Comprehensive Care Webinar Series

Webinar #3: Formulation (part 1)
Resources

Note: resources online are hyperlinked. Press Ctrl +click to follow link.

QC55 Formulation and Care Planning eLearning (3.5 hours)
Provides a comprehensive and interactive overview of the founding principles of formulation and intervention planning. The 5P approach to formulation is described and applied. The process of utilising a person's individual recovery goals within a shared formulation, to co-create clinical goals and intervention strategies, is explained and examples provided.

Case in Point
A free 30 page guide for AOD practitioners on how to best record clinical case notes and undertake case formulation.

Comprehensive Care Documents https://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs
The Comprehensive Care Documents address the integration of mental health (MH) and alcohol and other drug (AOD) services through the Consumer Integrated Mental Health and Addictions (CIMHA) application 5.0 release, with shared documentation across both services.
All Comprehensive Care documents will be housed at this site.

Comprehensive Care Resource Guide to Formulation, Care Planning and Case Review
https://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs (to be published online 14 November 2020)

Helping you understand formulation: Information for consumers of mental health, alcohol and other drugs services (brief version word) (brief PDF) (long version Word doc)

Collaborative formulation: Tips for clinicians of mental health alcohol and other drugs services

A case example: "Sandra"

Integrated Formulation Table without prompts
A resource developed by the Formulation Working Group to assist clinicians in developing a formulation. In Word version for easy editing.

VIDEO resources:

Integrated Formulation – Dr Jenni Panther

Video 1: Comprehensive Care and Formulation (16mins)
Video 2: Integrated formulation (19 mins)
Video 3: Formulation and CIMHA (3:26mins)
Video 4: Formulation example: "Sandra" (11:25 mins)
Video 5: Formulation to care plan – "Sandra" (6:58 mins)
Video 6: Resources and Key Messages (1:20 mins)

Prevention-Oriented Risk Formulation Video – Dr Kathryn Turner and Sarah McDowell (8:40mins)

Sharing the formulation with Sandra - video (11:08mins)

Case to Care Video (2:50mins) – The importance of language and inclusion for consumers and carers.

CIMHA Functionality videos – demonstrating use of CIMHA to navigate parts of the Comprehensive Care documents, covering care plan, longitudinal summary, case review & focused assessment. Presented by Jason Monk, Clinical Improvement Team, Mental Health Alcohol and Other Drugs Branch.

Also available at the pages below

Comprehensive Care Toolkit and Resource Pages
Resources to support the Comprehensive Care: Partnerships in Care and Communication Project, including webinar recordings, videos and other information. For Queensland Health Mental Health, Alcohol and Other Drugs Clinicians. The same resources are made available on each site to improve workforce access.

Insight: Comprehensive Care Toolkit https://insight.qld.edu.au/toolkits/comprehensive-care/detail
The Learning Centre: REO8 Comprehensive Care Resource Package
(register/log in and click 'enrol me' using the link, or go to www.qcmhl.qld.edu.au)

Initial Formulation

- Initial, screening, assessment, MSE, Diagnosis. Collateral history obtained.
- Clinician formulates an understanding of what is happening based on the information available in conjunction with the consumer (where possible).
- Formulation is saved in the **relevant assessment document** and must be entered into the **longitudinal summary** for those receiving ongoing care.

Care Planning

- Formulation informs the care plan by focusing on why this is happening rather than just what is happening (symptoms and diagnosis). Identifying areas of initial care delivery focus.

Case Review

- The MDT discusses the formulation and Care Plan, providing MDT expertise, opinion and theory to further develop the formulation and care plan.
- Involvement of the consumer and family/carers wherever possible.
- The outcome of the **ca(r)se review**, including the **updated formulation and care plan** are shared with the consumer, their carers, and other healthcare providers.
- The Ca(r)se Review document is saved and shared as appropriate, and the updated formulation is included in an updated version of the **Longitudinal Summary**.

Review of Formulation

- Change in presentaiton / setting / lack of progress / consumer need prompts the need to re-think the understanding of what is happening.
- Formulation is reviewed by the clinician with input from consumer, carers, the MDT and other healthcare providers as appropriate.
- **Second opinions, Complex Ca(r)se Reviews, Ad hoc case reviews** may support this process.
- The **Longitudinal Summary** is updated and the updated formulation is shared with the consumer as appropriate.

The following resources are available from: *'Standardising comprehensive care within mental health alcohol and drug services – Resource guide'*

The 5Ps Formulation

The 5Ps approach (Weerasekera, 1996) is an atheoretical approach to formulation. Most staff will be familiar with this and may have had experience of using it. It is not discipline specific and is atheoretical, therefore staff can use a variety of explanatory models based on their knowledge and experience. Its relative simplicity allows for use in more acute settings, however it can be used in any setting, and can be built upon as further understanding of the consumer is gained. Staff may draw on theoretical conceptualisations, if desired, to add depth.

The 5Ps highlight an approach that incorporates Presenting, Predisposing, Precipitating, Perpetuating, and Protective factors to a consumer's presentation.

The formulation is developed through a process of reflection on the data collected (e.g. history, mental state examination, collateral, diagnosis, risk screening, and other screening processes/tools).

Collaboration with the consumer in development and a feedback process are ideal where possible.

Following formulation, there should be an identification of the prioritised areas of focus for care – to inform the Care Plan.

The following pages describe two approaches to documenting the formulation using the 5Ps structure, including a narrative and flowchart.

5 Ps narrative table, from Comprehensive Care Resource Guide

7.4.3.2 5Ps Narrative Approach

Presenting Issues	Briefly summarise the problems the consumer identifies as bringing them into treatment, as well as any other problems identified during assessment. Presenting issues are usually broader than just Mental Health or AOD problems, such as psychological, social, health, legal, accommodation and financial problems.
Predisposing (or background factors)	These are issues in the consumer's childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health and other difficulties. Includes historical events and biopsychosocial factors that increase the likelihood (or risk) of the consumer developing social, emotional or behavioural difficulties.
Precipitating factors (or triggers)	These are the factors or key onset events that have triggered the consumer's difficulties and resulted in them accessing services.
Perpetuating (or maintaining) factors	These are the factors in the consumer's life, behaviour, beliefs and psychological or physical states that maintain the presenting issues or cycles of behaviour.
Protective Factors	Captures both individual and systemic strengths that exists alongside the presenting issue. These are the consumer's strengths and resources that offer hope and promote resilience.

The Integrated Formulation

The Integrated formulation builds on the familiarity of the '5Ps', with the aim of specifically integrating that structure with a number of other important aspects of formulation including:

- A more strengths-based approach
- Integration of the consumers' goals into the formulation
- A pause to reflect on the data gathered (static and dynamic factors) during risk screening and documented in the Risk Screen form. In addition to the central consideration of static and dynamic factors, reflections should also include consideration of the meaning of the events for the consumer, for example for suicide - humiliation, social defeat, entrapment, thwarted belongingness, or burdensomeness; and for violence the loss of status, or feeling provoked or humiliated.
- Embedding an overt consideration of Diagnosis (or Provisional Diagnosis), with a prompt for a 'pause point' (reflection) to specifically challenge cognitive bias. This prompts consideration of a range of differential diagnoses (Mental Illness, Substance Use, Personality Disorder, Physical Illness, Cognitive Impairment).
- Integration of a 'Risk Formulation' (the Prevention Oriented Risk Formulation (Pisani, Murrie and Silverman, 2016) into this broader formulation. Furthermore, multiple domains of risk (e.g. Suicide, violence, vulnerability) are integrated into the one formulation.

  Many MHAOD services across Queensland have adopted the Prevention Oriented Risk Formulation ('Risk Formulation') as part of a suicide prevention pathway, that moves away from a categorical approach to risk (high, medium, low) to conceptualising risk in relative terms, depending on clinical context **(risk status**), and also relative to the consumer's own baseline level (**risk state**). It focuses on the development of an individualised care plan that takes into consideration these relative risks and possible future changes in this risk in response to events (**foreseeable changes**) and what mitigations can be put into place within **available resources** (internal and social strengths). Specific training in the 'Prevention Oriented Risk Formulation' for suicide risk, is provided in the following courses through the Queensland Centre for Mental Health Learning (QC2 Engage, Assess, Respond to, and Support Suicidal People (EARS), QC28 Youth: EARS (Y:EARS) – eLearning component Module 4, and QC30 Violence Risk Assessment and Management – eLearning component Chapter 3).

  A major driver of the Integrated Formulation was to provide a practical approach to give staff clearer guidance on integrating this frequently used 'Risk Formulation' within the broader formulation.

How to use this Guide

1. Reflect on the data you have collected – the history, MSE and collateral. Document your data in the consumer assessment/ medical review/ case review as usual. Try to keep the history simple – the data only, keep reflection on it for the formulation (avoid duplication).
2. Try to make sense of the data by thinking about why this has happened to this person at this time.
3. Use the 'Integrated Formulation diagram' to guide you through the formulation. Work your way down the left-hand side of the guide. There are prompting questions in each section to guide you to reflect on the data you have.
4. Consider the 'prompts to reflect' to ensure that you reflect upon – diagnosis, risks, gaps, and counter-transference.
5. Enter your risk assessment in the standalone Risk Screen form. Reflect on the information in the Risk Screen before embarking on the Risk Formulation section.
6. Document your formulation in the relevant form (assessment/ case review/ longitudinal summary).

7. Add your formulation to the longitudinal summary for the consumer (if relevant).
8. Try to collaborate with the consumer where possible to both create and then share the formulation.
9. Integrated formulation table – is provided with and without prompts if you prefer to complete your formulation in a table and then paste into your clinical document.
10. Once the formulation is completed, reflect on the areas of focus for care planning for the consumer. Take into consideration the consumer's goals as part of this consideration.

Notes:

1. The greyed out 'Reflection' sections do not require documentation.

2. In terms of assessment of violence, the above process represents Tier 1 of the Violence Risk Assessment and Management (VRAM) framework. Consideration will need to be given as to whether a more comprehensive assessment of violence risk is undertaken in line with the three-tier framework.

An example formulation is available (see A case example: "Sandra")* as an example of the type of output you might produce. The detail and length of formulation will depend on the setting you work in, your experience, your discipline, existing preferences for model of formulation and time limitations (e.g. those in an acute setting may have less time to form a detailed formulation).

** "Sandra" Example will be available in the Resource guide following publication online.*

Integrated Formulation Table with Prompts

Person: Describe the person first – who are they, what is their role/ job/ interests/ cultural background
Presentation: Describe the clinical presentation including: Demographics, reason for entering the mental health alcohol and other drugs service, referral source and list of current problems, diagnoses (including comorbidities), prominent symptoms, prominent aspects of mental state examination and known risks of all kinds. Include recent/ present suicide ideation or behaviour.
"This has occurred in the context of…" **Precipitating Factors:** Describe the recent triggers or events that have exacerbated the problem, how and why these factors have affected the presentation e.g. **Biological** - Mental Illness, Substance Use, Physical Illnesses, Medication adherence. **Psychological -** Coping mechanisms, losses, loss of status, response to events – feeling defeated/ humiliated/ trapped/ burdensome/ provoked. **Social / Cultural aspects-** Housing, employment, finances, access to healthcare, isolation, relationships, culture, availability / curiosity about drugs.
"This is on the background of…" **Predisposing factors and Patterns of Symptoms and behaviour over time:** Describe how and why the consumer's lifetime experiences have contributed to the development of the current problems e.g. **Developmental Factors -** Problems during birth/ development/ attachment/ childhood/ trauma history. **Family History and Relationships –** Family history (genetics)/ family relationships/ family response to illness or problems; parental substance use. **Psychological and functional issues -** Development of coping style, interpersonal problems, social skills deficits; functional/ cognitive problems and their impact on illness and health seeking behaviour; drivers for substance use/ impulsivity/ self-harm; positive beliefs about substance use. **Social Problems -** Housing, employment, finances, access to healthcare. **Substance use –** Patterns of use, associated behaviours. **History of illness and response to treatment/ interventions –** Age of onset, reasons for diagnoses, suicidal behaviours, aggressive behaviour and forensic history, past complications, past treatments and response, reasons for and length of admissions and significant community-based treatment episodes.
"Some of the issues perpetuating the current issues/ illness include . . ." **Perpetuating factors:** Describe the potential contributors that maintain the problem or may worsen the problem if not addressed, such as insight, personality style/vulnerabilities, co-occurring conditions and substance use, employment status, lack of social supports, substance using peer group; family attitudes, beliefs and behaviour with respect to substance use.
"The Strengths of the consumer include . . . " **Strengths and Protective Factors:** Describe the Internal resources and external supports that can be drawn upon to improve their illness outcomes e.g. family support, stable accommodation, school, vocational, employment history, medication compliance, resilience, coping style and problem solving.

"The main issues and drivers identified by the consumer are . . ."

"The goals of the consumer include . . . "

Describe how the patient understands the current situation and presentation, what do they want now and what are their goals to work towards.

"**There are some gaps in the current information which will be important to follow-up on…"**

Outline significant gaps in the history and how these may affect your impression/ plan.

Reflection: Consider Risk Screen form and Reflective Questions.

Consider enduring and dynamic factors and reflective questions. (Document on Risk Screen form)

Reflection: Consider Diagnosis – document in appropriate section on form for Diagnosis.

Consider all diagnoses– mental illness, substance use, personality disorder, physical illness, cognitive impairment.

Consider possible differential diagnoses.

Risk Status- Consider risk compared to others in the current treatment setting and the treatment setting being considered. Also consider risk relative to the general population.

Provide examples and explain why you have come to these conclusions (this will be influenced by more enduring factors, as well as some dynamic factors).

Include Suicide, Violence, Vulnerability, Disengagement / AWA, Child Safety.

NB. The risk state may be higher than the population in the treatment setting being considered if there are adequate available resources and foreseeable changes can be mitigated.

Risk State – Risk relative to self at baseline or selected time period.

Give examples / rationale; Include Suicide, Violence, Vulnerability, Disengagement / AWA, Child Safety.

Available Resources – Internal and social strengths to support safety and treatment planning.

Foreseeable Changes – Changes that could quickly increase (or decrease) risk state.

Reflection: Given the above, consider the Areas of Focus for Care Planning.

Integrated Formulation Guide

Person and Presentation

Describe the person and clinical presentation including:

Role, interests, culture, demographics, reason for entering the service, referral source and list of current problems, diagnoses (including comorbidities), prominent symptoms, prominent aspects of mental and physical state and known risks of all kinds. Include recent/ current suicide ideation/ behaviour.

"This has occurred in the context of…"
Precipitating Factors - Describe the recent triggers or events that have exacerbated the problem, how and why these factors have affected the presentation.
Biological - e.g. Mental Illness, Substance Use, Physical Illnesses and Medication adherence.
Psychological- e.g. Coping mechanisms, losses, feeling defeated, humiliated, trapped, provoked, burdensome
Social- Housing, employment, finances, access to healthcare, isolation, relationships, loss of status

"This is on the background of…"
Predisposing factors and Patterns of Symptoms and behaviour over time- Describe how and why the consumer's lifetime experiences have contributed to the development of the problems.
Developmental Factors - Problems during birth/ development/ attachment/ childhood/ trauma.
Family History and Relationships – Genetics/ family history and relationships/ family response to illness/ problems.
Psychological and functional issues - Development of coping style, interpersonal problems, social skills defects; functional/ cognitive problems and their impact on illness and health seeking behaviour; underlying drivers for substance use/ impulsivity/ self-harm.
Social Problems and substance use - Housing, employment, finances, access to healthcare, Substance use pattern, associated behaviours.

Perpetuating factors
Describe the potential causes that maintain the problem or may worsen the problem if not addressed, such as insight, personality style/vulnerabilities, co-occurring conditions and substance use, employment status, lack of social supports.

Strengths and Protective Factors
Describe the internal resources and external supports that can be drawn upon to improve their illness outcomes such as family support, stable accommodation, school, employment history, medication adherence, resilience, coping style, problem solving

Main issues/ drivers/ goals identified by consumer
Describe how the patient understands the current situation, what they want now and their goals to work toward.

Gaps
Outline any significant gaps and how these may affect your impression/ plan.

Risk Screen form
Complete form while considering reflective questions.
Consider all areas of risk.

Consider diagnoses and differential diagnoses

Include co-morbidities – Mental Illness, Substance Use, Personality, Physical, Cognitive Impairment.

Complete appropriate section of form.

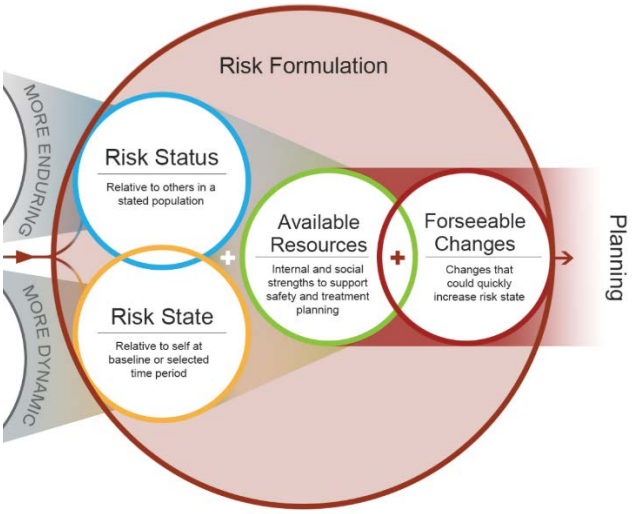

Image from Pisani et al (2016).

Pause to think

- What information is missing that might change my impression?
- How do I feel about this person and could this be influencing my impression?
- In addition to review of Risk Screen for suicide, violence, vulnerability and treatment non-adherence, reflections should also include consideration of the meaning of the events for the consumer, for example for suicide - humiliation, social defeat, entrapment, thwarted belongingness, or burdensomeness; and for violence the loss of status, or feeling provoked or humiliated.