

Commissioner's Policy Statement No. 33

Individualized Recovery Planning

In accordance with Section 17a-542 of the Connecticut General Statutes, as well as Federal and Joint Commission standards, regarding each person's right to individualized care and the provision of informed consent, it is the policy of the Department of Mental Health and Addiction Services that all services to be provided shall be based on an individualized, multidisciplinary recovery plan. Pursuant to Connecticut law, this process shall recognize that all individuals served by DMHAS, including those receiving inpatient services, are presumed to be competent and retain all of their civil rights to make informed choices about their own care unless they have been declared incapable by a court of law or unless such rights are specifically limited by law. Service providers shall not take coercive or retaliatory action against a person because the person has exercised his or her civil rights. The individualized recovery plan is thus to be developed in collaboration with the person receiving these services, advocates of the person's choice and others that he or she identifies as supportive of this process, with provisions to ensure that they have the opportunity to play active, meaningful roles in the decision-making process and to provide informed consent to all aspects of the plan. The person is encouraged to provide his or her goals and treatment preferences before the plan is developed. All changes in the recovery plan and the rationale for the changes shall be documented in the person's record. Service providers shall offer outreach and engagement services and client contact to the fullest extent possible for persons who refuse treatment.

The multi-disciplinary, individualized recovery plan will incorporate treatment, service, or care plans required by other bodies (e.g., CMS), and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, interests, goals, and preferences in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life. Whether a person has a psychiatric disability or an addiction, focusing solely on deficits in the absence of a thoughtful analysis of strengths leads to disregarding the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. The individualized recovery plan will thus be based on a strengths-based assessment that allows providers to balance critical needs that must be met with the resources and strengths each individual possesses, at that time, to assist in this process. Typical examples of the life context issues that may be addressed in the plan include education, employment, housing, spirituality, social and sexual relationships, legal issues, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, the multidisciplinary team will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative staff, peer providers, and relevant community representatives and/or others identified by the person.

When carried out in the context of acute inpatient psychiatric care or detoxification, the recovery planning process will view these treatment facilities as providing an essential, if time-limited, foundation for the person's future efforts toward recovery. As such, services to be provided within these facilities will identify and address, in addition to those elements described above, the precipitants to the person's admission and those elements of community-based care, supports, and activities that will be required to foster or sustain the person's recovery following discharge. To this end, discharge planning, including the identification of housing options, is to be initiated on admission and is to take into account, and address, any pending legal issues, potential needs for specialized assessments, or other potential barriers to discharge that the person will encounter as the acute episode resolves. Admission to inpatient facilities, regardless of projected length of stay, also must involve an assessment of the person's preferences for preventing and/or dealing with potential episodes of behavioral dyscontrol, as described in Commissioner's Policy No. 22F: Patient Personal Safety Preferences for Preventing and Managing Behavioral Dyscontrol.

To facilitate continuity of care across levels of care and over time, discharge planning is to include the active participation of those community-based providers who were working with the person prior to admission and those who most likely will be working with the person following discharge. As elaborated in detail in the person-centered planning principles attached, the inclusion of any parties in this process in addition to the person and his or her facility-based treatment team is contingent on the person's agreement, including his or her permission to release and/or obtain information from these parties unless a legal exception or requirement provides otherwise. In the case of individuals who have guardians or conservators of person, the agreement and consent is to be obtained from this person as well. Permission of the conservator or guardian is not required, however, for the person to authorize his or her advocate or attorney to be involved in the recovery planning process or to be provided with any relevant information under a release signed by the individual.

While inpatient or detox care can provide an essential foundation for recovery for individuals in acute distress, recovery planning is based on the recognition that for most people, most of the time, recovery involves the process of establishing or reestablishing a meaningful and gratifying life in the community. The primary focus of recovery planning, therefore, is on what services, structures, and/or supports the person desires and needs in order to establish and maintain a safe and healthy life in the community. Even in the case of prolonged hospitalization or residential addiction treatment, the primary focus of the person's recovery plan needs to continue to focus on the services, structures, and supports the person needs and desires in order to live successfully in the least restrictive environment possible. To the degree possible, the primary function of any institutional milieu should be to offer an opportunity to assess the person's capacities and needs for living successfully in the least restrictive environment possible and to equip the person with the skills, compensatory strategies, and other resources he or she will need in order to do so.

Given this community focus, one tool required for effective recovery planning is an adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis in relation to each person's interests, talents, and needs. Historically falling under the

purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal behavioral health system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based providers rather than with inpatient staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient and outpatient staff will be required to obtain and integrate this information into individualized recovery plans. Regardless of how it is obtained, a

comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

No person is to be discharged from a program, unit, or facility without ensuring that the person has been provided with a reasonable opportunity to develop adequate plans to obtain services and supports he or she will need following discharge. This shall include, but not be limited to, assuring that timely applications are submitted to establish an individual's eligibility for public benefits, medical assistance, and subsidized housing. For continuity of care and recovery planning to be maximized, it is preferable for the person to make connections with such services and supports prior to leaving the program or unit. This can be accomplished in a number of ways, including making scheduled visits, transitional meetings, phone contact, etc.

In addition to services and supports, discharge planning necessarily entails attention to the person's living situation and to the possibility of a continued need for a safe recovery environment. Given the importance of stable housing to sustaining recovery, it will be a goal of every provider to assure that the individuals they serve, including those being discharged from inpatient or residential settings, reside in the least restrictive, safest, and most dignified recovery environment with appropriate supports. The staff's primary role in this respect will be to explore and provide information to the person about available options for housing, services, supports, and resources following discharge, assuring that the individual's preferences are given full consideration. As it is with most other healthcare decisions, it will then be up to the individual—in consultation with staff and his or her natural supports—to make choices about which of these will be useful in his or her continued recovery. For such choices to be meaningful, staff are responsible for informing and educating the person about what realistic options are available and within what timeframes, and also for anticipating barriers, delays, and other difficulties so that alternative backup plans can be developed. Discussions about exploring and weighing

different options, and the person's responses to them, are to be recorded in the person's medical record so that there is adequate documentation of this process.

Finally, an emergency shelter will not be considered by providers to be an acceptable permanent housing disposition following inpatient psychiatric care. Rather, individuals who have yet to acquire stable housing and who continue to require a safe recovery environment will be offered opportunities to move to transitional housing or other supportive environments in which they will be offered assistance in continuing to pursue stable housing and recovery supports. In the rare circumstance that an individual receiving inpatient or residential care refuses all reasonable options and is determined to no longer require that level of care, the options offered and the basis for the person's refusals will be documented, the person will be advised of his or her right to access advocacy services, and the DMHAS Medical Director will be consulted in development of an appropriate disposition. This includes those circumstances in which a person expresses the desire to remain in a hospital setting despite staff assessments that the person no longer requires such an intensive and restrictive level of care. If it is documented that an individual has made an informed and voluntary decision to be discharged to a shelter, a motel, or another temporary setting, the person retains the right to pursue that option and to continue to receive services, supports, and assistance in obtaining more stable housing.

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Commissioner