Person-Centered Recovery Planning: From Theory to Practice

May 21, 2020 @ 11:00 a.m. | Virtual Training Webinar

New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Network

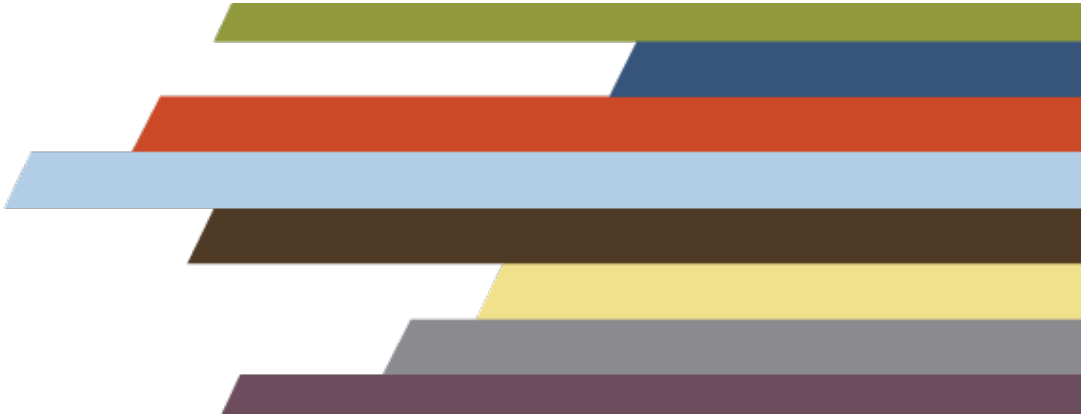
Funded by Substance Abuse and Mental Health Services Administration

Presenter:

Janis Tondora, Psy.D.

Associate Professor

Yale Program for Recovery and Community Health



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ADCARE EDUCATIONAL INSTITUTE OF MAINE INC

Meet our Presenter:

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Associate Professor
Yale Program for Recovery and Community Health

SAMHSA
Substance Abuse and Mental Health Services Administration

New England MHTTC

Mission

To use evidence-based means to disseminate evidence-based practices across the New England region.

Area of Focus

Recovery-Oriented Practices, including Recovery Support Services, within the Context of Recovery-Oriented Systems of Care.

Ensuring Inclusion

To ensure the responsiveness of our work, we will actively develop and maintain a network of government officials, policy makers, system leaders, administrators, community stakeholders, providers, researchers, youth and adults, and family members from each of the six states to guide the New England MHTTC's activities.


Resilience & Recovery
Resilience and recovery are based on respect.
Resilience and recovery emerge from hope.
Resilience and recovery are family- and person-driven.
Resilience and recovery occur via many pathways.
Resilience and recovery are community- based and promoted through collaboration.
Resilience and recovery are holistic.
Resilience and recovery are supported by peers and allies.
Resilience and recovery are supported through relationships and social networks.
Resilience and recovery are culturally-based and influenced.
Resilience and recovery are supported by addressing trauma.
Resilience and recovery involve individual, family, and community strengths and responsibility.

Housekeeping Information

Participant microphones will be muted at entry – you will be able to unmute during the discussion portion of our webinar.

If you have questions during the webinar, please use the chat or use the “raise hand” feature during discussion to have your microphone unmuted.

This session is being recorded and it will be available on the MHTTC website within 24 hours of the close of this presentation.

If you have questions after this session, please e-mail: newengland@mhttcnetwork.org.

Learning Objectives

- Identify a minimum of 3 differences between traditional methods of treatment planning and best-practice Person-Centered Recovery Planning.
- Define the 4 component “Ps” of Person-Centered Recovery Planning (Philosophy, Process, Plan, and Product/Purpose).
- Learn strategies for respecting strengths-based, person-centered principles while also satisfying expectations associated with accreditation and fiscal regulations, e.g., those associated with medical necessity criteria and/or funder documentation standards.

The Person-Centered Train: Who's on board?

Photo credit: ID 76281296 © Liquoricelegs | Dreamstime.com

Forces Behind PCRP

- Values-driven approach first and foremost!
  Golden Rule
- Endorsement by state behavioral health authorities
- Federal/national endorsement (Freedom Commission, SAMHSA, CCBHC, NCAPPS, etc.)

Funders (e.g., CMS) and accrediting bodies (e.g., CARF, JCAHO)

Accumulating evidence/data showing improved outcomes

Voice of service recipients:

When I have a voice in my own plan, I feel a responsibility to "work it" in my recovery.

You keep talking about getting me in the driver's seat when half the time I am not even in the damn car!

Poll: PCRP Implementation Concerns
Which of these is of most concern in YOUR organization?

- PCRP devalues the role of clinical expertise; what is the professional's role if the person in recovery is in the driver's seat?
- People receiving services are too impaired or uninterested to partner in the way PCRP requires.
- PCRP documentation puts us at risk for compliance issues, i.e., it might not meet medical necessity criteria.
- The forms/templates/EHRs don't have the right fields for PCRP documentation.
- There is not enough time to do PCRP, caseloads are too high.
- If PCRP increases choice, how do we manage risk issues that might emerge in the face of "bad" choices?
- Don't we already do PCRP? Is it really any different?

Common Concerns/Barriers

Person-Centered Care…A Fuzzy Concept?

"Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what 'It' is and what 'It' might look in practice."

Tondora et al., 2005, *Implementation of Person-Centered Care and Planning: How Philosophy Can Inform Practice*

PCRP represents a unique opportunity to move from person-centered THEORY to person-centered PRACTICE.

Photo credit: © 2009 Deborah Frazier

The 4 “Ps” of PCRP

The ***practice*** of PCRP can only grow out of a ***culture*** that fully appreciates recovery, self-determination, and community inclusion.

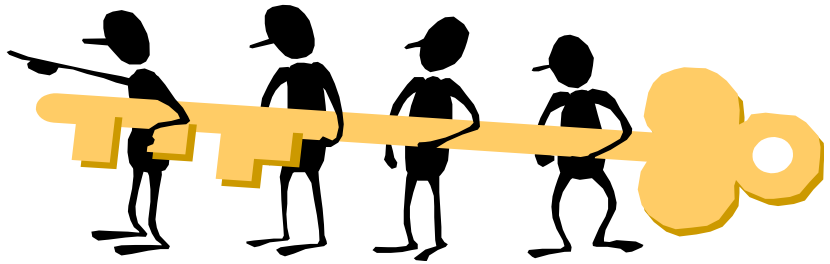
Can change what people “do”… but also need to change the way people feel and think.

4 Essential Ps:

- Philosophy – core values
- Process – new ways of partnering
- Plan – concrete roadmap
- Purpose – meaningful outcomes

Recently Released Web-based Video & Tips Sheet Series
http://www.promise.global/propel.html
Tondora & Davidson (YALE) and Rae, & Kar Ray (CAMBRIDGE)

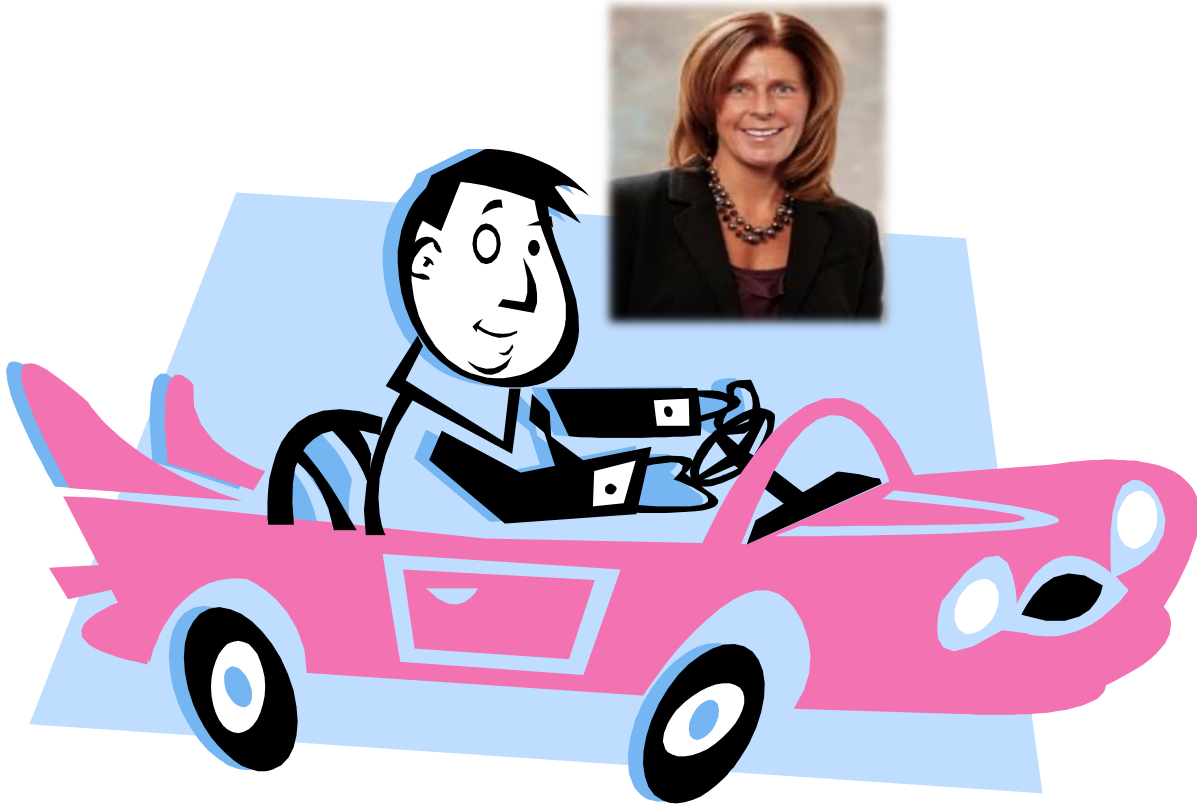
The Process of PCRP: Key Practices



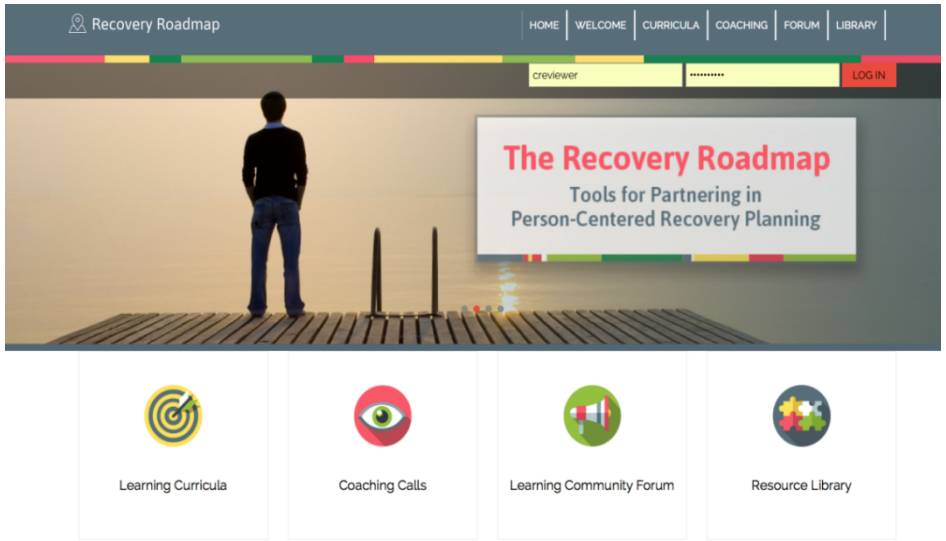
- Person is a partner in all planning activities/meetings; advance notice (person-centeredness)
- Person has reasonable control over logistics (e.g., time, invitees, etc.)
- Person offered a written copy/transparency
- Shift in structure/roles in planning meetings
- Education/preparation regarding the process and what to expect (Toolkit/ Recovery Roadmap)

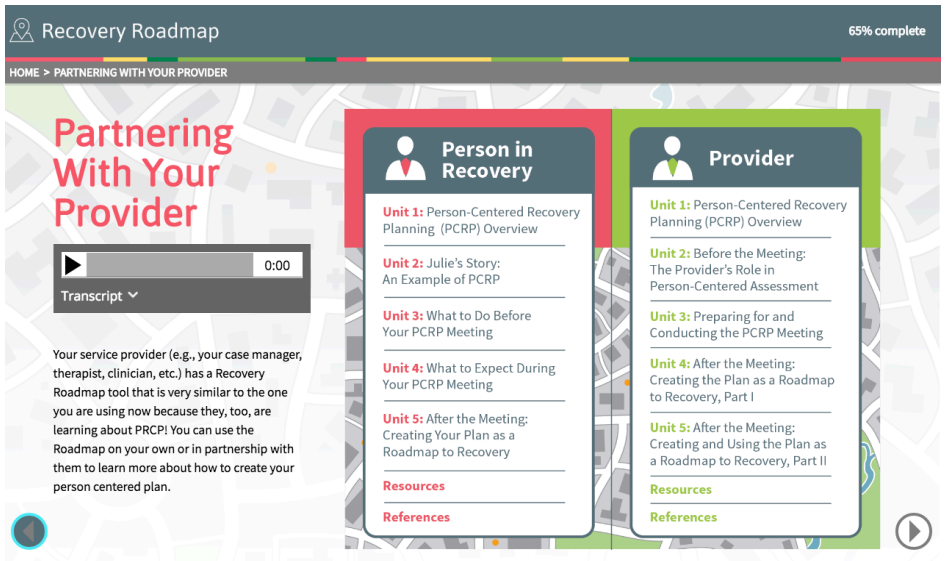
If the person is in the driver's seat, where does that leave ME?

- Does PCRP devalue the role of the professional or clinical treatment?
  - NO! PCRP is based on a model of PARTNERSHIP…
  - Respects the person's right to be in the driver's seat but also recognizes the value of professional co-pilot(s) and natural supporters



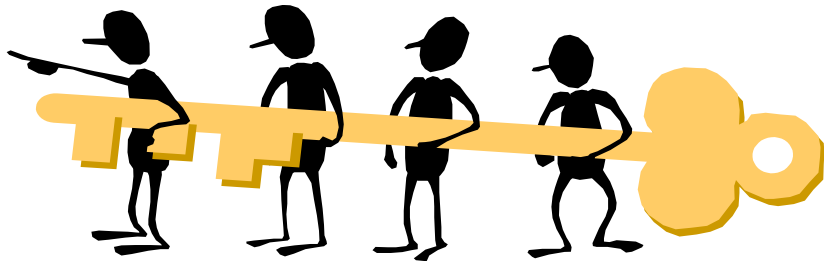
The Recovery Roadmap Project





- NIH-supported Phase I and II SBIR grants
- Developed innovative, multimedia tools to support the uptake of PCRP in behavioral health settings
- Versions for practitioners AND service recipients
- Randomized trial underway in State of CT

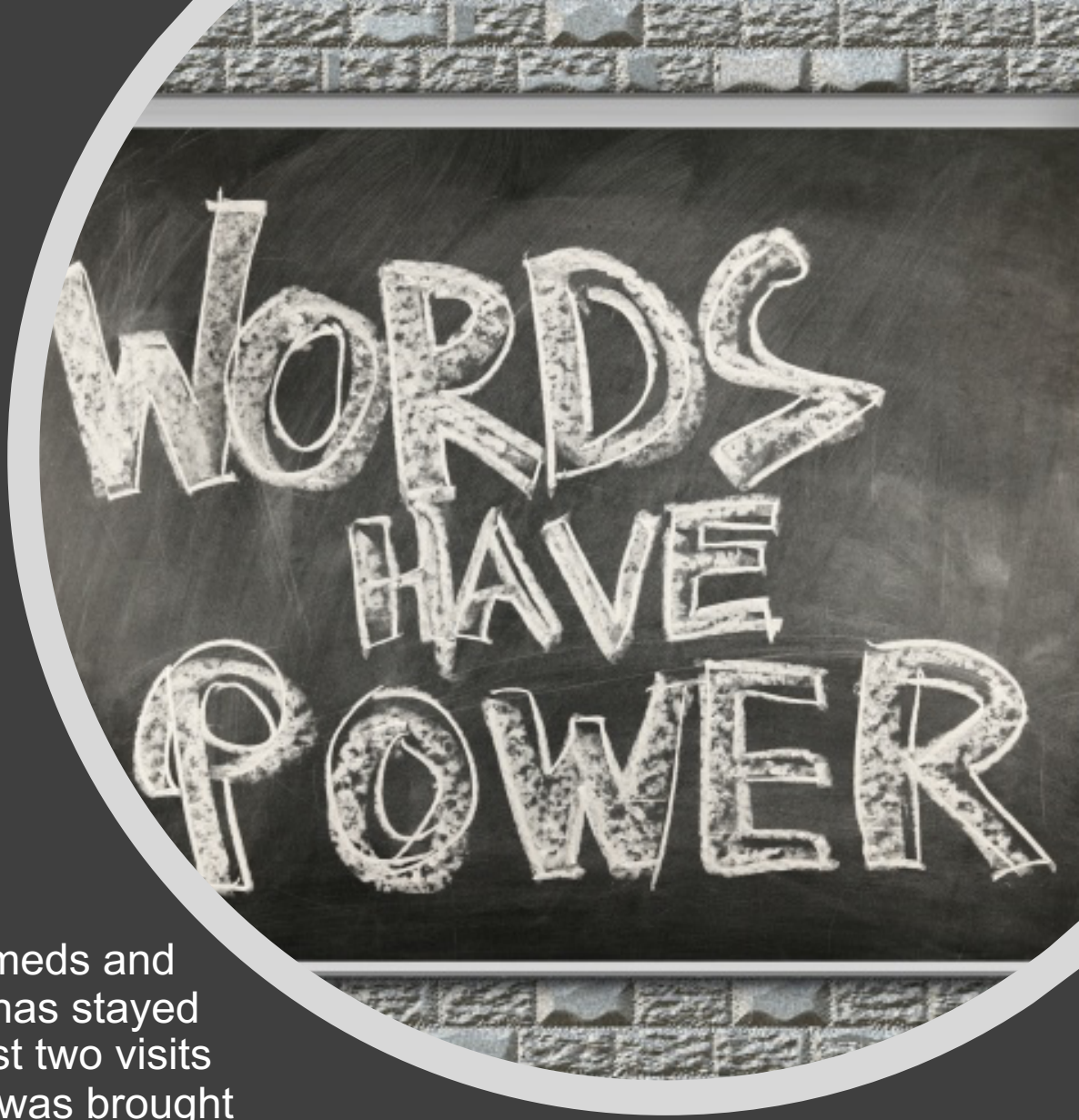
The Process of PCRP: Key Practices



- Recognize the range of contributors to the planning process
- Capitalize on role of peers wherever possible
  - Distribution of effort based on unique talents…promotes efficiency AND quality
- Understand/support rights such as self-determination
- Value community inclusion/life – “while,” not “after”
- Strengths-based approach in both language and assessment/planning

Strengths-based Language

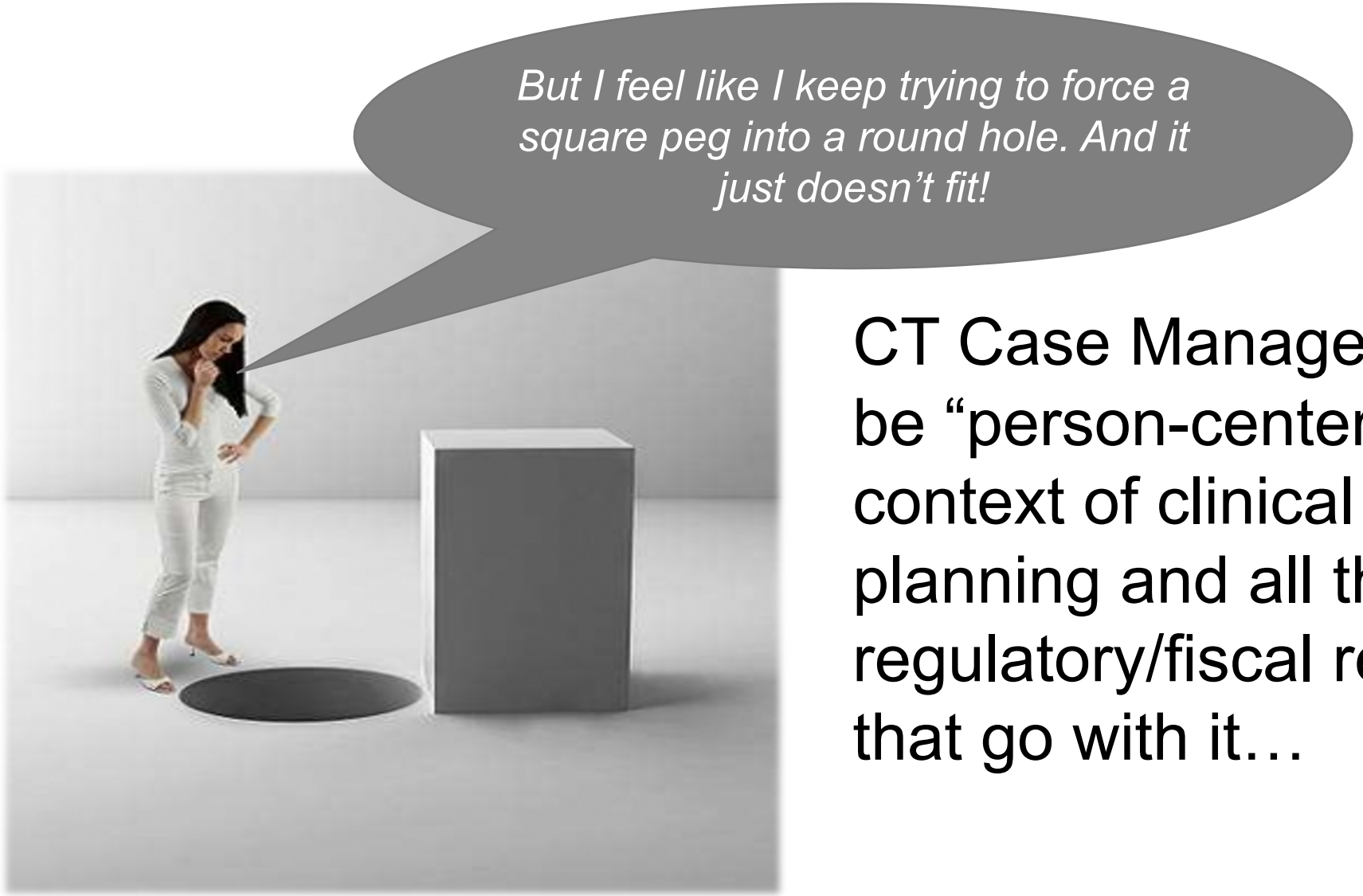
In the last 18 months, Sandra has worked with her doctor to find meds that are highly effective for her and she has been active in activities at the clinic and the social club. Sandra and team all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. However, people have become concerned lately as she has been missed at several activities, including a bloodwork appointment at Clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the staff could assist her.



For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

Sounds great… but how do you balance the spirit of person-centered care with the rigor required in plan documentation?

The Documentation Challenge:



CT Case Manager on trying to be "person-centered" in the context of clinical treatment planning and all the regulatory/fiscal requirements that go with it…

Meet Mr. Gonzalez

Mr. Gonzalez, a 31-year-old married Puerto Rican man, is living with bipolar disorder and he struggles with addiction to alcohol which he often relies on to manage distressing symptoms. During a recent period of acute mania, Mr. Gonzalez was having increasingly volatile arguments with his wife in the presence of his two young sons, ages 3 and 5. On one occasion, he shoved his wife to the floor which prompted her call to the police. When the police arrived at the home, Mr. Gonzalez was uncooperative and agitated, and he was subsequently admitted to an inpatient psychiatric facility for evaluation and treatment. His wife is open to reconciliation, and she is actively involved in his treatment at the hospital. Mr. Gonzalez states that his love for his family and his faith in God are what keep him going in difficult times.

Snapshot: A Traditional Plan

Goal(s):

Achieve and maintain clinical stability; reduce assaultive behavior; comply with medications

Objective(s):

Pt will attend all scheduled groups on unit and mall; Pt will take all meds as prescribed; Pt will complete anger management program; Pt will demonstrate increased insight re: clinical symptoms; Pt will recognize role of substances in exacerbating aggressive behavior

Services(s):

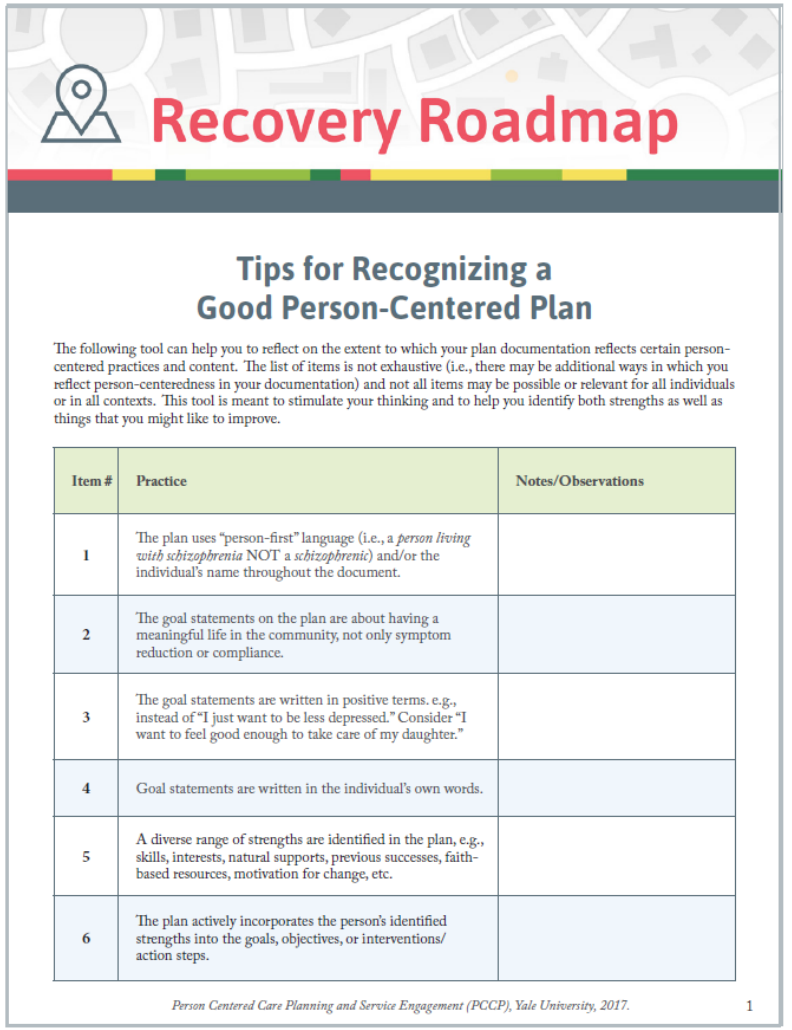
Psychiatrist will provide medication management; Social Worker will provide anger management groups; Nursing staff will monitor medication compliance

Traditional Plan

- Take my lithium
- Increase insight
- Reduce assaults
- Comply with group schedule

What Does It Look Like?

PCRP Documentation



Recovery Roadmap

Tips for Recognizing a Good Person-Centered Plan

The following tool can help you to reflect on the extent to which your plan documentation reflects certain person-centered practices and content. The list of items is not exhaustive (i.e., there may be additional ways in which you reflect person-centeredness in your documentation) and not all items may be possible or relevant for all individuals or in all contexts. This tool is meant to stimulate your thinking and to help you identify both strengths as well as things that you might like to improve.

Item #	Practice	Notes/Observations
1	The plan uses "person-first" language (i.e., a *person living with schizophrenia* NOT a *schizophrenic*) and/or the individual's name throughout the document.	
2	The goal statements on the plan are about having a meaningful life in the community, not only symptom reduction or compliance.	
3	The goal statements are written in positive terms. e.g., instead of "I just want to be less depressed." Consider "I want to feel good enough to take care of my daughter."	
4	Goal statements are written in the individual's own words.	
5	A diverse range of strengths are identified in the plan, e.g., skills, interests, natural supports, previous successes, faith-based resources, motivation for change, etc.	
6	The plan actively incorporates the person's identified strengths into the goals, objectives, or interventions/ action steps.	

Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017. 1

Big Picture View PCRP Elements

GOAL
as defined by person;
what they are moving "toward"…not just eliminating

Strengths/Assets
to Draw Upon

Barriers/Assessed Needs
that Interfere

Short-Term Objective
S-M-A-R-T

Interventions/Methods/Action Steps
- Professional/"billable" services
- Clinical & rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters

Goals: What Do People Want?

Independence
I want to control my own money.

Work /education
I want to finish school

Spiritual connection
I want to get back to church.

Health/well-being
I want to lose weight.

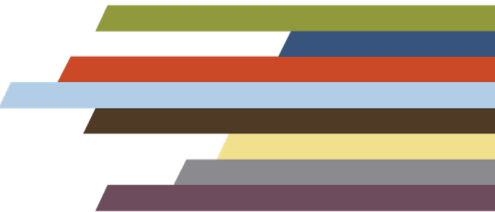
To be part of the life of the community…

Housing
I want to move out of the group home.

Social activities
I want to join a bowling league.

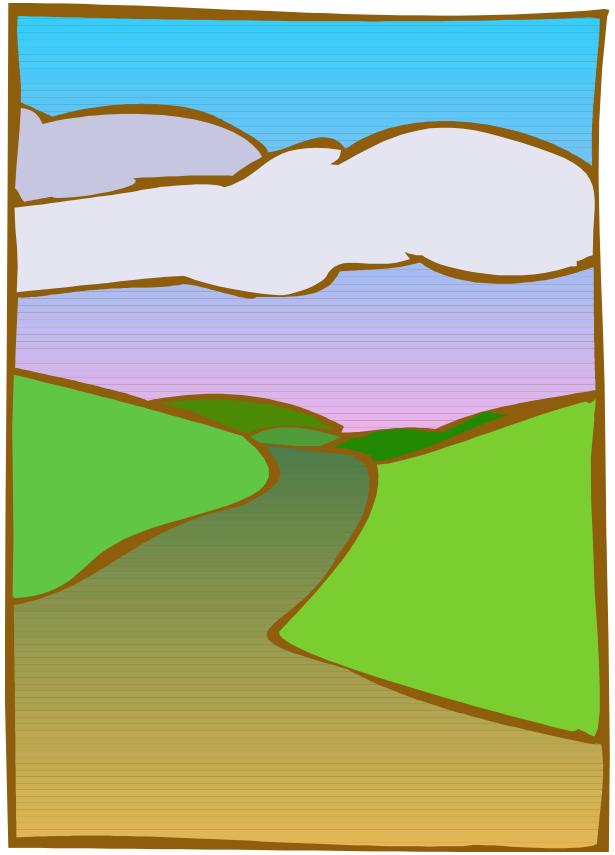
Satisfying relationships
I want to see my grandkids.

Valued Roles
I want to volunteer at the Senior Center.



Goals

- Long term, global, and broadly stated
- Life changes as a result of services
- Ideally expressed in person's own words
- Written in positive terms
- Consistent with desire for self-determination
  - Influenced by personal world view



Strengths

- Identifies aspects of the person's life that they can draw from to move toward a specific goal
- Promotes engagement and communicates message of hope and confidence in the person's abilities
- Captures the person's unique identity, resources, interests
  - best qualities/motivation
  - strategies already utilized to help, self-directed wellness
  - competencies/accomplishments
  - cultural traditions and connections
  - community and social relationships
  - environmental factors that will increase the likelihood of success

Capitalize on Strengths in the Plan

i.e., A person with a love for books might be engaged by asking him/her to help out in the agency library…

A person who loves music might benefit from access to CDs/headphones as away to quiet voices…

A spiritual person contemplating suicide might want direction from a Spiritual Director…

An animal lover struggling with obesity due to med side effects might walk a dog regularly.

Barriers

- What is getting in the way of the person achieving their goal?
  - Why can't they do it tomorrow?
  - What prevents them from doing it on their own?

- Consider:
  - Need for skills development, intrusive symptoms, lack of resources, problems in behavior, difficulty in activities of daily living, disruptions in meaningful relationships and roles, threats to basic health and safety, challenges/needs as a result of a mental/alcohol and/or drug disorder; diagnosis alone is NOT the barrier

In order to inform and individualize the plan, it is important to be explicit and describe not just WHAT is getting in the way, but HOW…

Descriptive Barriers Connect the Dots Back to the Goal

Weak Examples

- Anger issues
- Depressive symptoms
- Addiction

Strong Examples

- Outbursts and conflicts with neighbors
- Lacks the energy to take care of basic household tasks
- Substance use at apartment has led to police calls and risk of eviction

Short-term Objectives: What do they do?

- Concrete, positive CHANGES in behavior/functioning/status
- Divide larger goals into manageable steps of completion
- “Proof” you are getting closer; help to assess progress; is all your LINKING working?
- Send a hopeful message we believe things can, and will, be different for the better!

Objectives Should be SMART

Here's a way to evaluate your objectives. Are they SMART?

- **S**imple or Specific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-framed

Will you definitively be able to say, it was achieved, yes or no…?

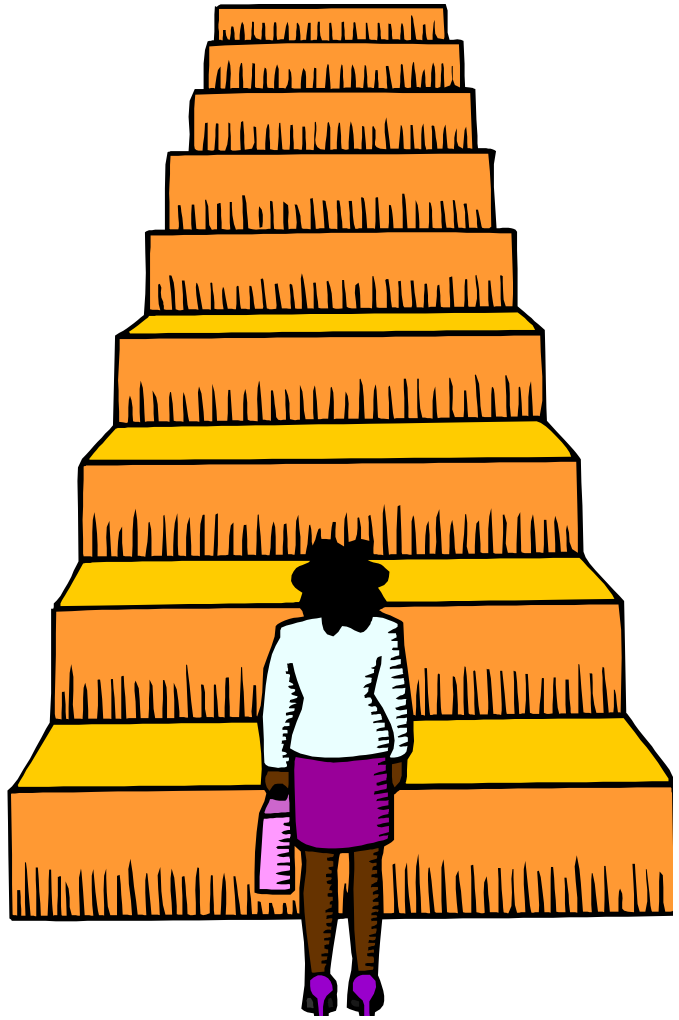
Technical Formula for Crafting Objectives

Within_____**(amount of time),** _____ **(Name)**
will have improved **(documented barrier)** _____, as evidenced by_____
(a meaningful change in functioning or behavior that is related to the life role goal.)

Examples:

- Within the next 30 days, John will have improved management of panic as evidenced by successfully riding the subway to work without exiting the train before his stop.

- Phillip will have increased social interaction as evidenced by meeting a friend for coffee at Dunkin' Donuts at least one time per week within the next 30 days.



Objectives Are About Outcomes, NOT Service Participation

The following objective is about service participation: **People can participate in services for years and not achieve the intended benefits!**

i.e., Wanda will voluntarily attend DBT group 2x weekly.

Objectives are about what you hope will change for the person as a result of services & the person's hard work:

i.e., Wanda will apply mindfulness techniques to reduce instances of self-injury to no more than one per week for 2 consecutive weeks.

Interventions/Services & Action Steps

The plan serves as a contract for who is responsible for what actions:

- Reflect a use of EBPs
- Respect individual choice and preference
- Describe medical necessity by clearly describing how services are intended to overcome that individual's barriers
- Are specific to the individual's objective, no "kitchen sink" service sets

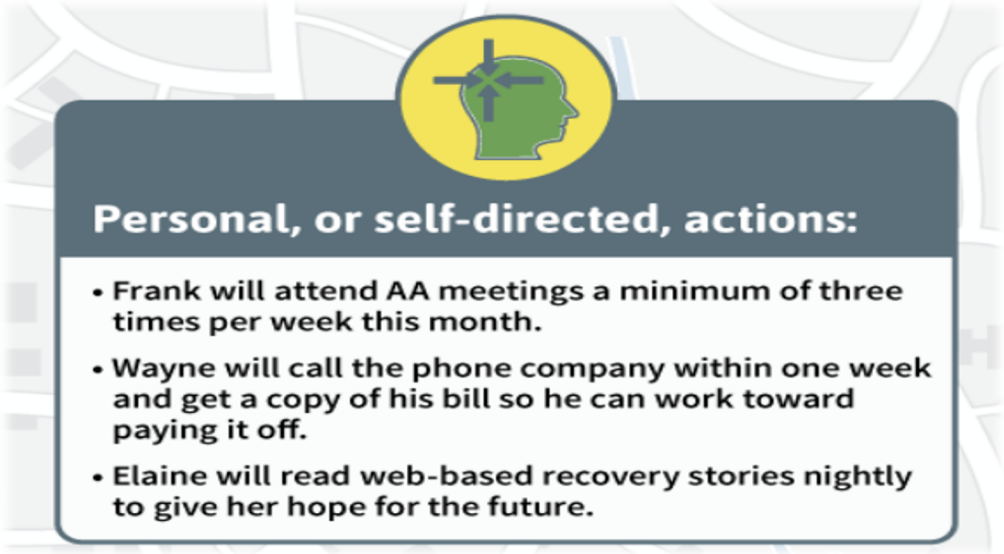
Critical Elements – The “Ws”

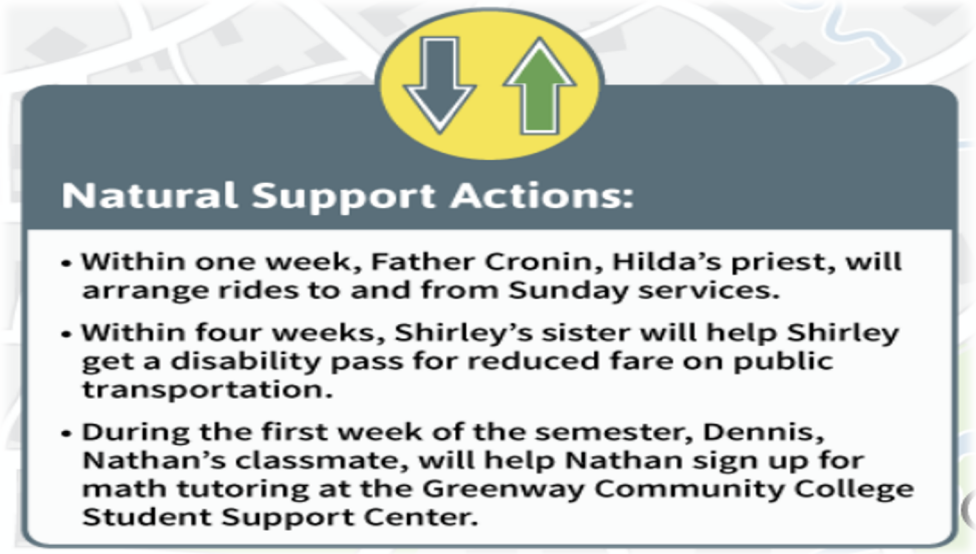
Professional services should specify…

- WHO will provide the service, i.e., name and job title
- WHAT: The TITLE of the service, e.g., Health & Wellness Group
- WHEN: The SCHEDULE of the service, i.e., the time and day(s)
- WHY: The individualized INTENT/PURPOSE of service

Interventions:
Self Directed and Natural Support Actions

- **Self-directed** actions are a reminder that the consumer, too, has a responsibility in contributing to the recovery plan.
- **Natural Support** actions reflect the growth of the informal recovery network that supports the person's recovery over time.

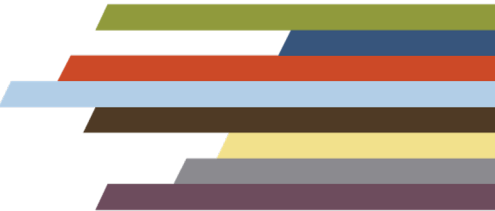




POLL: So what do you think?

Which of the below is the best goal statement for Mr. Gonzalez's PCRP?

- I don't want to lose control anymore.
- Mr. Gonzalez will better manage distressing symptoms without drinking.
- I want my family back.
- Mr. Gonzalez will attend the anger management group.
- I just want to be a good man.



Mr. Gonzalez Revisited…

Life Goal:

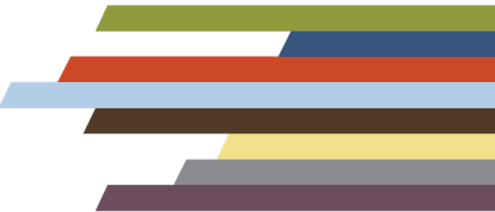
I want my family back. I don't want my boys to ever be afraid of me.

Barriers Which Interfere:

Acute symptoms of mania led to violence in the home; lack of coping strategies to manage distress from symptoms; abuse of alcohol escalates behavioral problems

Strengths to Draw Upon:

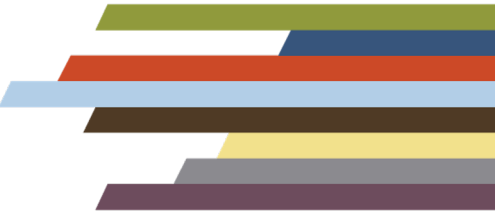
Devoted father; motivated for change; supportive wife; Catholic faith and prayer are source of strength/comfort; positive connection to Peer Specialist; intelligent



Sample Short-Term Objective(s)

Within 30 days, Mr. Gonzalez will apply learned coping strategies to have *positive interactions with wife and children during one supervised visit in family therapy session.

- **Services & Other Action Steps**
  - Doc to provide med management daily for 2 weeks to reduce irritability & acute manic sx
  - Family Specialist to provide family therapy sessions 2X weekly to coach Mr. Gonzalez to provide psycho-education to family regarding mental health and recovery
  - CSP Specialist to provide weekly coping and communication Skills-Training to improve Mr. Gonzalez's ability to manage distressing symptoms and to have healthy relationships at home (use of teaching, role playing, coaching, etc.)
  - Referral to spiritual counseling agency chaplain to promote use of faith/daily prayer as positive coping strategy to manage distress
  - Wellness Recovery Action Plan with Peer Specialist to promote illness self-management



Take home message…

- You CAN create a recovery plan which honors the person and satisfies the chart!
- This is central in your partnership with individuals so they can move forward in their recovery in the community of their choice!

We just need to stop accepting what is and start creating what should be…
Dale DiLeo

Closing Q&A…
Your Thoughts and Ideas

For more information:

janis.tondora@yale.edu