no hands)

6. Taking a client to a specialist appointment outside of your usual service area because no family member or other support service is able to do this.

7. Going to see several clients from the team in hospital to help clients maintain a connection with the team and the outside world and escorting them for a day pass to get belongings at their home (clients often end up in hospital unexpectedly i.e. escorted by police at 4 a.m.)

8. Sitting down with a client to formulate a pet care plan ahead of time in case a client "suddenly" ends up in hospital (if they have a dog, cat, parrot etc. someone will need to be able to care for the pet)—what if the pet care person suddenly became "unavailable" and there is no one else to do this task.

Yes (left hand)
No (Right hand)
Not Sure (no hands)

- Spending an entire day to do the following:

9. Before the court date set up an appointment with legal aid even though the client is refusing to attend
10. assist with getting a client to court on time,
11. sitting in court with the client
12. assist with finding duty counsel
13. answer any questions the client might have
14. explain all options available to the client
15. make recommendations on options to the client that you feel make clinical sense
16. support the client and respect their wishes even if they refuse to go to court or follow through with anything
17. never give up trying to convince the client of more adaptive ways of doing things

Yes (left hand)
No (Right hand)
Not Sure (no hands)

18. Provide support to a client living in a bed bud, cockroach infested apartment where the only entrance is up a rickety fire escape and past a vicious looking pit bull and a very cranky and unpleasant neighbor who hates hearing “you people” knocking on the clients door so loudly in the morning and threatens to call the police

If you answered yes to this what sorts of things would you include in your plan of care? (Text answers)
What would you do or say to try and get buy in from:
The team
The client
The neighbor
The community

Final Thoughts on “Doing that”

The question should not be:
“Do we really do that?”

It has to be:
“How can we figure out how to possibly do that” **<u>and also:</u>**

- keep team members/clients/community safe
- use resources responsibly
- not have your loved ones get mad at you for coming home late from work

If We Can And We Should Then We Must; If Not us, Who?

Homework for Session 2

- Elements of ACT work that fascinate me
- Elements of ACT work that concern me
- What I bring to my team especially
- What I expect from my team especially

Session 1 Recap

1. Intro to OAAF
2. History of ACT
3. Differentiating ACT from FACT
4. Evidence Base
5. What Makes ACT Unique
6. Model Fidelity and TMACT
7. Duties of Primes/Mini Teams
8. Can Do Approach
9. Do we really do that on ACT?

Session Two

Session Two Outline

- Teamwork
- Elements of Success
- Consensus
- Importance of Organizing
- Importance of Efficiency With Meetings
- Client Admissions and Retention
- Transition of Clients
- Protocols for Disengaged or Unable to Locate Clients
- ACT Role for Client Re-admission to Hospital
- Role of Various Team Members

Fidelity Review-Insider experience

- Excellent feedback from the reviewers (like accreditation however reviewers are experts in ACT)
- Scoring for each category is out of five and then all scores added up to give an overall score
  - 2.5 or less – Not ACT
  - 2.5 – 3.1 - Basic
  - 3.2 – 3.7 – Moderate
  - 3.8 – 4.3 – Good
  - 4.4 – 5 – Excellent
- TMACT –Does it presume that all provincial services are integrated or have funding criteria? (i.e. will the service next to yours accept your graduated clients? If your team doesn't take a client within so many days will your team lose funding – those dreaded waitlists)
- How much control does an individual team have? What flexibility is in the TMACT for Rural Teams or Hybrid Teams? Organizational limitations (collective agreements)? -Challenges of ACT life in Ont. Vs NY or Quebec

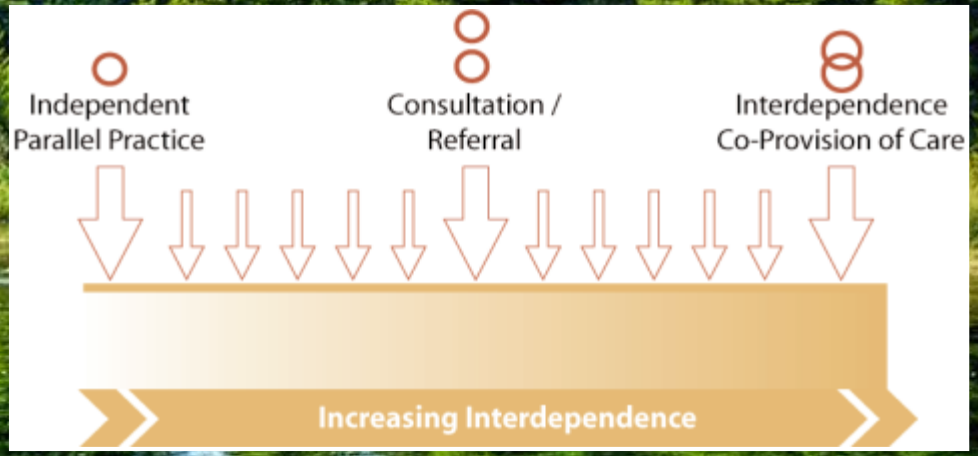
Ideal Size for a Mini Team

- From the PACT manual
  - Regular ACT team of 10 to 12 clinicians – 4 to 5 on a mini team
  - Rural ACT team of 8 clinicians 3 on a mini team

Team Work

Types of Healthcare Teams

- Independent health care management
- Parallel multidisciplinary care
- Consultative model
- Interprofessional collaborative
  - providers from different professions cooperate via ongoing communication (each other and patient/client and family) to create a plan that integrates and addresses the various aspects of health care needs.



https://www.med.mun.ca/getdoc/97ce54d8-96c5-4dea-b3f3-1ade1d2fd1b9/Types-of-Healthcare-Teams.aspx)
Canadian Health Services Research Foundation; June 2006
www.cfhi-fcass.ca/Migrated/PDF/teamwork-synthesis-report_e.pdf

Elements of a Collaborative Team

- Integrated clinical care
- Open communication
- Providers trained in team concepts
- Respect for other team members

https://www.med.mun.ca/getdoc/97ce54d8-96c5-4dea-b3f3-1ade1d2fd1b9/Types-of-Healthcare-Teams.aspx)

Challenges of an Interprofessional Team

- Different professions have very different ways of approaching their work, different priorities and use different jargon.
- key barrier can be misuse of power, where individuals use assumed authority or seniority to dominate decision-making.
- These factors can undermine interprofessional collaboration, innovation and outcomes.

Ravet (2012). From Interprofessional Education to Interprofessional Practice: Exploring the implementation gap, *Professional Development in Education*, 38/1, 49-64.

Transprofessionalism

- defined as a process of **collaboration** between two or more professionals across **and beyond** professional and discipline boundaries, such that boundaries blur and new synergies flourish

- deeper form of collaboration where professional roles, identities and ways of working are more fluid and differences are transcended

Ravet & Williams (2017). What We know Now: Education, neuroscience and transdisciplinary autism research, *Educational Research*, 59/1, 1-16.

Five Essential Ingredients For Team Success

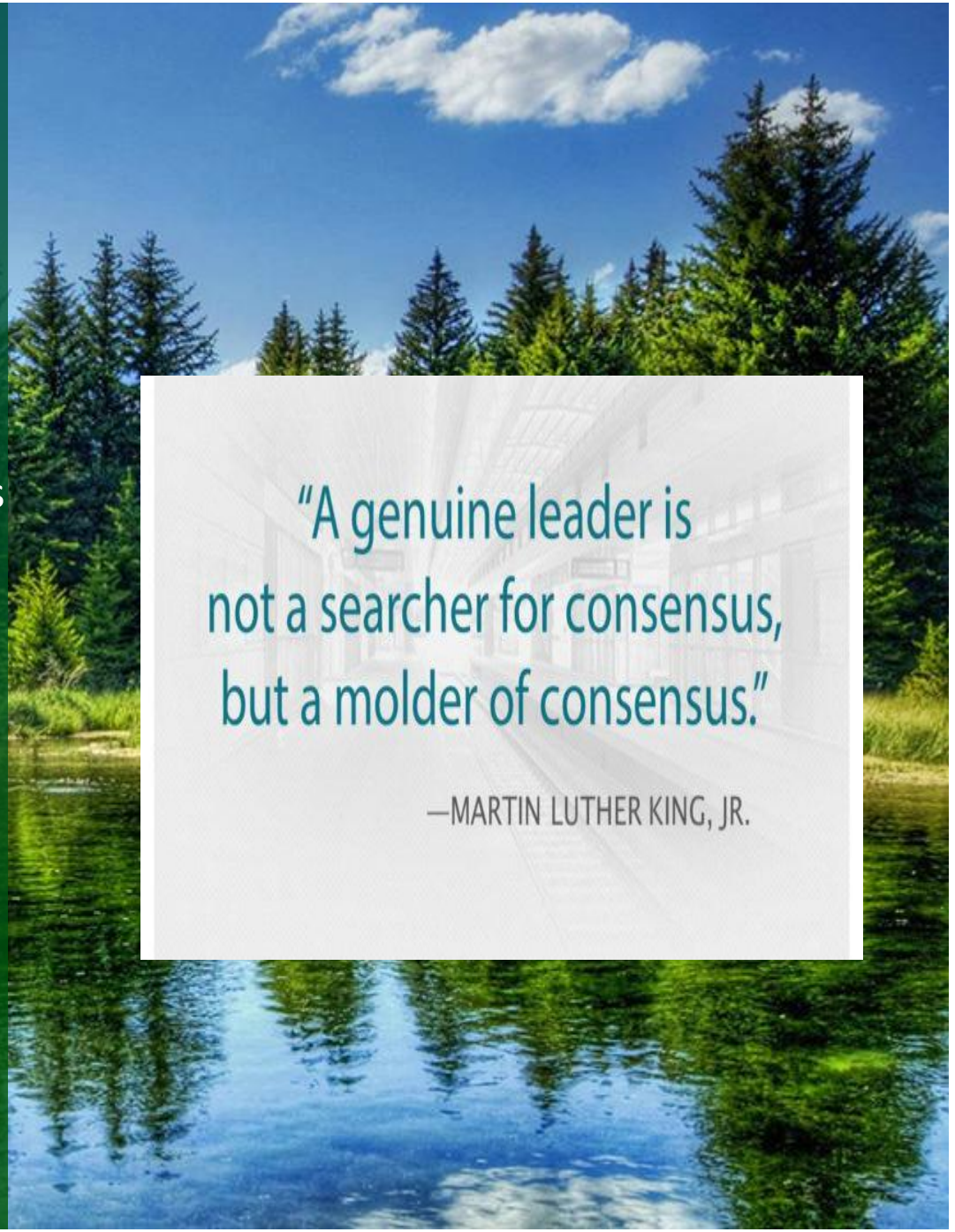
- **Role clarity**-who does what, who is responsible
- **Trust and confidence**
- **Overcoming adversity**-creative problem solving – can do approach
- **Overcoming personal differences** - putting client first-consensus
- **Collective leadership**– facilitates buy in from all team

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4530359/
Can Pharm J (Ott) 2015 Jul; 148(4): 176–179

Effective Teams Strive for Consensus

- Teams need to make decisions and solve problems as a group
- Effective decision making processes include building consensus
- Consensus = all members coming to an agreement
- Consensus Is:

- pooling opinions;
- listening effectively
- discussing ideas and differences
- not getting all you want
- an agreement that everyone "can live with " - no opposition



https://www.opm.gov/policy-data-oversight/performance-management/teams/effective-teams-strive-for-consensus/

Consensus Continued

- Consensus is not:
  - a unanimous vote
  - majority or minority rule
  - one person rule
  - bargaining

- Consensus is also not:
  - Perfect

https://www.psychologytoday.com/ca/basics/groupthink

Potential Downside to Consensus (Group Think)

- Phenomenon when a group of people get together and start to think collectively with one mind
- group is more concerned with maintaining unity than with objectively evaluating their situation, alternatives and options
- team pushes aside any data that may derail the consensus decision
- The desire to reach a consensus can cause people to ignore indications that what is proposed is a bad idea
- The group, as a whole, tends to take irrational actions or overestimate their positions or moral rightness
- Tends to occur in isolated groups

https://www.psychologytoday.com/ca/basics/groupthink
https://examples.yourdictionary.com/examples-of-groupthink.html

Real Life Example of Group Think

Collapse of Swissair in October, 2001

The **company** had been in **business** for 71 years.

Airline was once so financially solvent it was called the "Flying Bank." However, they began to believe they were invulnerable and as a result of failing to question poor decisions or explore all options and gross mismanagement, the airline eventually went bankrupt.

How can your team avoid slipping into a Group Think downward spiral?

Ask yourself – “is this decision truly the best we can come up with for this client?”

https://www.psychologytoday.com/ca/basics/groupthink
https://examples.yourdictionary.com/examples-of-groupthink.html

Homework Session 1

Elements of Act work that fascinate me:

1. The composition of a multidisciplinary team, which also works in a transdisciplinary way.
2. Working with clients over a significant period of time to enact and achieve change.
3. It is team-based approach to support those living in the community with mental health
4. We recognize recovery as a process with ups and downs, “not here today gone tomorrow.” and therefore we can adapt their support and needs through a team-based approach
5. Being able to meet with clients in the context which they live is a huge asset to occupational therapy as we can use compensatory and remedial strategies that are relevant and use their natural supports (or develop them if they are lacking).

Homework Session 1

Elements of Act work that fascinate me (part 2)

1. For me, the ACT Team is a spring board for each peer who needs to nurture themselves especially well for a certain time, acquire essential tools to go on with their goals and life projects and develop a solid network that can challenge them, encourage them and be there at the right moment for them.
2. The ACT Team is an amalgamation of key disciplines that hold hands in a circle and that presents themselves to the client/peer with a safety net, human kindness, remarkable listening skills, empathy for those who open the door to their world, tools to share to help them directly. The ACT Team invites the client and encourage them to agree to participate in the ACT Model and Peer ACT Model.
3. I remain amazed by the type of challenges that present themselves to the ACT Team, by the solutions the peers/clients find and put into place with the help of the ACT Team Workers. I am fascinated by the place the peer is able to occupy by being active in their communities. I thrive when I see a peer climb the ladder that leads to better health, a better life, accomplishment and recognition from those around him or her.
4. I love that the people around the ACT Team's table respect each one's personality, strengths and weaknesses and I love to get to know each colleague and respect them fully.
5. I love that there are ACT Teams all over the province and I believe in the importance and the strength of the ACT Network.
6. I have been with my ACT Team for the last fifteen years where I have learned a lot and I am now looking forward to the next fifteen years ahead where I will turn these lessons I've learned into lots of ACTion now.

Homework Session 1

Elements of Act work that concern me :

1. Danger of hurting myself badly or dying before my time.

2. Reproducing the “Hospital Model” at large and holding the peers as “prisoners” of glass walls in compartmented sub-communities.

3. Not being able to let my colleagues and I develop our full potential according to each one’s interest and strengths and to the situations and occasions that present themselves.

4. Having a culture that systematically diminish the peers’ accomplishments and reduces their abilities to grow and surpass themselves.

5. Being forced to face fears I have, too rapidly and before I am ready.

6. Feeling alone at my job—not being able to establish the right communication within the team.

Homework Session 1

Elements of Act work that concern me (part 2):

1. Sometimes the perception of our clients who view staff members as “family” or “close contacts” which can lead to enabling and professional boundary issues.

2. There is a possibility of burnout due to caseload overload and trying to meet client’s needs

3. It can cause team conflict due to opposing ideas when providing client supports

4. Being able to meet with clients in the context which they live is a huge asset to occupational therapy as we can use compensatory and remedial strategies that are relevant and use their natural supports (or develop them if they are lacking).

5. Sometimes I am concerned for the safety of my vehicle parked in certain spots; mostly glass/nails on the roads/parking spaces I use to see clients, occasionally there will be people loitering around who may be enticed to vandalize or attempt to break in to my car but nothing has happened to date.

Homework Session 1

What I bring to my ACT team especially:

1. My organizational skills, but also being able to view the whole person or bigger picture when problem solving.
2. Many years of frontline work with adults in the mental health sector and seniors with dementia
3. A sense of humor, and excellent consumer engagement skills.
4. A positive approachable attitude
5. Self-motivated with experience to work effectively alone or within a team
6. Enthusiasm and unbridled energy for getting things done! As an OT I have the unique opportunity to provide therapy which supplements medication or the work done by the social workers.

Homework Session 1

What I bring to my ACT team especially (part 2):

1. I bring the Peer Perspective with my communicative and pedagogical strengths. I also bring the solid experience I acquired with the challenges I surmounted and the support I have provided to close ones and a number of people along on my path in the mental health and/or addiction spheres.

2. I bring authenticity, honesty, professionalism, strong communication abilities. I am able to analyze complex situations and problems and have a large dose of Creativity in tool production. I bring with me appropriate self-consciousness, a number of project ideas, a touch of humor and leadership.

3. I communicate with fidelity my peer's tastes, true personality, moral and physical strengths, ambitions and dreams. I support each one of my colleagues according to their respective specialities and I am conscious of the flow and direction the team is taking according to the peer/client's needs and goals. I touch the areas of medication basic support, addiction's "bas-fond", dangers, working possibilities for peers and support towards obtaining employment, support in day to day activities of each one etc.

Homework Session 1

What I expect from my team especially :

1. I especially expect from my team the same respect and reaching out towards me that I tend towards each one of them.

2. I expect motivation on their part for them to thrive to flourish and grow personally like the peers-clients on our team do or work so hard to do.

3. I expect my colleagues to participate actively in creating the new face of mental health and addiction in our communities and beyond with creativity, energy and enthusiasm, synergetically.

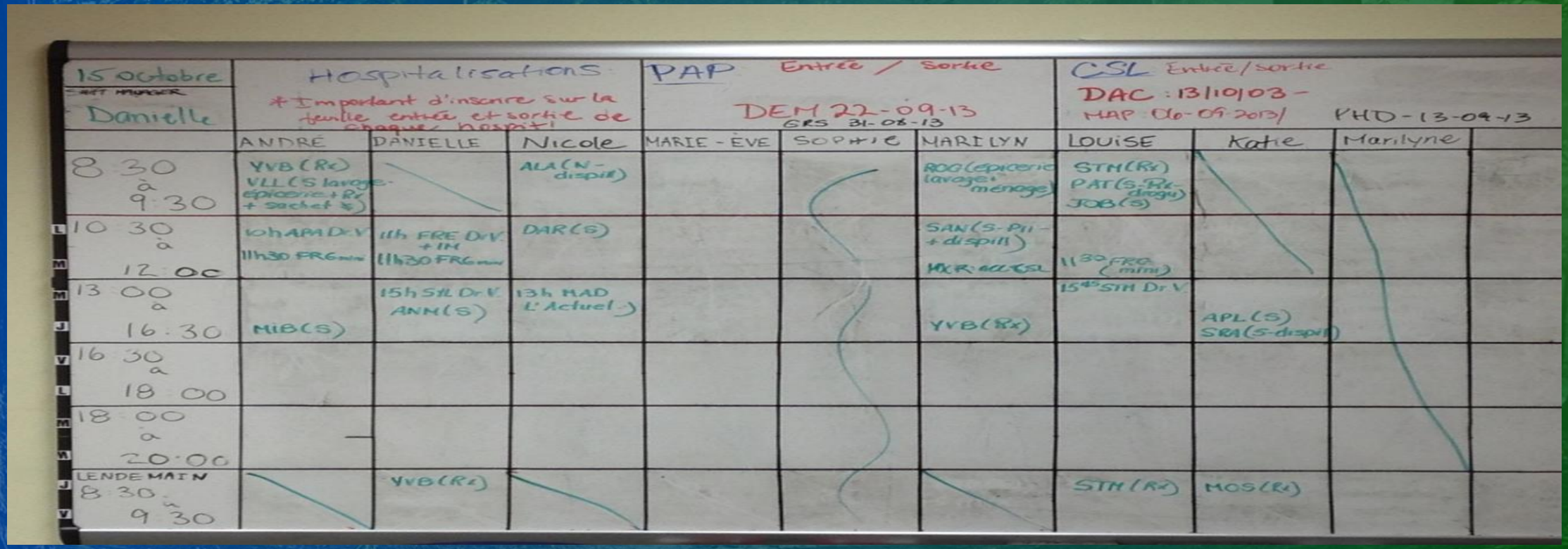
Homework Session 1

What I expect from my team especially (part 2):

1. Accountability to their roles and responsibilities not only as coworkers but health care professionals and their respective colleges.
2. Following through and communicating tasks/requests/delegations in a timely manner.
3. Being respectful each other, and being courteous and sensitive to each other’s needs and concerns.
4. Being willing to help each other instead of displaying an "it's not my job" attitude.
5. Being open to constructive feedback without being defensive or negative.
6. Being cheerful, positive and encouraging to other team members.
7. Support, equitable distribution of responsibility between members, feedback on how I can best support clients and conduct my role on the team.

Daily Meeting

Time to get organized!



Team Facilitator (not Team Lead)

Facilitates daily operations for the team and clients by:

- Provide direct support to team members including the monitoring of interventions, coordination of the daily schedule and support both in the office and field
- responding to calls and clients who have no appointments
- Taking and redirecting calls as necessary
- Triage Emergencies
- Support during a crisis or urgent needs of clients
- Communicates tasks evening shift
- Making adjustments to daily staff planner to ensure efficient and equitable division of labor
- Ensures that the tasks have been completed and report given to the team
- If shared role ? chance to get caught up on documentation/charting

Advantages of being organized

- Greater sense of equity in the team (every clinician sees what others are doing at a glance – need to ensure assignments are fairly distributed)
- Overview of needs (a page at a glance)
- Better coordination of services and effective use of resources (staff, vehicles, office time, use of team specialists)
- Helpful to have this done ahead of time in order to be quickly adjusted if need be (staff absences, last minute add on client needs, snow day)
- Ensures all client needs are met

Planning For Catastrophic Events!

Plan A
- Business as usual

Plan B
- All visits still get done
- Readjust workload
- Combine visit “runs”

Plan C
- Team Lead fills in as a regular clinician

Plan D
- Move visits to another day
- Cancel all non urgent visits using clinical judgement (i.e. focus on med drops/clozapine bloodwork, injections)

What is your plan A B C D?

Daily Meeting Agenda

- morning vs later in day
- Voice messages and crisis
- Review of visits from the day before (one minute per client)
- Clinical discussion or problem solving
- Potential safety issues
- “what information is critical for me to be aware of today and potentially for the future”
- good communication

Making Clinical Discussions Efficient

Typical day on my team (8 clinicians and 1 Team Lead)

- 30 to 35 visits in a day not including Stepped care.
- 1 minute per client visit = 35 (approx.) meeting time which includes clinical discussions and team input
- Must not sacrifice fulsome discussion
- Cultivate consensus yet avoid Group Think
- If an issue is taking a lot of time to resolve:
  - suspended until the team can gather again later in the day
  - Urgent matters might mean occasionally starting your day late
- Give examples of FACT teams and math on wasting 15 min per day

Sample Weekly Meeting Agenda

How is it going this week? Is there someone on the team that deserves a shout out for a job well done?

What do Weekend staff need to know (anticipate possible issues and or crisis)

Administrative items (e.g. scheduling, mandatory organizational requirements, education/cross training

Outreach/recruitment and flow - new admissions, possible transfers to stepped care or alternative services (ICM, FACT, Out Patient CM, Transitional Team)

Recovery Rounds (service plan reviews, mini team meetings, ATR or Assessment tools)

More in depth client review (on our team have review of clients assigned to half the primes on the team the rest discussed at next weekly meeting). Again keep discussion to 1 min per client on average

Admission of clients & Client Retention

Welcome

1. Do you know ACT admission crieteria?
2. Have you read the ACT standards?

Admission criteria

(* indicates required criterion)
Aged 18 +*
Axis I diagnosis * Examples: bipolar disorder, schizophrenia, or schizoaffective disorder
The applicant is willing to participate in the f requency and intensity of ACTT services*
Heavy system use: *
Intensive community support required: *
One or more of the following: *

- **Poor medication adherence and/or treatment resistant**
- **Severe persistent functional impairment**
- **Housing problems**

Additional factors:

- **Addictions:** Co-existing substance abuse disorder x 6 months or longer
- **Legal involvement:** In the past 2 years,
  - Substantial jail time, recurring police involvement, Not Criminally Responsible/Ontario Review Board, or court diversion/involvement

Not the best fit for Regular ACT

(possibly acceptable for FACT?) **does not include specialized ACT teams

- Primary diagnosis of personality disorder, substance abuse, developmental delay, or organic disorders (all more appropriately treated by other specialized services).
- Client is too violent, links to organized crime or has other significant risks that would impact safe community care. (modified ACT)
- Client is in long term care/nursing home or Homes for Special Care.

Active Recruitment of Clients

- Referrals should come from multiple sources, eg prisons, homeless population, community organizations, police, emergency services
- Examples of active recruitment
  - Regular liaison or visits to inpatient units, homeless shelters, police, probation, court diversion programs, local emergency departments biggest users, housing resources.
  - Other ideas?
- Admission rate to the team should not exceed 4 clients per month (? On average) in the last 6 months (24 new clients)
- This rate of admission allows the team time to ensure adequate data collection and being able to put a plan of care together collaboratively with the client in a timely manner.
- Mature team status deemed to be reached when client number reaches 60 (approx..)

Admission to the team

Transfer of care means lots of details to sort out. On your team….(please text answers to chat)

1. Who is responsible before service starts?
2. How soon after admission is a crisis plan on file?
4. When and how do your comprehensive assessments get completed?
5. When does the client meet the psychiatrist (is this a clinical decision or organization policy)?
6. Do your clients get an information or orientation package to “welcome” them to team
7. Does the client/family/significant others have a medication list?
8. Checklists or “to do” lists or admission guidelines are helpful. Your organization or sponsoring agency may have protocols for you to follow. If your team has none of these please get in touch with me.

Transition to Less Intensive Services

ACTT service may need to be long term but thinking about discharge should start at admission

1. Need to conduct regular evaluation of ACT service needs-Transition must be part of team culture
2. Specific criteria recommended (i.e. ATR, LOCUS) but should never trump clinical judgement
3. Clients should neither be pushed towards transition prematurely nor held back unnecessarily
4. Transition is gradual and individualized (planned for in the treatment plan)
5. Look at overlap service period of at least 3 months where ACT and the new service provider remain in place to ensure continuity of services and to allow for evaluation of the client
6. During this time frame re-admission to act (if needed) is done seamlessly and as a priority

Transition Discussion

1. Does your team have criteria for graduation from ACT?
2. Why would a clinician prematurely push a client towards transition?
3. Why unnecessarily hold a client back?,
4. What resources are available to your team for transition? (Stepped Care, FACT, ACT transition team, Out-patient services, ICM, family Doctor, other ideas?)
5. What is the projected graduation rate of clients from ACT? 15%? 20%? Or 25%?
6. What would happen if there were very few or no clients that graduate from ACT?

High Retention Rate For Clients

What counts as a "drop out“

- The team unable to locate client
- The client is incarcerated
- Client discontinuing service
- Transfer to a more intensive service (24/7 group home, long-term hospitalization)
- Client move that is unplanned with the team.

Note that teams should not have more than 5% “drop out” –TMACT standard

Promoting Client Engagement

- Collaborate (working in partnership, choice, empowerment, listen to them)
- Motivate (MI)
- Persevere
- Systematically evaluate (plan for possible withdrawl of service)

Protocol for Disengaged client

Client: **Client ID:**

Date of Last Contact:

Date Occurred	Steps Taken	Responsible Team Member	Outcome/Details
	Updated team regarding person's current status (i.e. identify explicit reasons for non-engagement).		
	The team has discussed, planned and utilized motivational approaches to build relationship and trust.		
	Considered whether team has different priorities than the person (i.e. What does the person want? Are their basic needs met? Are we ahead of the person?)		
	Three or more different ACT team members have attempted to engage the person (with consideration of relevant specialty roles).		
	Team leader attempted to engage the person.		
	Consulted with the person's supports that have an active release of information. Document name and contact information below ("N/A" if not applicable).		
	Emergency Contact:		
	Support #1, #2, #3		

	Landlord: Previous Provider:		
	Probation/Parole Officer:		
	Prescriber has attempted engagement at various locations in the community.		
	The team has enlisted the previous provider to encourage engagement in ACT services.		
	If applicable, the team has attempted a crisis intervention.		
	Sent person a letter regarding request for contact. (Mailed to last known address, emergency contact address, and other known addresses. Could occur simultaneously with other steps.)		
	Assessed need for and initiated additional legal mechanisms CTO, Court Diversion, ?others		
	SDM| Finances		
	SDM Treatment		
	Other steps taken based on team discussion process:		
	List any potential risks to the client/community		
	List any barriers pertinent to the issue (i.e. client refusing ACT services, client states they will do something but has not, alternative supports not available etc.)		
	List what plan ACT is putting in place and ensure all team has input including psychiatrist and manager		

Protocol Unable to Locate

Client: Client ID:

Date of Last Contact:

Date Occurred	Steps Taken	Responsible Team Member	Outcome/Details
	Updated team regarding person's current status (i.e. identify explicit reasons for non-engagement).		
	Attempted to call person at least 3-4 times per week.		
	Visited the person's home regularly without verification of person's presence.		
	Consulted with the person's supports with client consent on file. Document name and contact information		
	Emergency Contact:		
	Support #1, #2, #3		
	Landlord:		
	Previous Provider:		
	Probation/Parole Officer:		
	SDM for finances		
	SDM for treatment		
	Checked other potential community locations (in person or electronic sources).		
	Local Hospitals:		
	Homeless Shelters:		
	Nursing homes:		
	Jails/Prisons:		
	Other Agency Providers (i.e. primary health, previous provider, pharmacy):		
	Other locations frequented by the person:		

	Utilized larger agency/community process (beyond the immediate team) for discussing risk management and privacy concerns.		
	Sent person a letter regarding request for contact. (Mailed to last known address, emergency contact address, and other known addresses. Could occur simultaneously with other steps.)		
	Conducted a safety check with the landlord and police at the person's last known residence (wellness visit by police or missing person's report)		
	Assessed need for and initiated additional legal mechanisms CTO, ? others		
	Other steps taken based on team discussion process:		
	List any potential risks to the client/community		
	List any barriers pertinent to the issue (i.e. client refusing ACT services, client states they will do something but has not, alternative supports not available etc.)		
	List what plan ACT is putting in place and ensure all team has input including psychiatrist and manager		

Participation in Mental Health Hospitalizations

Close monitoring and early intervention can help prevent full blown relapse however if the client requires admission, the team is actively involved hospitalizations

- Activate a crisis plan
- Provide support in emergency
- Coordination with the natural support network
- Admission (if necessary) is quick and facilitated for client
- Team communicates with the client and staff so all know what is hoped to be achieved
- Visit regularly during hospitalization
- Actively involved in treatment and discharge Planning

The Team

Spoiler Alert!!!
All team members participate in treatment, rehabilitation, and support services

Dedicated Program Assistant

- Communication hub - triage/coordinate communication between team, clients and significant others
- Information Hub (basic information to callers)
- relieve urgent situations - temporarily manage them until other staff are available.
- Maintain records of staff time*, work schedules, order and maintain supplies*
- Inform and consult with ACT team members for the proper maintenance of the clinical client records.
- Collect necessary data and prepare reports.
- Did I miss anything important?

Team Lead

- *Directs day to day clinical operations of the ACT team* – ensures efficient use of all resources
- *Leads daily organizational/treatment meetings*
- Continually evaluates client status, plans and coordinates treatment to ensure immediate attention to their changing needs
- Directs and coordinates the client admission process
- Performs some administrative functions
- Clinical supervision/guidance of team members

Psychiatrist

- psychiatric assessments/history/course of illness/response to treatment(s), MSA/DSM 5 diagnoses
- Prescribing engaging in various forms of treatment i.e. MI, CBT, psychotherapy and support/prescribing/monitoring/teaching meds
- *Collaborates with Nurses regarding clients' physical health assessment/referrals/follow up*
- Cross training team on various forms of treatment
- *crisis assessment and management*
- *actively involved in inpatient admissions to ensure direct communication and seamless follow up*
- *Must be present weekly for a portion of the team meetings*

Nurse (RN/RPN)

- Possible blend of RPN/RN
- Minimum of 3 nurses on teams 80 to 100 clients
- Manage medication system
- Administer medications (i.e. injections)
- Monitoring physical status of clients including bloodwork monitoring in relation to psychiatric medications
- Develop strategies to facilitate med adherence *
- Cross training on medications/side effects/metabolic syndrome symptom management

A note on med drops :

They are not med administration under the right circumstances

Why is physical health promotion and monitoring so important?

Average reduction in life expectancy for clients:

- bipolar disease: between 9 and 20 year
- Schizophrenia: between 10 and 20 years
- Chronic Depression: between 7 and 11 years
- Heavy smokers between 8 and 10 years

Oxford University, 2014

Social Worker

- Counselling clients/families about severe and persistent mental illness
- Assisting clients in obtaining appropriate community resources
- Leads group counselling sessions to enhance the social development of clients
- monitoring home conditions to determine safety and promote positive living conditions, in partnership with the rest of the clinical team
- Provision of family/significant other support, restore contact, resolve conflict, and maintain relationships
- Assistance to clients with children (including individual supportive counselling, parenting training, and service coordination)

Occupational Therapist

- Individualized functional assessments.
- Problem solving for tasks associated with ADL's
- Individual assistance and support on a face-to-face basis, as needed
- Skills training
- Ongoing functional supervision (e.g., providing prompts, assignments, monitoring, and encouragement).
- Environmental adaptations to assist clients

Peer Specialist

- Able to self identify as an individual with severe and persistent mental illness (has lived experience)
- Successfully completed some form of training on mental health and recovery
- Functions to the fullest extent possible as a team member
- Coaching and consulting with clients to promote recovery and independence
- Health promotion strategies
  - Relapse Prevention
  - Building Social Networks/Promoting social skill acquisition
  - Lead a recovery focused group
  - Assist with learning skills for navigating social systems
- Cross training other team members on principles and strategies of recovery
- Individual consultations and “modeling” for team members

Addictions Specialist

- Individual consultations and "modeling" for team members
- Provide a stage-based, integrated treatment/service model that:
  - Is non- confrontational
  - considers interactions of mental illness and substance abuse
  - Engages in motivational interviewing/counselling
  - Includes counselling, cognitive skills training, community reinforcement)
  - Provides relapse prevention resources
  - Refer to withdrawal management services as needed

Vocation Specialist

- Job Development/Creation/Employer Outreach
- Skills Development/Training for Job/Education
- Skills Training on the Job
- Job Search Skills/Job Placement
- Employment Planning/Career Counselling
- Supported Education
- Supports to Sustaining Education/Employment
- Leadership Training to create and run a consumer-operated alternative business

Role of Specialists on Your Team

- Area of focus in team fidelity reviews, do you have specialists? (addictions, peer, vocation-IPS)
- Are they using their time in their field of expertise?
- If so, what does it do for clients?
- What is it that they are doing ?
- Do Clients really benefit directly or indirectly from the expertise?
- Is the expertise shared within the team? Utilized in select mini teams? Is the expertise used as a resource for Recovery plans.
- Individual consultations and "modeling" for team members

Allied Health Professionals

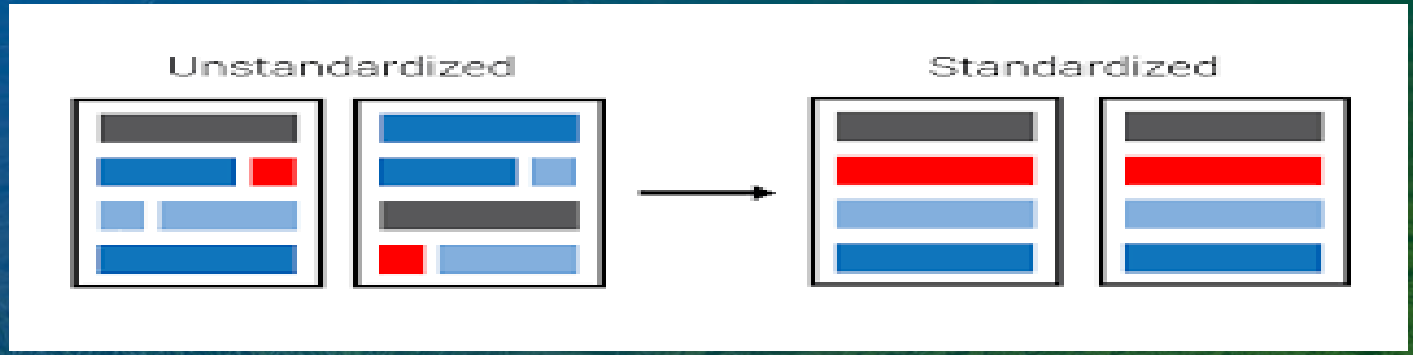
- Come with a variety educational/experiencial backgrounds
- Cultivate your personal expertise (to be the best unique you possible)
- Take on clinical leadership in your expertise while participating in all the team's tasks
- Claim your place in the mini-teams
- Take your expertise to the client
- Build close ties with community partners (monthly contact)
- Participate in cross training on the team

Session Three

Session Three Outline

- Motivational approach
- Harm reduction
- IPS
- Cognitive Behavioral Approach
- Crisis Response/Safety
- Justice Involved Clients
- Med Risk Issues
- Client Strengths Focus
- Natural Supports
- The Services in Your Neighborhood

ACT Standard Interventions and Approaches



Services Are Provided in the Community

- A majority of interventions are provided directly in the community rather than in a clinic or office
- Seeing clients in their community provides a better understanding of what the client experiences every day
- Helps clinicians tailor interventions to improve skills acquisition
- At least 75 % of face to face interventions are provided in the community

Transtheoretical Model

Stage #1: Pre-Contemplation “I don’t have a problem”
- Unaware
- Resistant

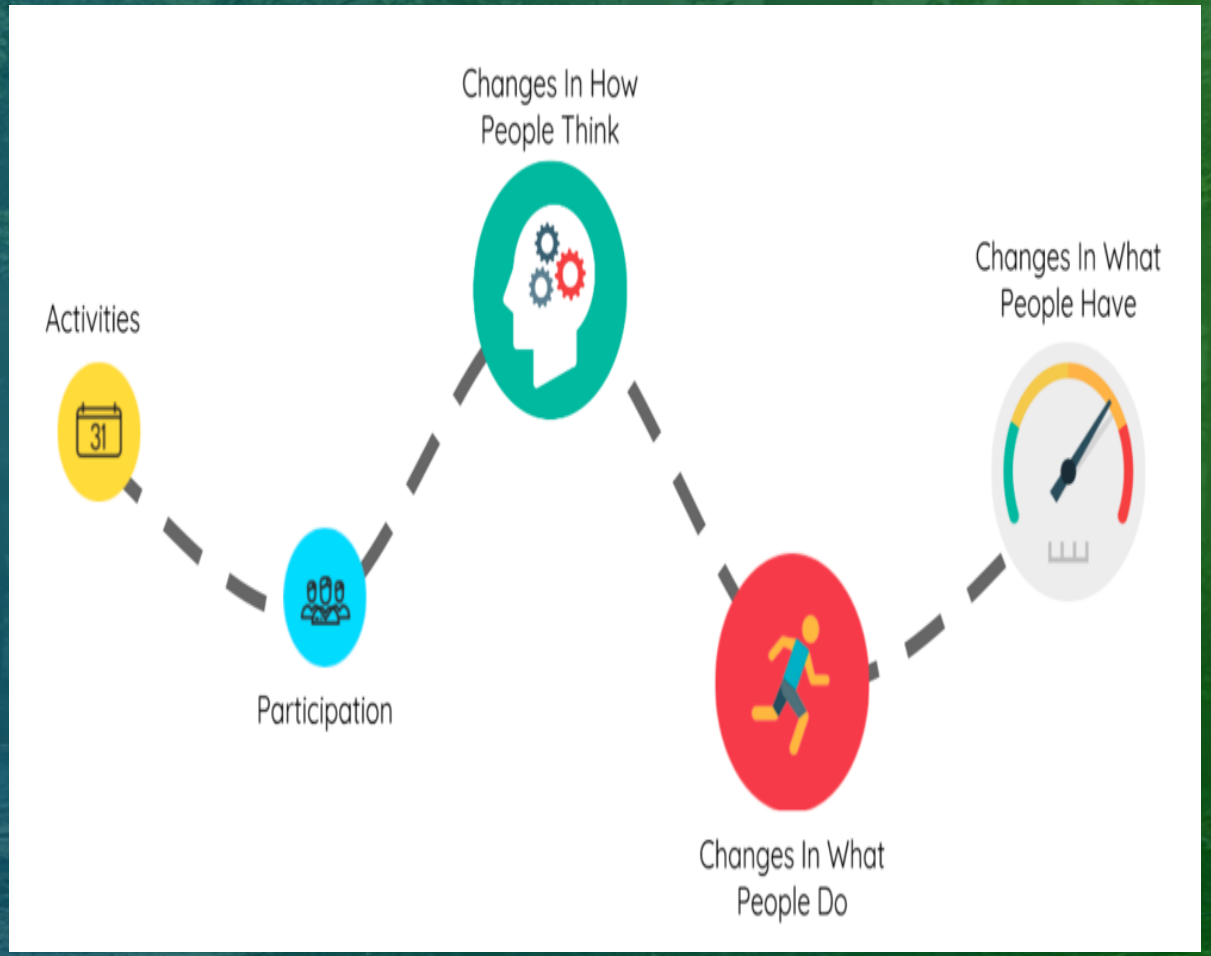
Stage#2: Contemplation “I might have a problem”
- Awareness
- Openness

Stage #3: Preparation “I will make a change”
- Anticipation
- Willingness

Stage #4: Action “I am making changes”
- Enthusiasm
- Momentum

Stage #5: Maintenance “I am living a new life”
- Perseverence
- Consolidation

EVENT: “A set back”
- SLIP, LAPSE, RELAPSE
- Danger
- Opportunity



https://srwc-mb.ca/the-stages-of-change/

Motivational Interviewing (MI)

Motivational Interviewing (MI) was developed and studied by William R. Miller, Ph.D., and Stephen Rollnick, Ph.D. According to Miller and Rollnick, "MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (Motivational Interviewing Network of Trainers (MINT) 2009).

Motivational Interviewing (MI), is evidence-based treatment, with an emphasis on substance-use disorders.

- conversational approach designed to help people discover their own interest in considering and/or making a change in their lives (e.g., diet, exercise, reducing and or eliminating the use of alcohol, tobacco, and other drugs).
- IT'S NOT JUST FOR ADDICTIONS!
- helps people acknowledge and make use of their own change-talk as a source of motivation.

https://www.centerforebp.case.edu/practices/mi

Clinician Stories About MI

Four core principles of MI:

- Express empathy
- Roll with resistance
- Develop discrepancy
- Support self-efficacy

https://www.centerforebp.case.edu/practices/mi

Integrated Model of Treatment For Concurrent Disorders

- The whole team looks at interactions between substance use and mental health problems and understands the importance of acting on both parts simultaneously
- The whole team believes in the harm reduction model (rather than total abstinence)

Do you really believe in harm reduction?

Risk of tension within the team !!

Individual Placement and Support (IPS) Model

A model of supported employment for people with serious mental illness

- Why is IPS important
  - Considered by many as an important part of recovery
  - Many people with serious mental illness want to work
  - Employment is a typical role for adults in our society

- Benefits of steady employment
  - Increased income
  - Improved self esteem
  - Improved social networks
  - Increased quality of life
  - Better control of symptoms
  - Reduced hospitalization
  - Reduced substance use
  - Reduced use of mental health services

https://ipsworks.org/

Stories About the Importance of Work

"When you are working, you are part of the real world. You feel connected. Having a job gives me stability. I have something to look forward to every day."

"In the past, people might have used labels to describe me such as 'homeless,' 'mentally ill,' and 'welfare mother.' Now my titles are 'financial administrator,' 'college student,' and 'working mom.'"

"I worried that if my daughter got a job, she would feel stressed. But just the opposite happened. She is doing much better than before."

Principles of IPS

- **Open to anyone who wants to work** (not excluded because of diagnosis, recent hospitalizations, criminal justice, or work readiness criteria)
- **Focus on any type of employment including competitive employment** (not steered into sheltered jobs)
- **Rapid start to job search** (as soon as client expresses interest, assessment/training kept to a minimum, job search at a comfortable pace)
- **Targeted job development** (Based on client interests, IPS specialists build relationships with employers to learn about the employers' needs in order to identify qualified candidates)
- **Client preferences guide decisions** (preference, strengths, and work experiences, not on a pool of jobs that are readily available)
- **Individualized long-term supports** (as long as needed and desired, help with job changes/career advancement, additional schooling and training)
- **Integrated with treatment** (same as concurrent disorder)

https://ipsworks.org/

Group work on ACT:
Critical element of developmental scaffolding

Crisis Response

- Team helps client resolve the crisis in the shortest time possible and in the least restrictive environment
- ACT acts as gatekeeper for hospitalizations
- close monitoring and early intervention can help prevent full blown relapse
- Good crisis intervention begins with proper assessment- clients may not disclose
  - Is there relevant context to what might be happening
  - Going to the client's environment may contain clues
- If safe to do so, attempt to intervene during a crisis or at least follow up in person the same day or next day if the crisis occurred overnight.
- hospitalizations can not always be avoided
- Form 1, 2, 47 (if on CTO) – Involuntary adm up to 72 hours for assessment

Stein & Test, 1980
https://blg.com/en/News-And-Publications/Documents/Publication_4649.pdf
Practical Guide to Mental Health And The Law in Ontario

Crisis Dissemination

- Situation so hot, client must leave the immediate environment - re-stabilization can be quick
- Place to stay for a few days to allow things to cool down at another home could be very useful

What could you do to help this client?
What local resources might you use?

Crisis Dissemination

- Consult with your team
- Why using local resources makes sense over admission to hospital
  - Hospitals are expensive
  - Stays in hospital make reintegration back into their home/community more difficult
  - A normalized solution, client can stay working or going to school or engaged in usual activities
- Cultivate local relationships
  - Crisis Beds/Shelters (?allow for reservation of a bed or facilitate use if they know ACT involved, offer safe place to store belongings etc.)
  - Local Hotel manager - ACT staff assures bill will be paid and that ACT staff available 24/7 in person or by phone if there are any problems
  - Is there someone willing to look after the cat? (family, friendly co-tenant)

Crisis Dissemination

- Ensure all client needs are addressed during the “temporary” situation i.e. food, meds, clothing, cat care issues
- ACT can increase supports to daily visits
- Psychiatrist to assess – is there more to paranoid symptoms than stress induced
- Client/ACT can meet with the landlord (discussed what was witnessed, what the issues appear to be, problem solving approach rather than accusatory, support to empower the client for this situation but also possible future ones, does the client really want to stay)
- Formulate a plan with Client as to how long she can stay in temp housing, what the plan would be for return or assist with finding new housing
- Meet with informal supports (family, friends, co-tenant) to plan for alternative coping if there are future crisis so that everyone is on the same page.
- Revise your written crisis plan

Crisis Dissemination 2

- Team discussion to prioritize issues to be addressed
- Landlord cares – good resource, frequent check ins, good line of communication
- Think outside the box – police, family, friends, PGT, others? (support the supports)
- Can significant others help with either monitoring or helping?
- ACT can assist to ensure rent paid on time, extreme clean service, weekly support to ensure client gets back on track with cleaning
- Increase Act visits, med monitoring, Act Pyschiatrist in to assess
- Take a closer look at possible drug use – toxicology screen, visit by concurrent specialist
- What might be the impact of stress and or drug use?
- Review crisis plan
  - What have we tried?
  - What have we learned?

Your Team's Crisis Response

- Does your team do your own crisis response after working hours?
- Do your clients have easy access to crisis response (wait times, any sorting or passing off of calls?)
- Is there a crisis plan available for crisis response that is brokered out?
- How soon after service start is a crisis plan made?
- Does your team have capacity to respond to a crisis in person during working hours? If the crisis happens after hours, how long before a team member is able to follow up?

Suicide
Risk Factors

- Previous attempts
- hopelessness
- Living alone
- male
- Age between 15-24 or > 65
- Chronic pain
- psychosis
- alcohol/drug abuse
- Family history of suicide
- Recent losses

Does your team/organization have standardized suicide risk assessments, protocols, professional practice guidelines?

Justice Involved Clients

People with mental health issues can often end up in the legal system

- Role of police and MH specialty units
- Role of courts and forensic system
- Court diversion
- Fitness assessment
- Court ordered Treatment
- NCR
- Mentally Disordered Offenders

Justice Involved Clients

FACT: Going to jail or prison demands a massive adjustment in a person's outlook and behavior

FACT: The coping skills developed in jail or prison are often difficult to give up when a person leaves those settings

FACT: It's important for providers working with justice-involved individuals to understand the culture of incarceration

FACT: It's important for providers to recognize the challenges faced by these individuals when leaving incarceration environments and arriving back at community clinical settings

FACT: people with mental health difficulties and legal issues face a double stigma (criminal and mental health)

Community Mental Health in Canada. Simon Davis. UBC press. 2006

Medication Risk Issues

Neuroleptic Malignant Syndrome

- Combination of hyperthermia, rigidity, and autonomic dysregulation (blood pressure up and down, tachycardia, fever…) that can occur as a serious complication of the use of antipsychotic drugs. Sweating, confused, tremor, rigidity, SOB…
- ANY antipsychotic can do it (even atypicals) and even after a period of being stable on it (although rare)
- Young males more suspectible
- The most widely accepted mechanism is that of dopamine D2 receptor antagonism, in different other areas in the brain, thus influencing a variety of physiological functions
- Can result in muscle necrosis and rhabdomyolisis and then renal failure
- A similar syndrome also has been associated with the rapid removal of medications with dopaminergic properties (eg, in patients treated for Parkinson disease).

Medication Risk Issues

Serotonin Syndrome

- Clinical emergency
- Occurs when the dose of a serotonergic agent is increased or another is added (not only SSRIs, can be other agents)
- Onset is hours to days
- Management:
  - D/C serotonergic agent
  - Supportive therapy
- Altered Mental State
  - Confusion→ disorientation→ coma, seizure
- Autonomic Nervous System: “autonomic instability”
  - Hyperthermia, diaphoresis, tachycardia, high blood pressure
- Neuromuscular
  - Hyperreflexia, tremor, rigidity

Clozapine

- SIDE EFFECTS

  - Agranulocytosis – incidence 1% (80% in the first month of treatment), b/w monitoring for safety

  - Myocarditis – inflammation that enlarges, causes scar tissue and weakens the heart. Can lead to heart failure (symptom chest pain). Clozapine contraindicated in patient with severe cardiac disease or family history of heart failure

  - Constipation (can be life threatening if it progresses undetected, untreated)

  - Orthostatic hypotension is often the limiting factor of therapy in the elderly

Lithium

- THERAPEUTIC OVERDOSE
  - Due to deliberate or accidental ingestion of drugs
  - Usually due to accumulation of lithium due to some change in patient status
  - Below normal salt intake or below normal water intake
  - Can cause irreparable damage to kidneys = dialysis
- Symptoms:
  - Nausea, vomiting, diarrhea, tremor, confusion, arrhythmias, convulsions

When caught early, lithium toxicity is often treatable with extra hydration and reducing your dosage. However, moderate to severe lithium toxicity is a medical emergency and might require additional treatment, such as stomach pumping.

https://www.healthline.com/health/lithium-toxicity#outlook

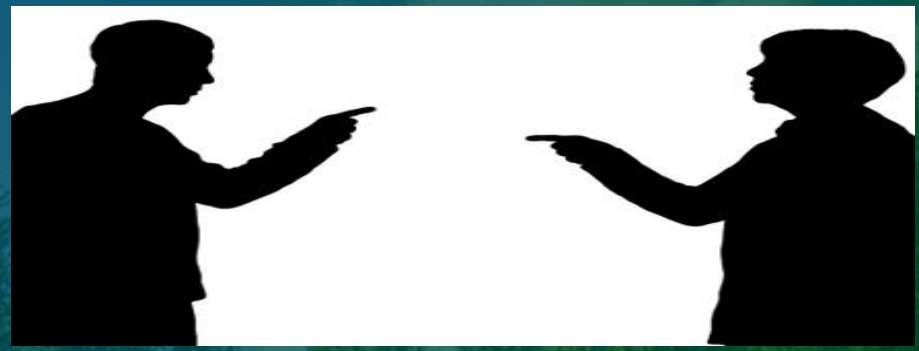
Clinician Safety
Get to Know Your Client

- Develop therapeutic Rapport (trust and respect)
- Complete your comprehensive assessments ASAP!
- Establish working relationships with the client's additional community supports and regularly communicate with them
- What are the client's goals (powerful motivators)
- Client strengths
- coping strategies (successful and less than successful ones)
- warning signs
- behaviour changes
- Any areas of concern
- Signs of stressors
- Signs of substance use

Clinician Safety
Remember Safety Basics

- Cell phone (keep it charged, keep it on, keep it within reach)
- Call ahead (does client know of visit, chance to assess client)
- Speed dial for office, other team members cell, 911
- Screamer device
- ID badge? Pros and cons
- Does your team do visits in pairs?
- Visit in community or safer place rather than client's home
- Visit with police escort?
- Does your team do clinician check ins? Frequency? How- app, cell?
- Safeword
- Does your sponsoring agency offer a standardized training (with community focus) that is updated regularly?

Clinician Safety
More Basics



- Reschedule or immediately terminate visits if:
  - There is a threat or actual verbal, physical and/or sexual violence
  - Signs of alcohol intoxication or drug influence with client or others in the home
  - Physical environment poses a serious imminent risk to health and safety (fire, asbestos, part of building appears to be ready to collapse)
  - An animal is believed to be a threat to your safety and the client is unable to secure them during a visit.
  - You are asked to leave – you are a guest in their home, their community
  - If you have reason to feel unsafe or threatened

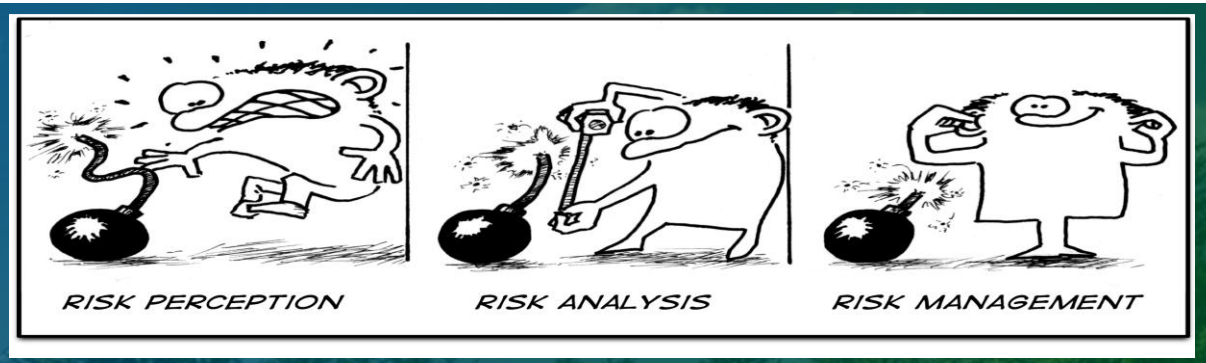
Do team members feel "safe/supported" in raising reasonable potential safety issues? How would your team respond to one that seemed unreasonable by many?

- Resources/problem solving
- What is embedded as team culture

Risk and Team Approaches

- Is there an immediate risk to the client? To the community?
- What is the primary clinician vs team responsibility with regards to promoting health/safety?
- Is there a plan? Who owns the plan?
- Are there resources that have been overlooked?
- Is there a competency assessment for a client with regards to housing choices?

Risk Mitigation Process/Plan

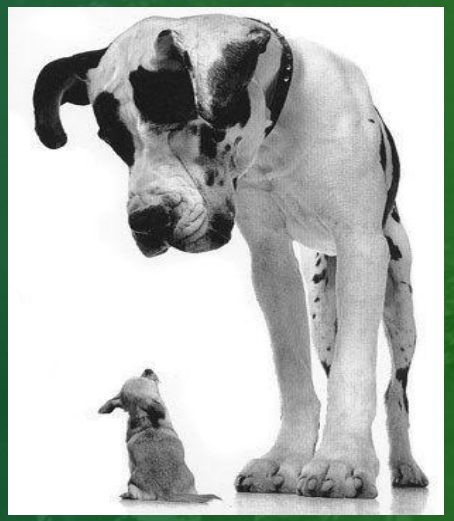


- Consult with the Team ASAP and then document (Service plan or crisis plan can be used)
- Include the following in your documentation:
  - Explain any potential risks to the client/community
  - List any barriers pertinent to the issue (i.e. client refusing ACT services, client states they will do something but have not, alternative supports not available etc.)
  - List what Act has tried (what was the team in problem solving)
  - List what plan ACT is putting in place.
  - Ensure that the entire Act team including psychiatrist and Manager know and have the chance to provide input
  - Are there other organization resources that you can access (i.e.risk management department or ethicist)

Client Empowerment/Choice Or Client Centered

- Ensure clients actively participate in all aspects of their recovery
- Clients are not simply the receivers of treatment. They have opinions about proposed treatment, planned interventions and how their care is organized.
- Clients have the power to solve problems themselves (or to learn how this can be done more adaptively), to overcome obstacles and make/reach their goals.

Assertive Approach



- Needs to be tenacious but non-coercive
- Interventions based on client choice, interests and preferences
- Mutual Respect (keep ears open for client reluctance and respond accordingly)
- Build a trusting relationship (meet client where they are at, work in partnership and get client buy in)
- Make clients aware of their rights
- Involve clients in positions of power (advisory committees at local and provincial levels)

Service frequency and Intensity

- High intensity of services as needed
- Minimum of 2 hours per week on average per client
- 3 contacts per client on average (can be daily initially and can be reduced down to once per week when clients are approaching readiness for less intensive service)
- Frequency of contact is more important than the duration however the quality of the contact must be present (clinicians must be focused on helping clients meet their goals and objectives)

Natural Supports

Every Family Has A Story to Tell.

Stories from Family Members

The serious mental illness of a close relative is a catastrophic event for families.

In the words of one family member -
"This terrible illness colors everything—a family cannot escape."

All family members are affected by a loved one's mental illness.

"The entire family system needs to be addressed. To assure us that we are not to blame and the situation is not hopeless. To point us to people and places that can help our loved one". The impact never goes away.

Families generally serve as the first and last resort for their relatives, often with little professional guidance. In the present era, families fulfill crucial roles as primary caregivers for relatives who reside at home, as informal case managers who advocate for their relatives with service providers, and as crisis intervention specialists who handle relapses and emergencies.

The Family Experience of Mental Illness : Implications for Intervention By: Diane T Marsh &Dale L Johnson
Professional Psychology: Research and Practice. Vol.28 (3) US : American Psychological Association pp. 229-237.

Natural Supports

Stories from Family Members part II

In response to their relative's mental illness, most family members experience a powerful grieving process as well as numerous intense emotions, including shock, disbelief, anger, despair, guilt, anxiety, and shame. This mother conveys the anguish that family members may undergo in response to the mental illness of a close relative:

“The problems with my daughter were like a black hole inside of me into which everything else had been drawn. My grief and pain were so intense sometimes that I barely got through the day. It felt like a mourning process, as if I were dealing with the loss of the daughter I had loved for 18 years, for whom there was so much potential. “

The Family Experience of Mental Illness : Implications for Intervention By: Diane T Marsh &Dale L Johnson
Professional Psychology: Research and Practice. Vol.28 (3) US : American Psychological Association pp. 229-237.

Natural Supports

Stories from Family Members part III

Family members sometimes feel as if they are riding an emotional roller coaster, their ride punctuated by the alternating periods of relapse and remission that often characterize the course of mental illness. These cycles create considerable turmoil for family members, who often experience intense distress when renewed hope is shattered by yet another relapse, as the following mother conveyed:

“When things are going well, you begin to hope and dream again about a better future and when things fall apart, it is like a small death. You are more vulnerable for having dared to hope again”

The Family Experience of Mental Illness : Implications for Intervention By: Diane T Marsh &Dale L Johnson
Professional Psychology: Research and Practice. Vol.28 (3) US : American Psychological Association pp. 229-237.

Contact with natural supports (supporting the supports)

- With the client or with the client's consent, the team provides support to significant others such as family, friends, landlords, employers etc.
- At least one contact with natural support on a monthly basis for at least 90% of clients (TMACT)
- Entire team works in partnership with natural supports by:
  - Provide education on illness and symptoms
  - Teach problem solving strategies to address difficulties caused by the disease
  - Individual support and direct them to support groups available in the community

How Can You Ensure This gets done?

- appoint a team member to monitor these contacts
- Ensure the contacts are listed in the service plan or Kardex or client intervention calendar/planner
- Open door policy for significant others
- With client consent ensure significant others are invited to attend service planning conferences
- Other ideas?

What Are the Services in your neighborhood?

- Housing
  - municipal or regionally sponsored,
  - mental health related,
  - homelessness initiatives,
  - shelters men/women/tansgender/nonbinary gender versus shelters for women with children or abused women or culture/religious affiliation shelters
- Provide assistance to find quality housing based on client need but also respecting client choice (applications, wait lists, supported vs independent)
- Respect for the privacy of room-mates or visitors within the home (couch surfers)
- Be proactive (timely access to decent, affordable housing that client's choose)

What if a client chooses to live in a bed bug infested, apartment where the landlord is known to take advantage of clients?

Neighborhood Services Continued

- Soup Kitchen, food bank
- Identification clinics such as John Howards society
- medical clinics - Nurse Practitioner clinics
  - psychiatry for follow up,
  - laboratories (cbc, antipsychotic monitoring b/w)
  - pharmacies that offer no charge dispensing fee/free blister or bubble pack
- Addiction supports
  - methadone clinics
  - safe needle or safe crack pipe programs
  - counselling, groups, residential treatment, day programs, withdrawal management detox programs, concurrent disorder programs-Easy access to all programs within Ontario

Neighborhood Services Continued

- CMHA or similar types of mental health services (housing assisted/supported vs independent, drop in centers, skills building programs, client run business i.e. catering

- case management, out-patient
- vocation supports, sheltered workshops
- ODSP and ODSP benefits
- Landlord Tennants ACT/Landlord Tennant Tribunal
- Fire marshall
- Public Health services
- police mental health unit, court diversion, legal aid
- Consumer/Survivor initiatives/programs
- cultural resources

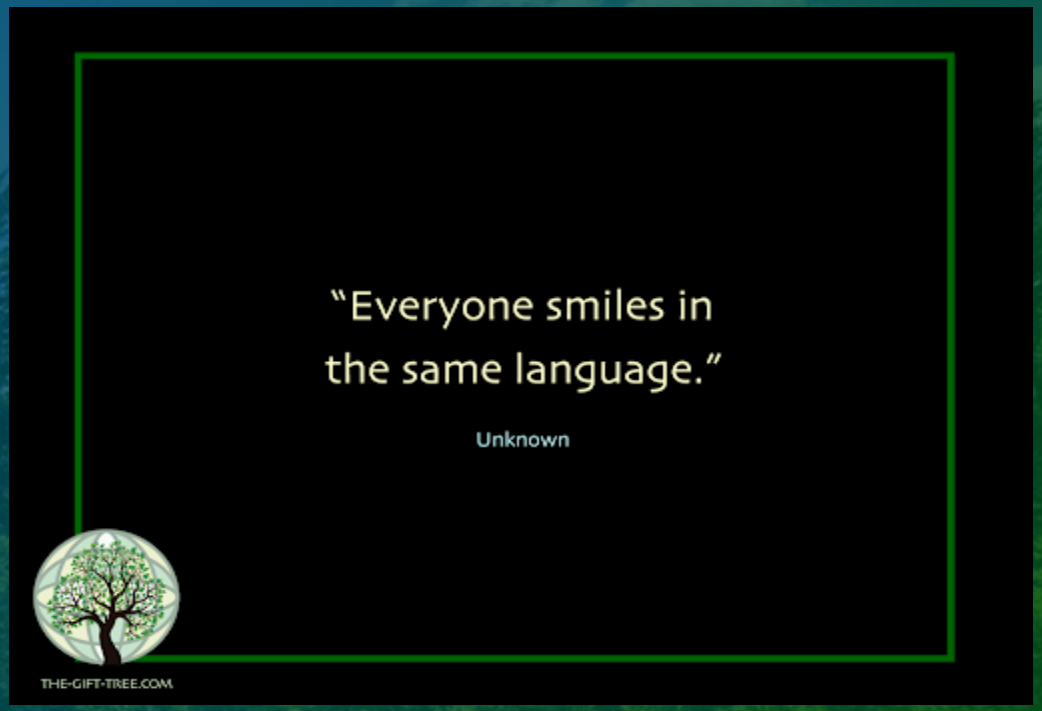
1. Is there some sort of referral or admission criteria (i.e. certain age, certain diagnosis, can only use the service so many times in a month/year etc.)
2. How can you refer someone to the service (i.e. is it drop in, form to be filled out, an interview, can the person refer themselves or does some sort of health professional have to make the referral etc.)

Session Four

Session Four Outline

- Cultural Competence
- Trauma Informed Care
- Ethics and Decision Making
- Service plan
- Recovery Oriented Plan
- Recovery Plan

Cultural Competence



A set of attributes that allow us to work successfully across cultures

- Specific Competencies
  - specific knowledge of a certain language or ethnic community
  - many diverse ethnic groups in a large multicultural society make it impossible to become familiar with every single one in depth

- Generic Competencies

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

Cultural Competence

- Generic Competencies

Skills include approaches to interviewing such as….

- Begining from a position of curiosity and not being afaid to ask questions about a person's background and beliefs
- Interviewer tolerates a certain degree of ambivalence and ambiguity, allowing the person to express themselves
- Do not jump in too soon with closed-ended questions/answers
- Do not make assumptions without checking with the client.
- Generic competence allows clinicians to go a long way without knowing the intricacies of every cultural group
- Specific information can always be sought (consultants, research)

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

What about non-verbal communication?

- Head shaking- is this a universal sign for yes or no? Canadian Inuit peoples raise their eyebrows to indicate yes, scrunching of the nose to mean no
- Eye contact - Ethiopia and parts of Asia, avoiding eye contact is a sign of respect not shyness or low self esteem
- Silence points in conversation is normal in some cultures -don't fill in these points with more talking
- Non verbal expression of emotion can vary widely across some cultures -need to have a cultural consultant to determine normal ranges of emotion.

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

Cultural Key Points

Even if a client speaks some English, having an interpreter available at times can be helpful (good communication important for accurate assessments and building therapeutic rapport)

Obtain collateral history when possible

Don’t jump too quickly to diagnose delusions (need to rule out culturally accepted beliefs or religious ideas first).

Don’t assume that clients will have an ethnic match with a clinician (ethnic communities can be a source of support but also stress – stigma/shame of mental illness with some cultures)

During an illness episode, assessment is best carried out in a familiar environment (home, community) as hospitals are foreign to some cultures.

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

Cultural Key Points

- Working with families is very important
- Family dynamics carry more weight in the social structure of many cultures than in Western society, where the focus is more on the individual
- Regardless of background, involving family members is important for the outcome of treatment

Clinical Considerations

The major categories of mental illness including psychosis, anxiety and affective disorders are universal therefore clinicians can expect there to be more similarities than differences when dealing with a major axis I diagnoses. Schizophrenia – thought disorder, delusions and hallucinations can be similar however thought content may be very different. i.e. Ethiopian man from a Muslim background may describe particular beliefs about having the special power to see good and evil in the world. Asking questions such as "Is it common for the people at your mosque to also have these beliefs, or are you the only one?" may help to elucidate between culturally acceptable religious beliefs and delusional process. Male in 30's living at home with parents can be the norm with some cultures (careful not to diagnose with dependent personality traits)

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

Myths

I need to act the same way as the client to be accepted. Just be respectful and professional- Your patient knows very well whether you are from their culture

I could never ask that question. Don t avoid certain areas because of ideas you have about a cultural group – any topic can be approached if you are tactful and respectful. Use a preamble to explain why you are asking certain questions

I have to know that culture very well before I can be helpful. You dont have to pretend to know everything beforehand. Acknowledge your limitations and ask questions.

Myths

If I speak louder maybe they'll understand. Volume is not correlated with increased understanding of English. Try to speak clearly and slowly, and ask one question at a time--don t use compound questions

An interpreter is only there to translate words. An interpreter is not a machine. They need to be treated as part of the treatment team, with briefings and debriefings before and after the interview. They might also provide some valuable cultural context – need to be allowed provide input beyond just what the client is saying.

Psychiatric Clinical Skills, D. Goldbloom, Ed. Mosby Elsevier 2006, Philadelphia USA

Trauma Informed Approach

"one does not have to be a therapist to be therapeutic."

4 Assumptions of the Trauma Informed approach: "The 4 Rs"

- A program, organization, or system that is trauma-informed:
  - Realizes –widespread impact
  - Recognizes – S &S of trauma with all involved in MH system
  - Responds – full integration of knowledge
  - Resists Re-traumatization

https://www.centerforebp.case.edu/client-files/events-supportmaterials/2015-0115_RPHVideoConference.pdf

Key Principles Of Trauma Informed Approach

6 KEY PRINCIPLES:

1. Safety throughout the organization – staff/clients, physically/psychologically
2. Trustworthiness and Transparency – building/maintaining with clients/families
3. Peer Support – utilizing their stories to promote recovery/healing
4. Collaboration and Mutuality – partnering/leveling of power
5. Empowerment, Voice and Choice – history of diminished voice/choice, staff facilitate rather than control recovery
6. Cultural, Historical, and Gender Issues – organization moves past stereotypes, recognizes and addresses historical trauma

https://www.centerforebp.case.edu/client-files/events-supportmaterials/2015-0115_RPHVideoConference.pdf

Key Principles Of Trauma Informed Approach

Exposure to trauma can affect many areas of one's life and can increase the risk of a range of vulnerabilities

Relationship Problems

Social Alienation

Low Self-Esteem

Physical problems

Difficulty Thinking Clearly

Difficulty with Feelings

Body Issues

Sexual Challenges

https://www.centerforebp.case.edu/client-files/events-supportmaterials/2015-0115_RPHVideoConference.pdf

Ethics

- Mental health work may mean some interference with the liberty of individuals
  - Involuntary admission to hospital
  - Competency to consent
- Right to refuse versus coercion – ACT, CTO
- Risk to self or others in the community – goal is risk mitigation as opposed to risk elimination which is practically impossible in the community
- Societal law as a starting point for ethical discussions but often does not cover the complexity of issues faced with F/ACT clients living in a community setting

Does your organization have an Ethicist?

Does your organization have an ethical framework clinicians can use to help with decision making?

Ethics

How would you react if……

- Home visit and client presents to the door almost naked
- Client asks to borrow money
- Client wants to give you money
- Client wants assistance with purchasing illegal cigarettes
- Client asks for transportation to go buy groceries but buys beer (only has little money and you know the client would be buying heroin if not spending their money on beer)
- Client smokes in the home and it bothers you
- Client gives you information and tells you not to tell their family or the team
- Client starts using drugs in front of you
- A team decision is hard for you to accept based on your personal values

Possible Solutions to Ethical Dilemmas

- Clear team/organizational policy or guidelines
- Ability to discuss at earliest team meeting
- Transparency of team members to each other and client
- Team consensus, cohesion and respect for the decision made
- Avoid any form of splitting
- Ethics resource (i.e. ethicist or ethics committee, ethical decision making tool)
- Creative solutions
  - team newsletter on not smoking during clinician visits
  - items such as bringing a client to purchase beer or regular reminders to be appropriately dressed for ACT visits in the Intervention plan
  - with the consent of your organization, put in welcome to the team newsletter some information about limits on keeping information private, drug use during visits etc

Possible Solutions to Ethical Dilemmas

"Sometimes there is no such thing as a good solution. Sometimes teams only have undesired options before them. In these cases teams have no choice but to put forth a decision that is the least undesirable"

Frank Wagner

Ethicist, Ontario Shores Centre for Mental Health Sciences, and University of Toronto Joint Centre for Bioethics Asst. Professor, Dept. of Family and Community Medicine Asst. Professor, Dalla Lana School of Public Health

Service Planning

Why so much confusion with terms?

- **Individual Service Plans**
- **Recovery Oriented Service Plans**
- **Recovery Plans**
- Multidisciplinary Plans
- Interdisciplinary Plans
- Action Plans
- Wellness Plans

What Is A Service Plan?

- A plan for treatment which tailors service activity and intensity to meet the treatment, recovery and support needs of the client
- Individualized to the client (comprehensive assessment, OCAN) with input from the client (preferences) and with client consent input from significant others
- Continuous (typically revised a minimum of every six months however should be revised whenever clinically indicated to meet day to day needs and not wait for the next scheduled review)
- Format for the plan is agency specific but will include who does what, when, where and how along with client goals clearly listed. May also include other information (age, diagnosis, relevant history etc.)

A Manual for ACT Start-Up; Allness and Knoedler 2003

What Is A Recovery Oriented Service Plan?

- Corresponds to the same definition as the Service Plan
- Incorporates specific actions enhancing the values and principles of the recovery model
- It is NOT a Recovery Plan.

Principles to Promote Recovery

- Involve the client (and significant others with client consent) in making decisions about the plan of care
- Acknowledge the person's potential taking account their views and preferences (goals)
- Inform the client (significant others with client's consent) of the team's opinion and recommendations about the situation and the nature of the care/services that are being offered (reflection of current situation, the needs identified)
- Develop SMART goals (Specific, Measurable, Attainable, Realistic and Time-sensitive) that support recovery priniciples. Consider the priorities, strengths and resources in the development.
- Consider how to incorporate natural resources available in the client's environment

What to do After Your Recovery Service Plan is Complete

- Ensure that the client is in agreement and satisfied with the plan
- If necessary, make revisions that respect the views and preferences of the client
- If possible, get the client to sign and date plan – formalizing commitment, approval, buy in (may be organizational limitations)
- Give a copy of the plan to the client
- In partnership with the client, measure the efficiency and impact of the plan during regularly scheduled reviews

Challenges of Writing Service Plans

"I don't have a mental illness"

"I don't want the help of an ACT team"

"I am the king of Canada"

"I want to become a lawyer"

"I do not want anything. I don't have any goals"

Other Challenges

- Difficult to engage the client or the client refuses to participate
- Clients who wants delusional content or illegal activity included as part of their service plan
- Finding the time to discuss/plan/evaluate interventions with mini-team
- Trying to address large number of goals, resources or needs (complexity)
- Trying to get buy in from Family/significant others
- Prioritizing goals vs holistic approach

Recovery Plan

- A format for tools that individuals can use to self manage their mental illness and guide their recovery process.
- The plan is made by and for the client themselves
- The client decides who may be involved as resources (family, friends, caregivers or others)
- ACT clinicians are responsible to help clients become aware of what tools are available

Basic Elements of a Recovery Plan

- Goals, objectives, personal priorities
- Strengths and resources
- Significant daily activities that facilitate maintaining wellness
- signs of relapse
- Strategies and resources the client wishes to engage in crisis
- Identify people around the client that are significant

https://www.youtube.com/watch?v=3qtBiPvSdkY&feature=emb_rel_end

https://mentalhealthrecovery.com

Sample Recovery Plan Format

Client Name: Date:

My Toolkit: **(Things I can do to feel better every day)** **1.** **2.** **3.**	**Skills Maintenance Plan:** **(what I have to do to so I continue to feel better)** **1.** **2.** **3.**
Relapse Triggers: **(circumstances or things that may contribute to make me feel worse)** **1.** **2.** **3.**	Relapse Signs: (Subtle changes in my thoughts, my attitude and behavior) 1. 2. 3.
When Im Not Functioning Optimally- Supports **(I can still manage my daily activities but I need more support)** **1.** **2.** **3.**	Crisis Situation – signs/resources/things I can do/Things I need others to do (I am unable to adequately manage my daily activities and I need the help of others to manage my well being) 1. 2. 3.

These are the people that I can contact if I need to talk or need help and support

Name	Phone Number

Focus on Strengths When Creating your Planned Interventions

They are clothed with strengths and dignity and they laugh without fear of the future based on proverbs 31.25

- Focus on strengths of the person and not on deficits or difficulties
- Strengths and resources identified in all assessments and reflected in the objectives and interventions of the proposed treatment plan
- Strengths Based Focus is fully integrated into care provided
- Everyone has the ability to recover and regain control over their lives
- Primary clinicians are responsible for co-ordination of services
- The therapeutic alliance is based on a relationship of trust, absence of coercion and clinicians encouraging clients to develop their own personal power
- Interventions are in the client's natural environment (in vivo) – their home, their community
- Promote optimal use of community resources

3 Pespectives for a Recovery Oriented Service Plan

- Client
- Team
- Client/Team

Client's Focus

Need	Current situation	Strengths	Goal	Interventions	Revision Date
Housing	Nothing to report		I have no goals at this time on this issue		

Teams Focus

Need	Current situation	Strengths	Goal	Interventions	Revision Date
Housing	Client is living in an unhealthy living environment but wishes to stay despite risks.		Improve client's living condition	-Contact the landlord of the apartment and inform them of the situation and explore ways that they can help make things work (i.e. banning guests in the apartment). -Notify police of possible illegal activity (drug sale).	6 months
	Client is refusing to allow the team to talk to the landlord likely in the context of being psychotic		Reduce client's health risks	Use a harm reduction approach during visits where the client appears to be open to discussing substance use. Have the team Concurrent disorder specialist set up weekly appointments to meet with Jennifer. -Offer support to attend a medication information group	

Client and Team's Shared Focus

Need	Current situation	Strengths	Goal	Interventions	Revision Date
Housing	Client loves their apartment despite feeling uncomfortable and facing possible eviction For now, despite team intervention, the client refuses to allow the team to contact the landlord or to consider moving	Client has housing that they love Client feels empowered enough to be able to refuse	Client to agree to allow the team to speak with the landlord to discuss what can be done to avoid eviction	-Ongoing health teaching regarding the risk to health -Explore with Jennifer the reasons for ambivalence -With Jennifer's consent, try to develop a relationship with the brother to facilitate further dialogue and buy in from the brother.	6 months

Patricia Benner