CRESTWOOD BRIDGE HOUSE
EUREKA
CORE PROGRAM

The Bridge House is an Adult Residential Facility for adults, age 18 to 60 years, with mental health challenges, serving a maximum of 24 clients who reside at the facility. The Bridge House program is designed to support and meet the recovery needs of adults with chronic mental health issues as they return to community, living from a more restrictive environment or require a period of additional structure, support and respite from a more independent living situation. Referrals may come from a variety of sources, including conservators, mental health agencies, Regional Facilities and the community, including self-referral.

Daily groups and activities are diverse and rich in content, and individual recovery services vary with each client in accordance with his or her skills, needs, abilities and preferences. The Bridge House program's psychosocial rehabilitation approach is presented within a clubhouse model, where input from those receiving services is sought, and life experiences are viewed as valuable resources to all. Each client is recognized as being multifaceted, and improvement is encouraged in all aspects of his or her life, including personal empowerment, hope, having a meaningful role, and spirituality. The principle goals of the program are to work with clients to identify self-motivators so that they are invested in their recovery, teach the skills for independence, and work with community supports to assure continuing progress towards and following discharge.

Fee information is available upon request.

Goals

- Provide 24-hour support and supervision.
- Identify barriers to greater independence and work to minimize and/or eliminate them.
- In partnership with the client, develop reasonable, attainable recovery goals.
- Provide recovery services and support that are individualized and effective.
- Encourage community and family-based support.
- Maintain a homelike and healing atmosphere.

Objectives

- Establish or strengthen skills necessary for successful community living.

- Educate clients on medication use and encourage accurate self-representation when working with health providers.
- Empower clients to make healthy decisions based on their individual goals, and foster independent problem-solving, use of suitable coping skills and planning for wellness recovery (Wellness Recovery Action Planning).
- Explore self-expression and identity through the arts, work, and hobbies.
- Develop skills to engage in relationships that are mutually satisfactory and meaningful.

Services

- Provision of a therapeutic milieu, including groups and activities provided at the facility and in the community.
- Intensive assessment process.
- Integrated co-occurring recovery program for clients with substance abuse issues.
- Medication Education.
- Therapy or consultation with a licensed clinician.
- Vocational program including Dreamcatchers Empowerment Network services.
- Life skills education.
- Peer support opportunities.
- Community immersion.
- Wellness Recovery Action Planning.
- Motivational Interviewing.
- Family support and education.
- Recreation and leisure opportunities.
- Core Gifts.
- Aspects of Dialectical Behavioral Therapy.

Discharge

Evaluation for discharge, as with provision of services, is an individualized process. Discharge planning starts from the moment of admission by assessing the clients' discharge goals, their strengths and barriers related to less restricted community living, and the resources available to support them. Factors for consideration include:

- The client has consistently refrained from engaging in behaviors that endanger themselves or others.
- The client has demonstrated an understanding of what steps they must take to participate in their own recovery process (i.e. being able to identify coping strategies, recognizing indicators of potential relapse, and seeking out support).
- The client has shown an understanding of the role of medication in maintaining wellness.
- The client has met the goals and objectives of their Recovery Service Plans.

- The post-discharge level of care that will be available to the client is consistent with the clients' needs.
- The client has been maintained on their medication regimen for the time period medically indicated to adequately assess the therapeutic response.

Discharge readiness is addressed in weekly and quarterly progress assessments. Decisions regarding discharge include input from the client's home, county and the client. The client's family or support persons of choice are also included when possible and requested by the client.