Recovery Vision

Solid plans start with acknowledging the individual's personal Recovery Vision or Outcome which is also known as the client's goals for services. A Recovery Vision or Outcome statement is a description of what the person's hopes and dreams are about their future. It is "owned" by the person, often stated in their own words. These statements tend to be set in the future somewhere over-the-horizon, and may or may not change over time, but could become more refined.

Recovery goals might include such statements as:

- "I want to stay sober and healthy enough to take college classes."
- "I want to get my diabetes under control"
- "I want to be healthy enough to move into my own apartment, get a long-term job, and be in a healthy relationship."
- "I want to be a good parent and take care of my kids"

Some clients may not be able to say what their goals are – either because they are too influenced by the symptoms of the mental illness, haven't been asked, or because they have given up hoping/believing that goals could ever be reached. Recovery-oriented processes such as including the client's perceptions in all assessments and fostering hope in all interactions can assist the client in clarifying goals.

ICSP Goals are typically long-term outcomes that state what the person will be able to do in 18-36 months. They typically translate the Recovery Vision or Outcome statement into definitions of functioning that will be restored through services. These always point to what the recipient will be able to do in the future, where the recipient will be at in the future. They should be specifically tied to areas referenced in the assessment. They are major steps on the way to recipient meeting his or her recovery goals.

ICSP objectives are short-term aims describing what the recipient wants to accomplish in the next 90-180 day.

ICSP objectives might include such statements as:

- I will be able to manage my diabetes well enough to go back to school.
- I will have gained the skills and knowledge I need to take care of my own apartment.
- I will be able to stay calm in social situations.
- I will have a stable source of income
- I will maintain my health care coverage.

Objectives are measurable. Progress can be determined at the 90 to 180 days review.

ICSP activities/tasks/steps identify what the recipient, the case manager, and involved others will do to implement the ICSP. These activities, tasks, and steps identify what natural supports, services, programs and resources the recipient will access to achieve the objectives.

Examples of these might include:

- I will sign out for and complete the online *Diabetes Self Management* course offered by my health plan.
- With the referral and accompaniment of my case manager, I will apply for ABC ARMHS services to help me with my apartment skills.
- With the referral and accompaniment of my case manager, I will obtain a therapist at the community mental health center to help me with my social anxiety.
- With a phone referral by my case manager, I will go with my father to apply for Social Security Disability.
- I will complete the renewal forms for my Minnesota Health Care Program coverage, and review with my case manager next month before submitting.

Recipient progress toward ICSP goals should be incorporated into the reassessment process and updating of the ICSP in the MH-TCM process.

The ICSP review should reflect the progress toward the client's goals, changes in client functioning, effectiveness of the current services and resources and natural supports planned, updates of MH-TCM tasks/activities planned, any additional goals to be addressed, new preferences of the client, and what is next.

The review explains why goals are continued or changed and provides continuity of planning over time. In general, there is an expectation that objectives will change with the review of the ICSP. Because they have either been met (fully or partially) or they have not been met and need to be modified to be attainable.