A Treat First Approach:

Ensuring A Timely, Effective Response to a Person's Need While Engagement, Screening, Assessment, and Planning Processes Unfold

Purpose of This Document

This document provides an overview of a Treat First Approach and describes service elements and activities associated with the first four visits or sessions provided to a person requesting services. It is intended to provide guidance for practitioners who are implementing the practice concepts and steps during a formative testing phase.

Benefit of a Treat First Approach

Approximately 20% of all consumers will believe that their issue is adequately resolved after one visit and will not return for a second visit for positive reasons. Currently, no-show rates in many sites are between 40-60% and are usually because of the client's need (i.e., their reason for requesting services) was not addressed at the first visit. The Treat First Approach corrects the problem of delay by emphasizing the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a quick response for any urgent matters when a new person presents with a problem and requests help from the agency:

Use of a Treat First Approach overcomes historic difficulties encountered by a person requesting services of having to wait for help until many required data collection tasks are completed before getting help. Delays discourage some persons from returning for a second visit. Ensuring a timely and effective response to a person's request for services is a first priority in the Treat First Approach. This strategy provides a way to achieve immediate formation of a therapeutic relationship and initiation of a response to the person's concern while gathering needed historical, assessment and treatment planning information over the course of a small number of sessions or visits.

Basic Design of a Treat First Approach

Making the most of the initial contact with a person seeking help is recognized as a key to successful engagement and quick results that benefit the person. The Treat First Approach begins with a quick screening, rapid engagement, and short intervention approach in which the reason that a person requests assistance may be addressed or resolved within the span of one to three sessions or visits.

A segment of the population of persons requesting behavioral health services may be served successfully using a short intervention approach. For others who may require longer, more extensive, or specialized interventions, the early steps in the Treat First Approach would enable the service provider to gather sufficient assessment information in order to develop a clinical case formulation and comprehensive service plan by the fourth visit. The concepts, principles, and processes used in the Treat First Approach provide a responsive way of initiating a service process for a person requesting help. Brief intervention techniques such as a Treat First Approach are part of a full continuum of behavioral health care services provided in Certified Community Behavioral Health Centers, Medicaid Health Homes, and other community-based services.

A Treat First Approach provides a useful way of engaging and assisting new persons requesting help from a service provider by providing a quick response to their concerns. Using a Treat First Approach requires that practitioners engaging with the person quickly scan (screen) the person's situation to determine if any presenting factors may constitute a threat of harm to the person or to someone in the person's life. If so, necessary steps are quickly taken to keep people safe or healthy. Thus, the Treat First Approach is used as a non-crisis model. In an identified crisis situation, the practitioner follows the local crisis protocol.

Another quick discernment made by the practitioner involves the prospect that a person's request for help could be resolved within one to three sessions or visits. Some life issues (e.g., coping with the break-up of a relationship or a job loss) may be amenable to resolution with a short intervention. Other life circumstances (e.g., multiple problems, acute psychoses, cognitive inability to focus, severe substance abuse, long history of relapse, low level of social support) for which a person is requesting help may require more intensive and sustained efforts and supports.

Thus, a practitioner should quickly understand the range and severity of presenting problems and the type of services that may be necessary to meet needs and solve problems. Doing so may require conducting additional assessments, using any necessary protective strategies, gathering of collateral information, or involvement of others supporting the person may be determined and accomplished.

Strengthening Clinical Practice

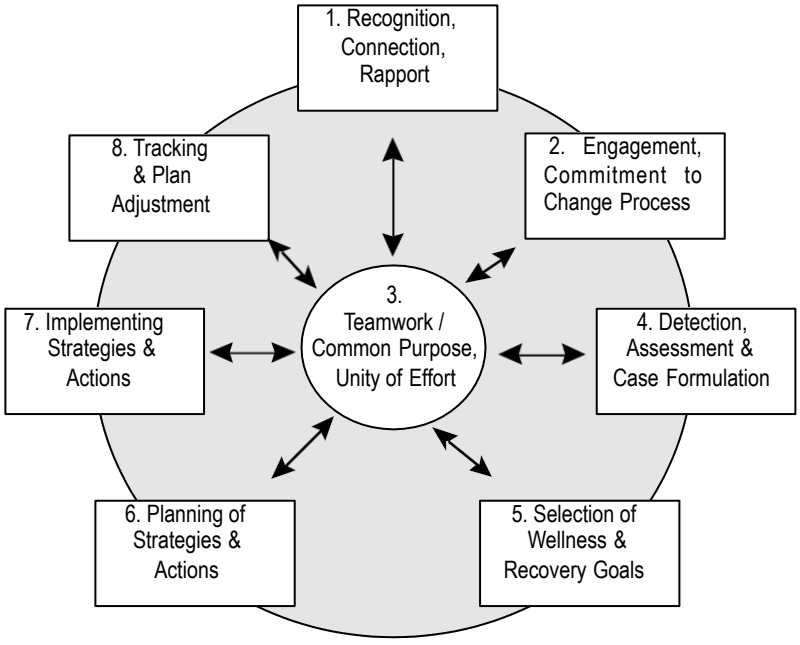
Strengthening clinical practice is a goal when implementing the the Treat First Approach. Practitioners employ core practice functions and clinical activities to join with a person receiving services to support a positive life change process that helps the person get better, do better, and stay better. Typical practice functions include: connecting with a person based on a recognition of the person's identity and situation; detecting and responding to any urgent problems; building positive rapport and a trust-based working relationship; engaging the person in a positive life-change process; understanding the person's strengths, needs, and preferences; defining wellness and recovery goals to be achieved; building common purpose and unifying efforts though teamwork (when longer-term services are indicated); planning intervention strategies, supports, and services; implementing plans; and tracking and adjusting strategies until desired outcomes are achieved. The diagram shown below illustrates core practice functions typically encouraged by service providing agencies.

The diagram illustrates early and ongoing clinical practice functions that progressively come into action over the course of the first four sessions of the Treat First Approach. Tip sheets are provided in the *Addendum* for the practice functions used in first order actions of a Treat First Approach. Tip sheets describing suggested practices follow the description of the first four sessions. The tip sheets cover the following suggested practices:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Brief and solution-focused interventions
- Motivational interviewing

Tip sheets are provided to promote and strengthen clinical practice.

Basic Functions Supporting Effective Clinical Practice



Practice Functions May Occur Interactively, Concurrently, and Progressively

Visit 1

Visit 1 Goals and Activities:

Overview

The first visit focuses only on the person's request for help, clarifying the concern, and beginning a solution-focused intervention process. The conversation should center on the following areas:

- Who and what are important to the person;
- The person's vision of a preferred future;
- The person's exceptions, strengths, and resources related to the vision;
- Scaling of the person's motivation level and confidence in finding solutions;
- Person's expectations in seeking help;
- Ongoing scaling of the person's progress toward reaching the desired future.

Treat First Practitioners

A therapist would be the first point of contact if a presenting problem is psycho-social in nature, including relationship difficulties. A Community Support Worker (i.e., CSW/CPSW) may be the first point of contact if the identified problem is social, functional, or involves basic human needs or linkage to community resources.

Visit 1 Goal

The goal of the first visit is to gain a full understanding of the presenting problem and the impact of that problem on the person's life. This is done using relationship building skills for Recognition, Connection, and Rapport to build on the person's understanding of his/her concern or situation and what the person wants to be different in the future. The foundational elements of Treat First Clinical Practice applied in the first visit are:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Brief and solution-focused interventions

Activities & Expectations

Registration. The client completes registration materials before meeting with a therapist or CSW. Basic one or two question screens can be included in the registration materials relative to substance use disorder, depression, risk and crisis, and trauma. The materials may include a section for the person to list medications and a Community Engagement Checklist indicating current or historical linkages to community resources, identification of a Primary Care Physician (PCP), or other providers. This should allow the therapist or CSW/CPSW to have a quick sense about the status of the individual so to be fully engaged and present with the person rather than consumed with paperwork.

Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning of the session, and how useful and beneficial the session has been in making progress towards achieving the person's desired future. There are four specific questions for both check-in's. If the person is in an immediate crisis that must be addressed before moving on to any other portion of the visit.

Information Gathering. While the first visit is focused on developing a therapeutic alliance and building trust to first address urgent needs, it should also be a time to initiate the gathering of information. This includes information necessary for completion of a Diagnostic Evaluation by the conclusion of the fourth visit.

Screening & Assessment. If there are significantly alarming indicators in the responses provided in the registration process, more in-depth screening may be necessary. It is important to ensure the person's safety and that the person understands the boundaries of scope of practice of the practitioner so to set appropriate expectations. Besides the information gathered in the registration process a therapist should complete a Mini-Mental Status Exam (MMSE) as an important part of the first visit and determine a provisional diagnosis. A full MSE (Mental Status Exam) may be necessary pending registration information.

Next Visit & Follow-Up

A second visit is scheduled for the following week and before the person leaves, if warranted.

Recommendations & Tips

- Using Solution Focused Brief Therapy (SFBT) concepts - See the Tip Sheet in the Addendum
- Check-in questions and rating scales can be found in the Addendum

Visit2

Visit 2 Goals and Activities: General

Overview

During the second visit, additional historical data are gathered. The focus is placed on medical and behavioral health history, extended support systems, identification of strengths and barriers to treatment, and other issues specifically related to presenting problem(s).

Treat First Practitioners

Formative information for developing a clinical case formulation may be assembled, and the beginnings of a treatment or comprehensive service plan are noted.

Visit 2 Goal

The service provider discusses with the person the probable number of visits needed to resolve this particular episode of care. If it becomes apparent that the person has a newly identified condition (e.g., SMI or SED) that requires complex rehabilitation services, up to and including psychiatric medication, then a more formal approach to assessment, case formulation, and planning will be initiated.

Foundational elements of clinical practice that may be used or added during the second visit include:

- Recognition, connection and rapport
- Engagement and commitment
- Detection and quick response
- Motivational, brief and solution focused intervention
- Assessment and formulation
- Wellness and recovery goals

These basic practice elements are initiated in visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help. Tip sheets explaining these elements of practice are provided in the *Addendum* of this document.

Activities & Expectations

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Information Gathering. Information for developing a clinical case formulation is being gathered and assembled. With a focus on behavioral health, medical history, strengths and barriers to treatment, extended support systems and other issues related to goals/problem. The provisional diagnosis is further explored utilizing a more formal approach to assessment through various techniques, strategies and diagnostic review tools.

Treatment Planning. Elements of a treatment plan are beginning to develop. Initial wellness and recovery goals are explored. The service provider and the person discuss the possible number of visits that may be necessary to resolve current and/or future goals or problems.

Next Visit & Follow-Up

A third visit is scheduled before the person leaves, if necessary for resolution of the reason that the person is requesting help.

Recommendations & Tips

Building on the prior functions it is anticipated that from 50 to 65% of all needed data for a diagnostic evaluation, treatment plan (including complete crisis plan if needed), and modified diagnostic review should be available following the completion of the second therapeutic visit.

- Daily Living Activities- Functional Assessment (DLA-20)
- Functional Skills Evaluation
- Motivational Enhancement
- Brief Solution Focused Techniques/Strategies
- How to interpret self/session check-ins

Visit 3

Visit 3 Goals and Activities:

Overview

Therapeutic services provided during a third visit are framed by a substantially sound understanding of the person's diagnostic situation, functional status, and evolving clinical case formulation. Additional targeted data (following local assessment and treatment planning templates) are systematically gathered to flesh-out a shared understanding by the person and provider on how to effectively address the issues raised by the person and to plan a treatment schedule for the remainder of the episode to resolve the issues.

Treat First Practitioners

If concurrent completion of the diagnostic evaluation is possible, then the therapist (not the CSW) should complete it and coordinate the completion of the treatment plan (which may involve more than one direct service provider by now) separately from a visit.

Visit 3 Goal

Where possible, data gathering for a complete diagnostic evaluation can be completed in this visit, but therapeutic concerns must be the priority. The new critical element - introduced in Visit 3 is Teamwork - common purpose and unity of effort. If completion of the diagnostic evaluation is not possible the person may be invited back for additional visits with the fourth visit ensuring a mutual agreement between the therapist and consumer on the detail in a diagnostic evaluation and the sharing of a completed written treatment plan with the person. This third visit could be billed as either a diagnostic evaluation or as an individual therapy visit.

The foundational elements of clinical practice that may be used or added during the third visit include:

- Recognition, connection, and rapport
- Engagement and commitment
- Detection and quick response
- Assessment and formulation
- Wellness and recovery goals
- Teamwork - common purpose and unity of effort
- Brief solution-focused strategies

These basic practice elements are initiated in Visit 1 and continue as indicated over successive visits as practice unfolds to assist the person requesting help.

Activities & Expectations

In summary, these are the activities expected to occur during the third visit:

- A Self Check-In is conducted with the person to assess how well he/she is doing at the beginning of the session and what has changed since the last session.
- Services delivered are based on understanding the person's diagnostic situation, functional status and evolving clinical case formulation. The clinical case formulation evolves over time as more knowledge is gained.
- Additional data are gathered to build a shared understanding by client and therapist on how to effectively address issues raised by the client.
- Determination made about what else may be required to resolve this episode of care.
- Need for more visits are discussed along with goals and any new goals to be met.
- Based on goals selected, more specific and detailed treatment plans are developed.
- A treatment schedule is planned to resolve any remaining ongoing issues.
- A Session Check-In is conducted with the person. Rating scale results are used by the practitioner to evaluate the person's perspective on how useful and beneficial the session has been in making progress.

Next Visit & Follow-Up

The likelihood of a fourth visit is largely dependent on the degree to which the person and therapist/CSW have established the person's identified goals and desired outcomes along with a positive therapeutic relationship.

Recommendations & Tips

Tips sheets explaining these elements of practice are provided in the *Addendum* to this document.

Visit 4

Visit 4 Goals and Activities:

Overview

By the fourth visit, some of a person's issues may have been resolved in earlier sessions while other remaining concerns may require further efforts to address. The likelihood of reaching a fourth visit may depend in part on the degree to which the person and therapist/CSW have identified further goals, achieved progress to some goals, and formed a positive therapeutic relationship. It is expected that the service provider will have a complete and clinically defensible diagnostic evaluation and treatment plan by or upon completion of the fourth visit in any episode of care.

Treat First Practitioners

By this fourth visit for persons having serious diagnosis and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs. The treatment team may now consist of not only a therapist and CSW, but other treatment providers such as a Psychiatrist, a Nurse, and Peer Support Specialist and so on may now be part of the person's treatment team.

Visit 4 Goal

By the end of the fourth visit, a broader array of clinical practice functions will have begun unfolding. Early and ongoing clinical practice functions progressively come into action over time the course of the first four sessions. Tip sheets are provided in the *Addendum* for the practice functions that are applied in first order actions of a Treat First Approach.

Activities & Expectations

Self & Session Check-In. A check-in is conducted with the person at the beginning and the end of each visit. Relative rating scale results are used by the practitioner to evaluate the person's perspective on how they are doing at the beginning and end of a session. A Self Check-in at the beginning shows how well he/she is doing and what has changed since the last session. At the end of the session a Session Check-in is conducted with the person by the practitioner on how useful and beneficial the session has been in making progress towards achieving the person's desired goals.

Accomplishments by Visit 4. By conclusion of a fourth visit, the following items will be completed by the provider:

- Screenings, evaluations, and assessments that provide a sufficient bio-psycho-social understanding of the person's situation (e.g., reasons for requesting assistance, aspirations for wellness/recovery, preferences, risks of harm, and any significant unmet needs) to develop a useful clinical case formulation and course of action.
- Clinical case formulation including a clinical history and concise summary of the bio-psycho-social factors contributing to the present disorder. It focuses on clinically significant distress and impairment in functioning experienced by the person. The case formulation considers the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern.
- Final Diagnosis: based on a full Clinical Formulation
- Wellness and recovery goals to guide a course of action.
- Comprehensive treatment plan to define a course of action for meeting the person's wellness and recovery goals.

Functional understandings and clinical case formulation have been used to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences.

Continuation into Ongoing Services

For persons having serious diagnoses and/or experiencing complex life situations, additional sessions or ongoing services may be required to address their needs.

A Treat First Approach may be useful for all persons receiving services.

Recommendations & Tips

Tips sheets explaining these elements of practice are provided in the *Addendum* to this document.