Seeing Me: Principles of Recovery-Oriented and Person-Centered Service Planning

Presented by:
Laurie Curtis, MA, CPRP
And
Carole Taylor, MSN, RN
May 14, 2008

Community Care Recovery Institute’s 2007-2008 Winter/Spring Teleconference/Webinar Series
Community Care

Community Care Behavioral Health Organization (Community Care) is a non-profit, federally tax-exempt, behavioral health managed care organization (BH-MCO) that manages behavioral health services for nearly one million members in Pennsylvania whose health coverage is sponsored through Medicaid, Medicare and commercial plans. It is a subsidiary of the University of Pittsburgh Medical Center.
About Community Care Recovery Institute

Under contract with Community Care, Pat Deegan, Ph.D. & Associates and Advocates for Human Potential, provide consultation and training to support the initiative implementing recovery-oriented, consumer-directed services in the communities it serves, known as the Community Care Recovery Institute (www.recoverylearning.com ).
UPCOMING EVENTS!

http://www.ccbh.com/aboutus/events/

• May 28  A Day of Self-Discovery
  Sponsored by Community Care
  William Pitt Student Union
  University of Pittsburgh, Pittsburgh, PA

• June 5  Managing Recovery: The Role of Medical Treatment and Medications
  Sponsored by Community Care
  The Inn at Heritage Hills, York, PA
Training Abstract

Service planning is central to mental health service delivery for many reasons: fiscal, clinical, and legal. But perhaps the most important outcome of effective service planning is to help individuals craft roadmaps for personal recovery. This 90-minute workshop will explore the principles and challenges of recovery-oriented and person-centered service planning. Laurie Curtis will offer practical examples and guidelines for putting the person back into the process and seeing service planning as an opportunity for building relationships, exploring possibility, and helping individuals to engage in services that are meaningful and helpful for their personal recovery.
Abstract (continued)

Carole Taylor will review Pennsylvania licensing standards for treatment plan development. Carole's presentation will include detail about the current rules and regulations for treatment planning, domains, and information regarding goals, objectives, and methods. This Webinar will also discuss timeframes and member involvement in the process as required by regulation.
Laurie Curtis, MA, CPRP, is a consultant and educator on best practices in community mental health services and supports for people with psychiatric disabilities, with an emphasis in the areas of recovery-oriented services, consumer empowerment, consumers as colleagues, and alternatives to coercive treatment. She is an expert in program development and evaluation and curriculum design. Laurie helped develop the policy document, “A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults” for the Commonwealth of Pennsylvania.
Event Speaker

Laurie has provided consultation and training in over 35 U.S. States, 3 Canadian Provinces, Australia, and New Zealand. She is on the Core Faculty of Southern New Hampshire University, Program in Community Mental Health, and has provided professional development workshops on a range of topics relating to psychiatric services, community support, recovery from psychiatric disability, and ethics in services.

She is currently a member of a work group developing a new SAMHSA-funded Evidence-Based Practice Tool KIT on Consumer Operated Services Programs, and is developing a “Supervisor’s Tool Kit” for mental health service teams focusing on personal safety and risk management while delivering services in high-risk neighborhoods and to persons with high-risk profiles. Laurie is currently the project director for the SAMHSA/CMHS contract to adapt Shared Decision-Making technology to the mental health field.
Event Speaker

Carole Taylor, MSN, RN, is the Chief Clinical Officer of Community Care Behavioral Health Organization. She is a clinical nurse specialist and has a Master’s Degree in Psychiatric Mental Health Nursing from the University of Pittsburgh. Carole has 35 years of experience, both in the private and public sectors. She has extensive community mental health experience in the full continuum of care; was the former Vice President of Quality and Patient Services for a private, for profit managed care organization and private psychiatric hospital, and has been involved in start up for a private psychiatric hospital and a managed care organization.

Carole has a variety of experience in inpatient psychiatric care, private practice, research, consultation, and education. She has been on the nursing faculty at Waynesburg College, Community College of Allegheny County and the University of Pittsburgh School of Nursing.
Teleconference Agenda

12:00  *Welcome* – James Schuster, MD, MBA, Chief Medical Officer, Community Care Behavioral Health Organization

12:05  *Logistics* – Pam Rainer, LMSW, Senior Program Associate, Advocates for Human Potential

12:10  *Presentation* by: **Laurie Curtis**, MA, CPRP, Project Director for SAMHSA/CMHS contract to Adapt Shared Decision-Making Technology, Advocates for Human Potential, Inc.; and **Carole Taylor**, MSN, RN, is the Chief Clinical Officer of Community Care Behavioral Health Organization.

1:15  *Question & Answer Session*

1:30  *Conclude Teleconference*
Pose A Question

• We invite you to pose a question or make a comment during the Q & A portion of the teleconference/webinar. You may submit your question by posting it on the web site or indicating to the operator that you would like to speak live to the presenter. The operator will provide full instructions for you.

• The speakers will answer as many questions as possible during the teleconference.

• Please note that sending a question does not guarantee its inclusion in the teleconference. If you provide your name and organization at the time you ask your question, we may use it during the call. Anonymous questions also can be submitted.
Finding Me:

Recovery-Oriented and Person-Centered Service Planning
Objectives

- Remind us to put the PERSON back into planning
- Reframe treatment planning as treatment opportunity
- Overview elements of recovery-oriented person-centered planning
- Explore common pitfalls
- Review CCBHC guidelines for person-centered, recovery oriented treatment planning
Why create service plans?

"I wouldn't have gone into medicine if I'd realized that there'd be this much papyrus-work."
Why A Plan?

Tool for Personal Growth and Change

Roadmap and Outcomes

Service Coordination and Communication

Billing, Liability, Accountability
Paradigm Shifts

- New understanding of mental health, mental illness and recovery.
- Policy changes at local state, federal levels
- Shifts in perspective about mental illness, role of system, capabilities of people labeled
- Changes in helping relationship:
  - Expert to partner
  - “Doing for” or “doing to” to “doing with”
  - In “best interest” to “shared decision-making”
- More consumer/customer driven
- Focus on recovery, resilience, wellness, social inclusion, not just illness suppression or symptom management.
- Illness orientation to a wellness orientation
- Services to communities/social inclusion
- Coercion to choice
We have names for each of these “places” and for going both directions.
Why a Person-Centered Plan?

- Tool for Personal Growth and Change
- Roadmap and Outcomes
- Service Coordination and Communication
- Billing Liability Accountability
Basic Treatment Planning Guidelines for Medicaid Reimbursable Services

Treatment planning process is **INCLUSIVE**.

Services must be **MEDICALLY NECESSARY** and not duplicated.

Treatment planning meetings must be **DOCUMENTED** in the chart with dated **SIGNATURES**.

Plan must be in **COMPLIANCE WITH MEDICAID POLICY**

Include **MEASURABLE GOALS AND OBJECTIVES**
Remember, the Magic is in the Method

Collaborative process, not just plans

Reflection, not just prescription

Pathways, not just paper…. 
A Person-Centered Plan is..

• A vision for a desirable future and to develop an action plan to achieve that vision

• Built through planning meetings which bring together the participant and his or her primary clinician and ideally, with his or her network of professional and natural supporters

• A way to link treatment and services with attaining desirable and meaningful personal goals
Person-Centered Planning is…

…an outward sign of the presence of respect for the value of all persons.

The basic beliefs at the root of the Person-Centered Planning process are that:

• All people have the right to plan lives for themselves that are personally meaningful and satisfying.

• All people have talents and strengths that they have the responsibility to develop.
Person-Centered Planning is a way of ‘thinking about people that respects their interests, hopes, dreams, and desires.

It is a process of discussion and self-evaluation in which a person discovers how he or she wants to live and explores what needs to be done to reach these goals.
But, our plans already ARE recovery-oriented and person centered! (aren’t they?)
Diagnosis/Code:  
Axis I: Schizophrenic  
Axis II:  
Axis III:  
As manifested by: Depression  

PATIENT STRENGTHS: (including skills, interests)  
A + 6x3 Eat Study  
201 Committ  

PATIENT LIMITATIONS:  

DISCHARGE PLANS:  
Return to street address, follow up, Cit.  

RX: Regular  
County  
Projected Discharge Date:  

**Person Centered Plan**

**Name:**

**Admission Date:** 8/7/2007

**FCP Start Date:** 8/21/2007

**Case #:**

**Program:** ADULT OUTPATIENT

**Review Date:** 12/13/2008

**Review Sealed:**

**Unit:**

<table>
<thead>
<tr>
<th>Plan Outline:</th>
<th>Time Frame</th>
<th>Objective</th>
<th>Interventions</th>
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</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
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<td></td>
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<tr>
<td>* Psychiatric symptoms</td>
<td></td>
<td></td>
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<tr>
<td>The client will demonstrate management of psychiatric symptoms</td>
<td>12/13/2007 - 12/13/2008</td>
<td>Affect, verbalizations and behaviors reflect decrease in depressed mood</td>
<td>• Case Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Affect, verbalizations, and behaviors reflect decrease in mania</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Affect, verbalizations, and behaviors reflect stable mood</td>
<td></td>
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<tr>
<td>* Skill Development for eventual Employment</td>
<td></td>
<td></td>
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<tr>
<td>The client will demonstrate skills necessary for success in vocational pursuits</td>
<td>12/13/2007 - 12/13/2008</td>
<td>Arrives at the Clubhouse Program promptly and as scheduled. Demonstrates good judgement, problem solving and decision making in the workplace</td>
<td>• Skill Building</td>
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<tr>
<td>* Completion of household chores per roommate agreement</td>
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<tr>
<td>The client will maintain, neat, clean, orderly living space</td>
<td>11/30/2007 - 11/30/2008</td>
<td>Changes sheets weekly. Keeps closet and drawers neat and orderly. Keeps floor of room (including under the bed) free of debris daily. Washes clothes weekly, maintains laundry</td>
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<tr>
<td>* Maintain Stable Housing</td>
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<tr>
<td>The client will obtain living arrangements that are stable, safe, and affordable</td>
<td>8/21/2007 - 11/30/2007</td>
<td>Identifies and learns basic skills for maintaining a residence</td>
<td></td>
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<tr>
<td>Real Person Centered Plan</td>
<td>False Person Centered Plan</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
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<tr>
<td>The individual sets the agenda</td>
<td>Team meets only once a year or once a quarter</td>
<td></td>
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<tr>
<td>The team works on the individual's agenda</td>
<td>Planners are mainly professionals</td>
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<tr>
<td>There are measurable accomplishments</td>
<td>Programs drive the plan</td>
<td></td>
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<tr>
<td>The team celebrates those accomplishments</td>
<td>Nothing seems to change</td>
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<tr>
<td>The plan is about the <em>individual's life</em></td>
<td>Meetings are a drudge</td>
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<tr>
<td></td>
<td>The plan is about a <em>document</em></td>
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</table>
Common Pitfalls
Statements are not sufficiently individualized, strengths based, or directed toward recovery.
“Patient Strengths”

- Voluntary admission
- Signed form
- Support of family
- Job
- Ambulatory
- No hallucinations
- Can make needs known
- Connected to ICM
- High school graduate
- Good appetite
- A & Ox3
Check List Approach: Patient Strengths/Assets

☐ Supportive Family/Friends
☐ Financial Resources
☐ Stable Living Situation
☐ Stable Work Situation
☐ Stable Outpatient/Treatment Situation
☐ Other__________________________
Strengths can be....

- Cognitive
- Emotional
- Physical
- Resources
- Connections & Allies

- Community
- Character/Attitude
- Values
- Effort
- Historical
- Experiential
“Patient Limitations”

- Stress
- Family problems
- Chronic mental illness
- Chronicity of illness
- No insight
- Poor judgment
- Involuntary commitment
A “dead-man” could do it successfully

Goals and objectives lack positive action
Reflection

- Not threaten or act on self-destructive thoughts.
- I will not destroy property
- PT will cooperate with blood pressures.
Focus is on staff needs and rules compliance rather than personal growth or meaning.
Reflection

• *I will take meds as prescribed for stability and obey all house rules.*

• *Staff will be allowed to monitor and search my clothing after smoke breaks.*
Goal is attendance – not the purpose or desired outcome of attending a program or service
Reflection

• Attend scheduled groups.
• Take medication as prescribed
• Comply with testing
• PT will attend all groups and activities on a daily basis
• PT will attend RT groups
More than 2 or 3 objectives makes plans too long or complicated to be remembered or used.

…and…
Reflection

- Pay rent monthly on date agreed and submit a two weeks notice before moving to independent living and save for deposits.

- Patient will reduce consumption of alcohol to no more than one glass of wine on the weekend for four consecutive weeks and will otherwise remain abstinent from alcohol.
The person is presented as an object to be treated, fixed, serviced, managed, medicated, maintained......

Do you treat IT, or help ME deal with it?
Reflection

• Client verbalizations, affect, and behaviors will reflect decrease in depressed.
• PT will accept prescribed medications
• Patient will…
• Client will…
• Consumer will…
Focused on what staff or others will do for a person… no active role for the person.
Reflection

• Staff will meet with client weekly to monitor and assess symptoms.
• Patient’s history will be assessed.
• Instruct patient....
• Encourage patient to....
• Patient will be offered....
• Patient will be educated in....
Expectations are “supra-normal” or unrealistic.
Reflection

• Consumer will learn all necessary skills to obtain employment.
• Client will keep area on, under, and around bed cleaned daily.
• Will be able to function independently.
• Follow all rules.
• I will obey and respect staff at all times.
Say what?

Lack of Clarity
Say what?

• *Improve mood*
Specificity provides clarity
Say what?

- Client verbalizations, affect, and behaviors will reflect decrease in depressed mood.

What will a person understand and find meaningful in his/her day-to-day life?
What does it look like for ME?

- How would you know things are a bit better?
- How would you know things are a lot better?
- How would you know that things are a bit worse?
- How would you know that things are a lot worse?
- Happiness is…

COMMUNITY CARE
Behavioral Health Organization
Engage! Involve! Make it fit ME!
How are things going?

• Rating scales
  – How is ________ today on a scale of 0 – 5, if 5 was the worst it’s ever felt for you?
  – Mood monitor

• Tools and checklists
  – Absence/presence/intensity of distressing symptoms
  – Absence/presence/intensity of “good things”
  – Frequency of doing specific “good things” or “personal medicine” activities

• Warning signs
But we already do this!

The following slides provide examples of goal and objective statements from service plans. What do they tell us?

- Who is the informant?
- What is the plan mostly about – the service or the individual?
- Are they person-centered?
- Are they recovery-oriented?
- Are they achievable?
  - Measurable?
  - Understandable?
  - Time-specific?
- How could they be reframed and revised?
Goal statements

• Take medication as prescribed
• Comply with testing
• Take medication without prompting
• Report changes in symptoms
• Attend scheduled groups

• Improve mood
• Invest in family/community services
“Discharge Criteria”

- Stable mood
- Zero suicidal thoughts
- There will be no suicidal thoughts, plans, or actions
- Self-report 50% reduction of depressive symptoms
“Discharge Criteria”

• Accept D&A treatment
• Develop insight about negative affects of alcohol on well-being
“Discharge Criteria”

• Remain independent with all activities of daily living including medication administration without assistance, support, monitoring.

• Be able to obtain and maintain ongoing psychiatric treatment.

• Maintain symptom-free for two years without treatment or medication.
“Discharge Criteria”

- Moved out of service area
- Deceased
Principles of Recovery-Oriented Service Planning

People know they have a plan
Principles of Recovery-Oriented Planning

People are involved in designing, deciding, and writing their plans

People own the PROCESS, not just the completed piece of paper
Shared Decision-Making

In health care, shared decision-making is an interactive and collaborative process between individuals and their health care practitioners about decisions pertinent to the individual’s treatment, services, and ultimately their personal recovery.
There are TWO experts in the conversation

An individual brings lived experience, knowledge, values, and preferences

A practitioner brings expertise on treatment options, risks and benefits
Principles of Recovery-Oriented Planning

The PERSON is present and visible in the plan!

Plans are written in “first person” and use individual names
Principles of Recovery-Oriented Planning

Plans use every-day language

Make “street sense”!
Make sense to ME

Avoid lingo, buzz words, shorthand abbreviations professionalized multi-syllabic obfuscation and pontification
Principles of Recovery-Oriented Service Planning

No two plans are alike
Principles of Recovery-Oriented Planning

People decide what is important to THEM
SIBLING REVELRY

WOW! YOU BOUGHT US AN AQUARIUM!

YES - I WANT TO TEACH YOU RESPONSIBILITY.

I EXPECT YOU TO CHANGE THE WATER AND CLEAN THE FILTER EVERY WEEK.

MAN MARTIN

CAN WE GET A FISH SOMEDAY? LET'S SEE HOW YOU TAKE CARE OF THE AQUARIUM FIRST.
Principles of Recovery-Oriented Planning

Goals are meaningful to individuals and help them to move forward in their recovery.

Plans outline positive and productive steps for change.
LONG TERM GOALS: At discharge the patient will:

- Discuss post discharge schedule to take medications as prescribed
- Manage any psychotic symptoms
- Manage activities of daily living
- Manage self-destructive/homicidal feeling
- Manage in less restrictive setting
- Report an adequate aftercare/prevention plan

Dreams: "I want to return home."
Desires: "Iarned like to do more in life."
Individual strengths: "I can do things that I put my mind to."

All Community Supports Needed (others that help me with what I want and need. Be specific who is what? How are they helping? Include family, friends, church, etc...) My mom, mom, mom.

"Hally be a help to me as God is going home!"
Principles of Recovery-Oriented Planning

People have copies of their plans and find them useful as tools for personal recovery.
Principles of Recovery-Oriented Planning

Plans change because people change
“Harry’s mood stabilized in ’78, and it hasn’t budged since.”
Principles of Recovery-Oriented Planning

Plans do not focus on past problems

Plans are forward-looking and hopeful
Principles of Recovery-Oriented Planning

Plans are built around personal strengths, resources, assets and interests that can be mobilized for recovery and growth
Principles of Recovery-Oriented Planning

Plans identify meaningful contributions the person can make to establish a valued social role

Plans focus on more than just formal services and treatment and include community resources
Remember, the Magic is in the Method

Collaborative process, not just plans

Reflection, not just prescription

Pathways, not just paper….
Community Care
Treatment Planning Standards

Carole Taylor, RN, MSN
Chief Clinical Officer
Community Care
Behavioral Health Organization
Basic Treatment Planning Guidelines for Medicaid Reimbursable Services

Treatment planning process is INCLUSIVE.

Services must be MEDICALLY NECESSARY and not duplicated.

Treatment planning meetings must be DOCUMENTED in the chart with dated SIGNATURES.

Plan must be in COMPLIANCE WITH MEDICAID POLICY

Include MEASURABLE GOALS AND OBJECTIVES
Basic Treatment Plan
Component Requirements

• Involvement of consumer and/or significant other with signature
• Dated and signed by the clinician
• Dated and signed by the consumer
• Written in language understandable to both the consumer and treatment staff
Basic Treatment Plan
Component Requirements

Shall include the following basic information:

» Name

» Date of Birth

» Medical Record Number

» Strengths and Assets

» Diagnostic impression for Axes I-V based on DSM-IV TR

» Current medications including name, dosage, and frequency
Basic Treatment Plan
Component Requirements

Presenting problem statement described in measurable behavioral terms including:

- Current symptoms
- Substance abuse issues
- Consumer’s own statement of the presenting problem
Basic Treatment Plan
Component Requirements

Review of domains are required and include the following for both strengths and opportunities:

- Psychiatric/emotional
- Psychological
- Family
- Social
- Environmental
- Educational
- Occupational
- Vocational
- Avocational
Basic Treatment Plan
Component Requirements

Treatment goals must be **mutually agreed upon** with the consumer
Basic Treatment Plan
Component Requirements

Treatment goals are linked to treatment objectives

Treatment Objectives must be:

- Specific
- Behavioral
- Measurable
- Assigned target dates
Basic Treatment Plan
Component Requirements

Action plan must accompany treatment objectives and include:

- Specified frequency and duration of intervention
- What the consumer can actively accomplish to reach treatment goal
- What the clinician/provider will do in terms of types of service, frequency, and duration of intervention
Basic Treatment Plan
Component Requirements

Treatment plan and other treatment options including advantages and disadvantages are to be discussed with the consumer, and if appropriate, with the consumer’s family.

Treatment plans will include the consumers’ preferences of clinician and location of treatment services.
Personally meaningful direction or goal

How services can help (objectives linked to goal)

What service providers will do (action steps)

Are we getting there? (measureable outcome)

How individual can help

What individual decides and agrees to do (personal action plan)

Am I getting there? (measureable and subjective self-assessment)
Penney & Stastny
The Lives They Left Behind
“Suitcases Project”
2008
Bellevue Literary Press
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Following the Teleconference

To listen to archived teleconference presentations check out the Community Care Recovery Institute Web Site:
www.recoverylearning.com

Please complete the evaluation form posted live on the webinar. Your feedback is very important in developing future teleconference content.
More Information

For more information, contact: www.recoverylearning.com or www.ccbh.com

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Thank you for participating in today’s teleconference.
Training Certification

Name of Recipient: ___________________________

Completed the Teleconference/Webinar on May 14, 2008 for:

Writing Recovery Oriented Treatment Plans

Presented by:

Laurie Curtis and Carole Taylor

May 14, 2008

James Gavin

May 14, 2008

Pat Deegan, PhD & Associates, LLC
Examples of Discovery Questions - Conversation Starters
By: Laurie Curtis

There are many questions to pursue. These questions are a starting point for exploring the life, personality, and preferences of an individual. Rephrase the questions as needed to the person can understand what is being asked.

1. How do you see your life different 3-5 years from now?
2. If you could wave a magic wand and change one thing in your life, what would it be?
3. When are you most happy? Sad? Angry? Frightened?
4. What worries you about your life now? About your life in the future?
5. What are some of the things that come easy to you or that you think you do well?
6. What are some of the things that are difficult or challenging to you? Or that you think you might not do well?
7. What excites, encourages or motivates you? What makes you want to do something?
8. What are some of the things you would like to do in the future? That you would like not to do?
9. What do you like to do for fun? What are some of the things you would like to try sometime?
10. What makes you unique?
11. If you could rewind your life, the way you can rewind a video, what part would you play over again? Would you erase any part? What? Why? How would you change the script?
12. Who are some of the people who are important to you? Family? Friends? Church? Neighbors? Co-workers? Staff?
13. What are some of the thing other people rely on YOU for?
14. Who are some of the people you would like to meet, see, or do things with?
15. What is your favorite kind of work? Your least favorite kind of work?
16. What are some of your work experiences - good and bad?
17. Where do you see yourself living 3-5 years from now?
18. When things are going well for you, how do you know? What is happening around you? Inside you? What are you doing? Not doing? Who is there? Not there?
19. When things are not going well for you, how do you know? What is happening around you? Inside you? What are you doing? Not doing? Who is there? Not there?
20. When you went into (crisis) (the hospital) in the past, what was happening just before? What do you think might have prevented that situation?
21. When things are not going well, what strategies have you tried to manage or cope with the situation? What works best for you? What strategies don't seem to work well for you?
22. How do you know when to ask for help with something (a task, a decision, a problem, a crisis)? How do you usually let others know you need or want help?
23. Do you think others truly understand what you are feeling? Thinking? Why do you think this?
24. What are some of the things you do that you think earn you respect (face) from others?
25. What are some of the things you do that you think make you lose respect (face) from others?
26. Have you ever used alcohol or drugs to solve a problem or earn respect?
27. What was the best place you ever lived? Why? The worst place?
28. What was the worst job you ever had? Why was it so bad? What about the best one?
29. What is something about yourself or your accomplishments that you are proud of?