Writing a Quality, Person-Centered Integrated Summary

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Agenda for Meeting

- Reviewing elements of a quality integrated summary
- Identifying the links between the assessment, formulation/summary, and person-centered plan
- Writing a comprehensive summary based on the complete assessment

Breaking down the PCRP Process

1. Orientation and Intake to the Team
2. Pre-Planning: Education and Preparation
3. Strengths-based Assessment/Formulation to Inform the Plan
4. The Planning Meeting
5. Co-creating the Plan
6. Evaluating Progress
7. Maintaining the Record

3:Strengths Based Assessment and Formulation

A plan is only as good as your *assessment and understanding* of the individual…

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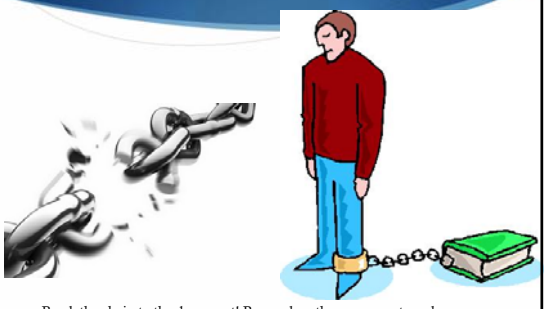
Assessment at a Glance

- Assessment…
  - initiates the helping relationship and therapeutic rapport
  - is an ongoing process (not a one-time event!)
  - involves comprehensive domain-based data gathering across multiple life areas
  - balances the identification of barriers with the **exploration of strengths**
  - solicits information from multiple disciplines as well as the person in recovery and natural supporters/ collateral contacts (where permissible)

Assessment at a glance

- Takes time and a trusting relationship
- Comprehensive domain based data gathering - attending to cultural factors throughout
- **Considers stage / phase of change process**
- Must be a reciprocal dialogue – not an interrogation
- Explore strengths beyond the individual
- Expand what we value as a "strength"
- Explore what has worked for them (or peers) in the past, e.g., WRAP
- Be creative in HOW we ask questions

(For more information, see Tondora and Davidson, 2006; Van den Berg and VanDenBerg, and Grealish, 1996; Rapp, 1998)



Break the chain to the document! Remember, the assessment can be non-linear and it is not necessary to follow the format of the FA verbatim or in sequence

Non-linear

- Review assessment ahead of time to be knowledgeable of content
- Gather information wherever, however it comes up. For example, during "How do you spend your day", work may naturally come up. Or, during developmental milestones, it may become clear that the person received special education.
- Fill in these 'already answered' questions as you go to minimize repetition, saving time and helping build a relationship through careful listening.
- One place to 'break the chain" and to shorten assessment time is the Mental Status Exam
  - Many of the items can be observed in casual conversation and noted during/after the assessment (e.g., affect, mood, attitude, appearance, judgment)

Assessment – Not a passive process

- Your role is to help rebuild hope and access dreams of the person
- Share your inspiration and creativity, as well as your knowledge of resources
- At the same time, balance your own aspirations and hope for the person with their current readiness to change
- Various factors may have led to 'giving up' on a person's previous aspirations
  - Have they been told "you'll never work again"
  - "You will bring shame to your family"
  - "You don't want to push yourself too hard"

How does all the assessment information come together to inform the plan?

- Data collected in assessment is by itself *not sufficient* for treatment planning
- Data must be woven together in a cohesive understanding of the whole person in the Case Formulation or **"Integrated Summary"**
- This requires some skill, experience, judgment, and practice!
  - Fact-finding often feels easier than interpreting/ hypothesizing!

From Assessment to Understanding: Integrated Summary

- Moves from the **"what"** (facts only) to the **"why"** (i.e., how you make sense of the data.)
  - Informed by both the person's understanding as well as by your professional opinion
  - Information in summary should have a direct impact on the plan
  - Recorded in a chart narrative – in CSP in the "integrated summary"
  - "shared" with person served

A well-written integrated summary is the BRIDGE between the data/assessment and the plan!

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*One way of Putting together an Interpretive Summary

- **Central theme of the person**
- **Interrelationships between sets of findings**
- **Needs, strengths, limitations**
- **Clinical judgments regarding the course of treatment**
- **Recommended treatments**
- **Level of care, length, intensity of treatment**

***CARF Accreditation Standards**

And another…

I. Cultural identity of the individual

II. Cultural explanations of the individual's illness

III. Cultural factors related to the psychosocial environment and levels of functioning

IV. Cultural elements of the relationship between the individual and the clinician

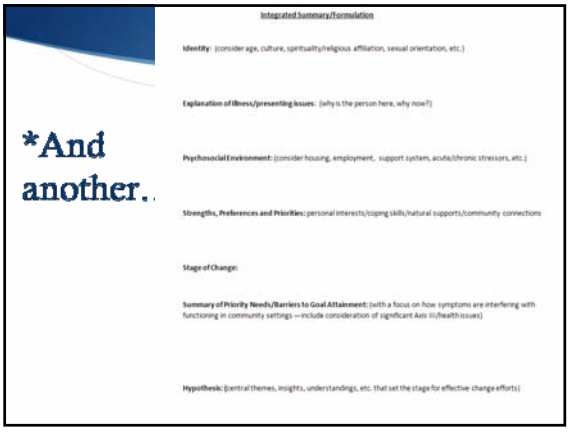
V. Overall cultural assessment for diagnosis, care and the working relationship)

* Cultural Formulation of the DSM-IV

And another…

- *Do not duplicate the information provided earlier in this document. Instead, provide a brief narrative summary and analysis that blends the findings and opinions of the interviewer(s) and the preferences of the person/family into a concise synthesis. Describe the origin of the presenting problem(s), severity and factors contributing to its continuation, where the problem occurs (home, work, in community) and whether it is short or long term. Describe the significance of the problem(s) in the person's cultural and developmental context. Summarize the person's motivation for treatment and support, readiness for change, potential barriers to change and preferred learning style(s). Finally, assess person's strengths and assets that can be leveraged to make progress toward the person's goals.*
  - **State of MA, CBFS Documentation Guidelines**

*And another..



Integrated Summary/Formulation

Identity: (consider age, culture, spirituality/religious affiliation, sexual orientation, etc.)

Explanation of Illness/presenting issues: (why is the person here, why now?)

Psychosocial Environment: (consider housing, employment, support system, acute/chronic stressors, etc.)

Strengths, Preferences and Priorities: personal interests/coping skills/natural supports/community connections

Stage of Change:

Summary of Priority Needs/Barriers to Goal Attainment: (with a focus on how symptoms are interfering with functioning in community settings — include consideration of significant Axis III/health issues)

Hypothesis: (central themes, insights, understandings, etc. that set the stage for effective change efforts)

*And another…

- ***P*ertinent history (*brief*)**
- ***P*redisposing factors**
- ***P*recipitating factors**
- ***P*erpetuating factors**
- ***P*revious treatment and response**
- ***P*rioritization by person served**

***Adams & Grieder, 2004**

Prioritization As An Important Step in the Logic of Building Recovery Plans

- Individuals often have multiple needs and goals. Addressing too many things at one time can make the plan feel fragmented and efforts can be diluted across too many areas.
- Work collaboratively with the individual to PRIORITIZE.
  - Takes into consideration need for efficiency/targeted focus
  - …& a balance between client/professional perspectives
- During this process, we must balance what is "important TO" the person with what we feel might be "important FOR" them.

Important To vs. Important For: For more information,
See the Work of Michael Smull, The Learning Community for Person Centered Practices

Balancing Priorities in the Plan

Important *TO* the Person **Personal Perspective**	**Important *FOR* the Person** **Professional Perspective**

• Meaningful relationships
• A home/place of my own
• Valued roles/purpose
• Independence/Self-determination
  • Cultural/personal preferences may impact
• Faith/spirituality
• A job/career
	• Basic health and safety
	  • Reduction of clinical sx
	  • Maslow's basic needs
	  • Harm reduction
	  • Management of risk issues
	• Legal obligations and mandates
	• Community Safety

A Modified – Guiding "Ps"

- **Pertinent history:** e.g., personal; psychiatric; & legal, cultural, work, family, children
- **Predisposing factors:** e.g., trauma history, head injury, co-occurring medical issues, family hx/dynamics
- **Precipitating factors:** e.g., What led to current admission or involvement?
- **Perpetuating factors:** e.g., What factors contribute to repeated adverse outcomes??
- **Previous treatments and responses:** e.g., A synthesis (not a chronological listing) of adverse and positive responses to range of previous treatments
- **Protective factors: e.g., strengths/assets that will improve person's chance of achieving stability and recovery**

Linking the P's to the FA

- Pertinent History – can draw from sections of the FA
  - History of Present Illness
  - Developmental/Personal History
  - Family History
- Predisposing Factors – can draw from FA sections:
  - Family history
  - Trauma Screen
  - Employment
  - Trauma hx
  - Medical hx

Linking, cont'd

- Precipitating factors
  - Look across all domains, but particularly social support, employment, medications, substance use, change in family/social network
  - May be clear from presenting complaint
- **Perpetuating factors**
  - **Clinical (professional) hypotheses** on how past history has perpetuated problems in living; links between sets of data findings. These may be tentative, especially for first admissions
- Previous treatment and response
  - What has the person found helpful? See section in Behavioral Health Background.

Linking, cont'd

- Protective factors
  - Look across domains – may require reframing experiences to pull for resiliency/survivorship (i.e., despite long history of sexual abuse by a family member during childhood, Marinda was able to complete through 11th grade in school).
  - See strengths checklist
  - Include community supports and social supports; cultural affiliations and/or traditions
  - Work history and educational background
  - Developmental history
  - Leisure activities and interests

Why is it important to go beyond the data??

- Assessment data may have multiple references to a person not using medication effectively and the consequences of this behavior. In the Integrated Summary, we often note that a "long history of medication non-compliance in the community has led to repeated hospitalizations."
- This is NOT Formulation but rather, a mere re-stating of the data/facts. The task in Case Formulation/Integrated Summary is to try to understand **WHY** the person is not using meds effectively as a tool in his/her recovery.
- This formulation/understanding may take the plan in very different directions.

WHY Does the Person Not Use Meds?

- Person is concerned re: side-effects: exploration of meds with different side-effect profiles; consultation with nutritionist to get support to off-set weight-gain; family-based interventions to help couples deal with sexual side-effects
- Person does not believe they have an illness/believes meds are poison: trust-building; motivational approaches; psycho-education; peer specialist engagement interventions; empathic understanding
- Person has religious objections to taking medications; has cultural preference to use alternative healing strategies: collaboration with faith-based or cultural healers; integration of alternative strategies along-side traditional treatments/me in plan
- Person experiences stigma re: use of psych meds; family/others have advised them not to take it: family-based interventions; peer support; exposure to positive recovery role models
- Person becomes disorganized/can't track complex med schedule: cognitive remediation; occupational therapy consult to develop compensatory strategies to promote organization

An example, Roberto

ASSESSMENT DATA

- 26 year old, married Puerto Rican father of 2
- Highly successful pre-military experience; first to graduate HS
- Iraqi war veteran; honorably d/c
- Emerging sx of PTSD following witnessing of assassinations
  - Family conflict; hypervigilance; substance abuse; sleep disturbance, inability to work; distressing flashbacks
- Back injury; chronic pain
- Estranged from wife and kids; moved back home with parents
- Fam hx of MDD, suicide; pt had referral for counseling in HS

INTEGRATED SUMMARY

- Core themes of shame, loss, guilt
- war trauma has exacerbated a likely underlying vulnerability to depression
- ideas about being "macho,"pride/ self-sufficiency/ "family provider" role likely influenced by cultural, spiritual, and military values and traditions
  - Deepen feelings of guilt and failure over current situation
  - May impact ability to seek MH tx and also preference in provider
- Contemplative stage of change
- May be using substances to alleviate back pain and/or to maintain social connection with vet friends
- Priority is to regain valued role as provider for family

Writing an Integrated Summary

- Take the data from Roma and write up the Integrated Summary
- If needed, one group member can informally take on the role of Roma and respond to questions about her wants, preferences, history, or any additional information that would inform your understanding
  - Identify one person to write up the Formulation
  - Identify one person who will present your work to the larger group
  - Be prepared to:
    - Talk about the process
    - Discuss any problems you encountered

Questions and Comments

- Your experiences (personally and with staff?)
- What would you like to know more about?
- What would be helpful in terms of supporting staff to write brief, quality summaries?
- Would an outline/structure be helpful?
- Thank you!!