Person-Centered Recovery Planning: Partnering for Wellness and Recovery

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Wednesday, September 14th

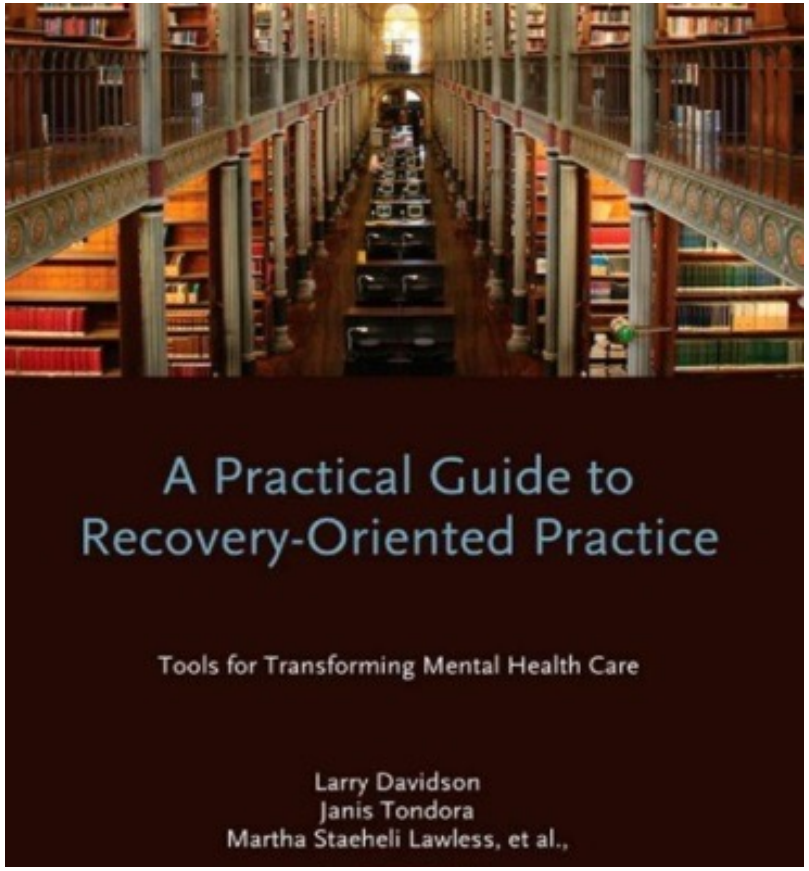
1:30pm - 4:00pm

New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Ne

Funded by Substance Abuse and Mental Health Services Adminis

(SAMHSA #1H79SM081775-01)



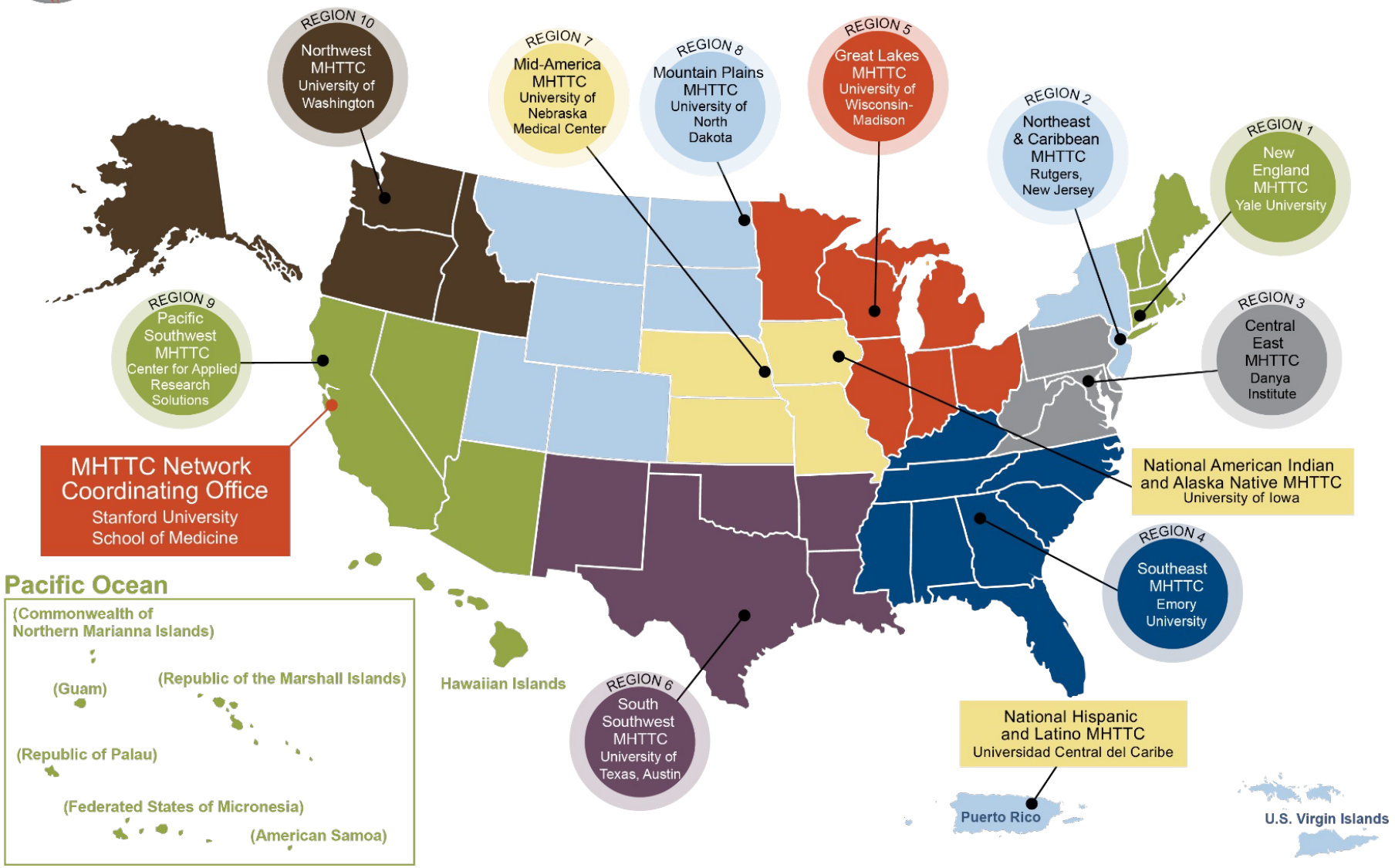
Introductions and Background

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



New England MHTTC

Partners
Yale Program for Recovery and Community Health in partnership with C4 Innovations and the Harvard University Department of Psychiatry

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.

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

With special thanks to our funder,

SAMHSA
Substance Abuse and Mental Health Services Administration

Our Guiding Principles

An Acknowledgement…

- Behavioral health work is often high stress and can cause you to feel burnt out emotionally and physically
- We recognize that you all are doing the very best you can, often in the face of overwhelming circumstances
- Nothing about today's conversation should be taken as an indictment of your good work; nor does it invalidate your expertise
- Opportunity to learn and take it to the next level!

Forces Behind PCRP

- Values-driven approach first and foremost! *Golden/Platinum Rule*
- Endorsement by state health and social service authorities
- Federal/national endorsement (Freedom Commission, SAMHSA, NCAPPS, etc.)
- Funders, accrediting bodies, licensing
- 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.

An Evolution Over Time

Traditional

Independence and community activities come after someone is clinically stable.

Following providers' instructions is valued.

Professionals hold the information (e.g., plans, assessments, records).

Problems (the "problem list") drive treatment.

Outcomes focus on clinical stability (e.g., fewer symptoms, fewer hospital stays).

Focus on professional services (e.g., medications, therapies, case management).

Treatment often happens in formal treatment settings; only mental health professionals are listed in the treatment plan.

Priority on keeping the person safe and doing what is in the "best interest" of their safety and stability.

Person-Centered

Independence and involvement in the community are viewed as civil rights and are supported in clinical treatment.

Active participation and empowerment of the person is strongly encouraged.

All team members have access to information to increase collaboration.

Interests, abilities, and personal choices are key in the recovery plan. Focus is on the person's goals.

Outcomes also include quality of life and recovery areas (e.g., employment, stable housing, greater control over their treatment and life).

Many different supports are valued and included (e.g., faith-based supports, peer support, supported rehabilitation).

A range of settings and natural supporters are valued and part of the treatment plan.

Safety remains a priority, but people are supported in trying new things. Responsible risk-taking is seen as a natural part of growth and recovery.

But don't we ALREADY do this? Exercise/Reflection

- ✓Compliance with treatment
- ✓Decreased symptoms/Clinical stability
- ✓Better judgment
- ✓Increased Insight…Accepts illness
- ✓Follows team's recommendations
- ✓Decreased hospitalization
- ✓Abstinent
- ✓Motivated
- ✓Increased functioning
- ✓**Residential Stability**
- ✓**Healthy relationships/socialization**
- ✓Use services regularly/engagement
- ✓Cognitive functioning
- ✓Realistic expectations
- ✓Attends the job program/clubhouse, etc.
- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daughter
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓**A home to call my own**
- ✓**Love…intimacy…sex**
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning

Think About It…

Just imagine…

- Beyond US and THEM
  - People with mental health and addictions concerns generally want the exact same things in life as ALL people.
  - People want to thrive, not just survive…

And an illustration…
Meet Mr. Gonzalez

Mr. Gonzalez is a 31-year-old Puerto Rican cisgender man. He is married and has 2 young sons (ages 3 and 5). He lives 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 boys. On one occasion, he shoved her to the floor which prompted her call to the police. When the police arrived, Mr. Gonzalez was uncooperative and agitated, and he was subsequently admitted inpatient 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 (he is a devout Catholic) 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

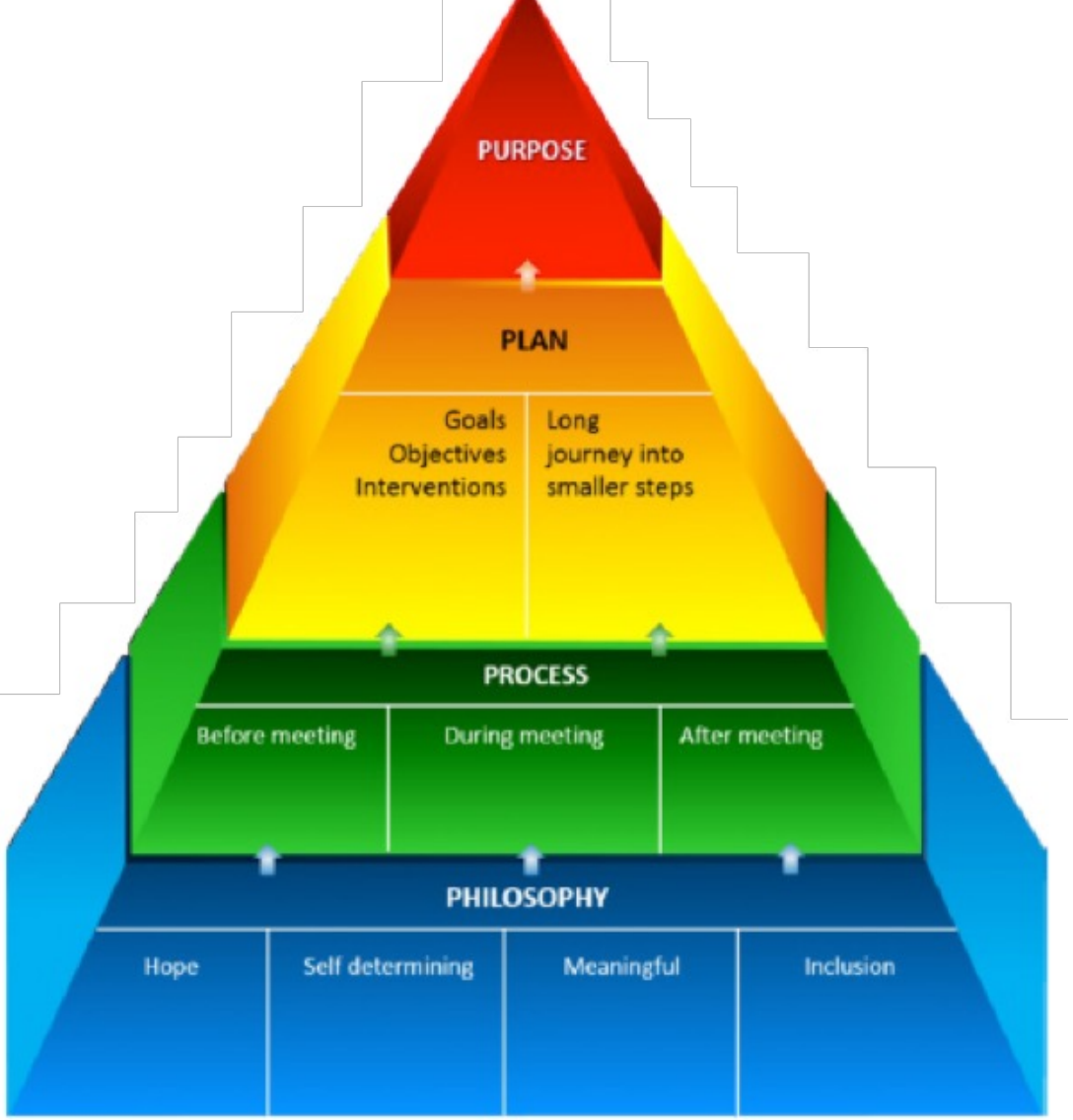
What exactly is it? The 4 “Ps” of PCRP

Philosophy – core values and beliefs

Process – new ways of partnering and sharing decision making

Plan – a concrete roadmap to guide the work

Purpose – meaningful person-centered outcomes



Web-based Video Overview of PCRP in Behavioral Health See:
https://youtu.be/IuNYB9Prnk0
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

Consider Your Meeting Dynamics

- Spatial set up of the room speaks volumes
- Team members arrive on time; introductions
- A range of contributors are involved in the planning process
- The person is given your/the team's full attention,
- The person is not "talked about" during the meeting as if they are not there.
- "What comes next" is explained to the person, including an opportunity for them to review the plan; provide input

Educate and Prepare the Person

- *This toolkit can be useful for anyone – regardless of whether they have a psychiatric condition or an addiction.*

- *Everyone needs help at times setting goals, and figuring out what they want.*

- *This toolkit has some aspects specific to people with a mental illness or addiction, but could be really used by anyone.*

https://medicine.yale.edu/psychiatry/prch/research/Toolkit_030511_204164_284_23930_v1.pdf

Summer | 09

Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan

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Supported by generous funding from CT's Transformation Grant

Embrace HOPE

The Process of PCRP: Key Practices

- Recognize the range of contributors (including peers) to the planning process
- Understand/support rights such as self-determination
- Value community inclusion/life - “While,” not “after”
- Employs a strengths-based approach
- ALL of the above impacted by cultural factors and, in many cases, equity issues

Recognize Culturally-Specific Aspects of Planning, Recovery, and Goal Setting

- Working with anyone is inevitably a cross-cultural enterprise.
- Practice cultural humility
- Implications for PCRP in terms of the relationship, goal setting, and planning and treatment preferences.

PCRP is about FREEDOM

At its core, person-centered care and planning aim to increase one's degree of freedom. Freedom to build a good life in a community of your choice. Freedom to realize your full potential. Freedom from oppression. Freedom to control choices that impact your life and your experience in care. Now more than ever before, both the COVID-19 pandemic and recent violence against people of color have made painfully clear the fact that not all people are equally free.

Tondora et al., 2022

EVERYTHING!

If we listen to the voice of people receiving services

Community Life: What does it have to do with *Recovery??*

- *There is this little pub down the street that I just love. I like to go there and have a tonic and lime and just chat with the patrons. I am not sure what it is about that place?? But it makes me feel good. Maybe…maybe it's a lot like 'Cheers' – you know, a place where everybody knows my name… I am just Gerry, period. Not "Gerry the mental patient…"*

Language and the Challenge Before Us

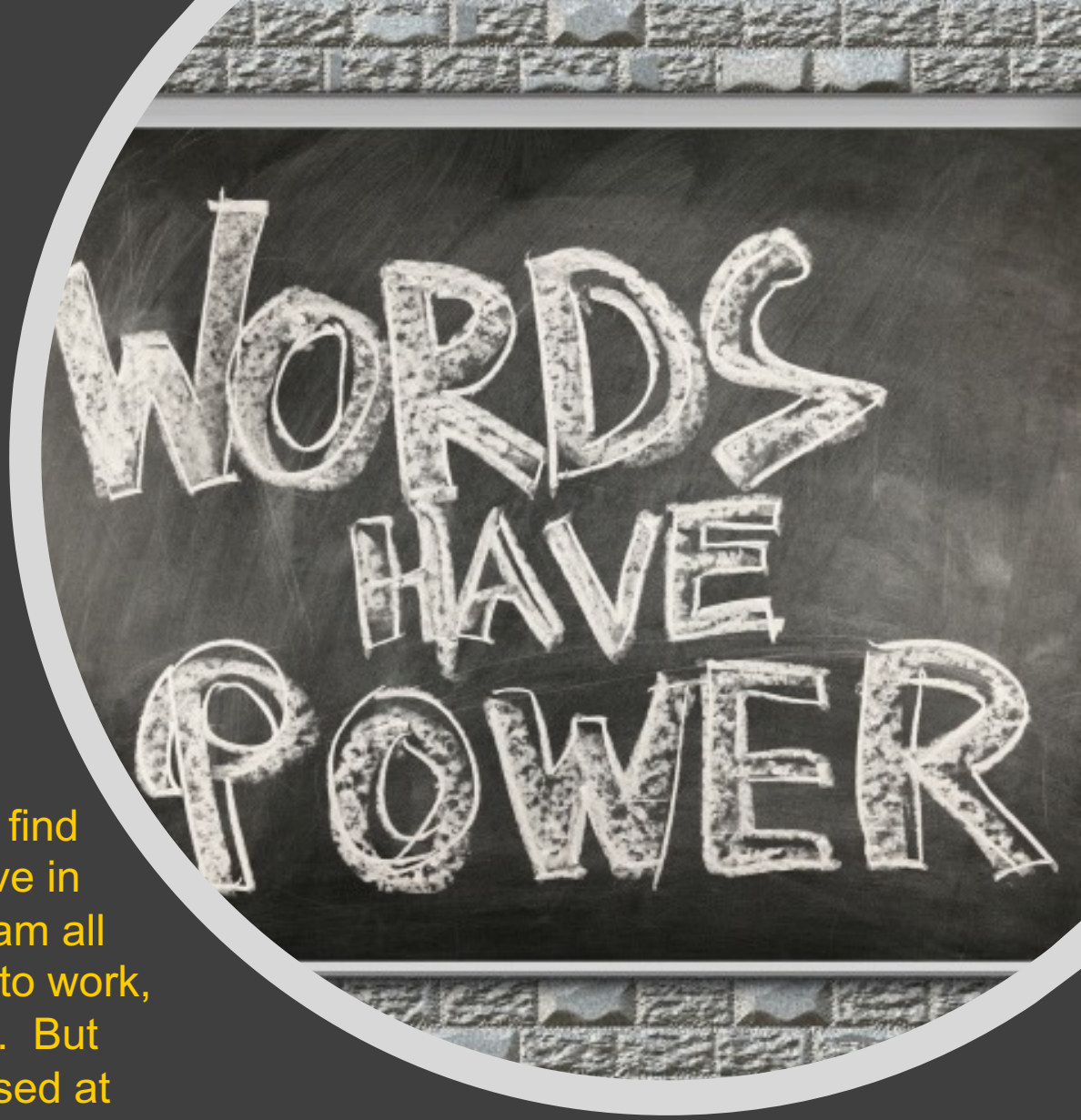
- Person-centered values do not consistently translate into person-centered language

- Despite growing consensus around the importance of a strengths-based approach in a recovery-focused system, the actual language (both written and verbal) routinely used in behavioral health service settings can be pejorative, dehumanizing, and disrespectful.

Strengths-based Language

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.

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 her 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. But 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.



Strengths-Based Language

What goal would motivate **YOU** in Your Recovery?

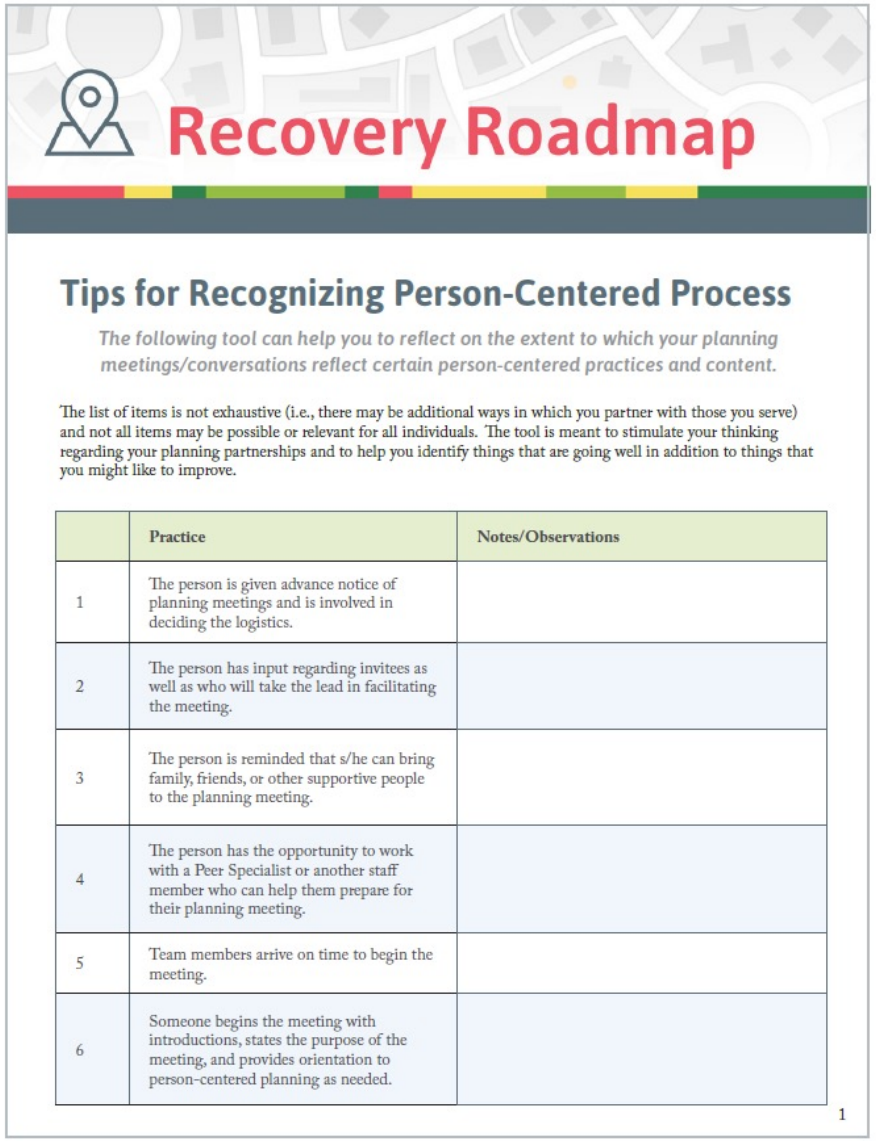
Recovery Plan Goal

- "I want to have friends and family back in my life."

Treatment Plan Goal

- Patient will experience improvements in interpersonal boundaries and socialization, communication, and relational skills

Recovery Roadmap Resource: PCRP PROCESS



Recovery Roadmap

Tips for Recognizing Person-Centered Process

The following tool can help you to reflect on the extent to which your planning meetings/conversations reflect certain person-centered practices and content.

The list of items is not exhaustive (i.e., there may be additional ways in which you partner with those you serve) and not all items may be possible or relevant for all individuals. The tool is meant to stimulate your thinking regarding your planning partnerships and to help you identify things that are going well in addition to things that you might like to improve.

	Practice	Notes/Observations
1	The person is given advance notice of planning meetings and is involved in deciding the logistics.	
2	The person has input regarding invitees as well as who will take the lead in facilitating the meeting.	
3	The person is reminded that s/he can bring family, friends, or other supportive people to the planning meeting.	
4	The person has the opportunity to work with a Peer Specialist or another staff member who can help them prepare for their planning meeting.	
5	Team members arrive on time to begin the meeting.	
6	Someone begins the meeting with introductions, states the purpose of the meeting, and provides orientation to person-centered planning as needed.	

1

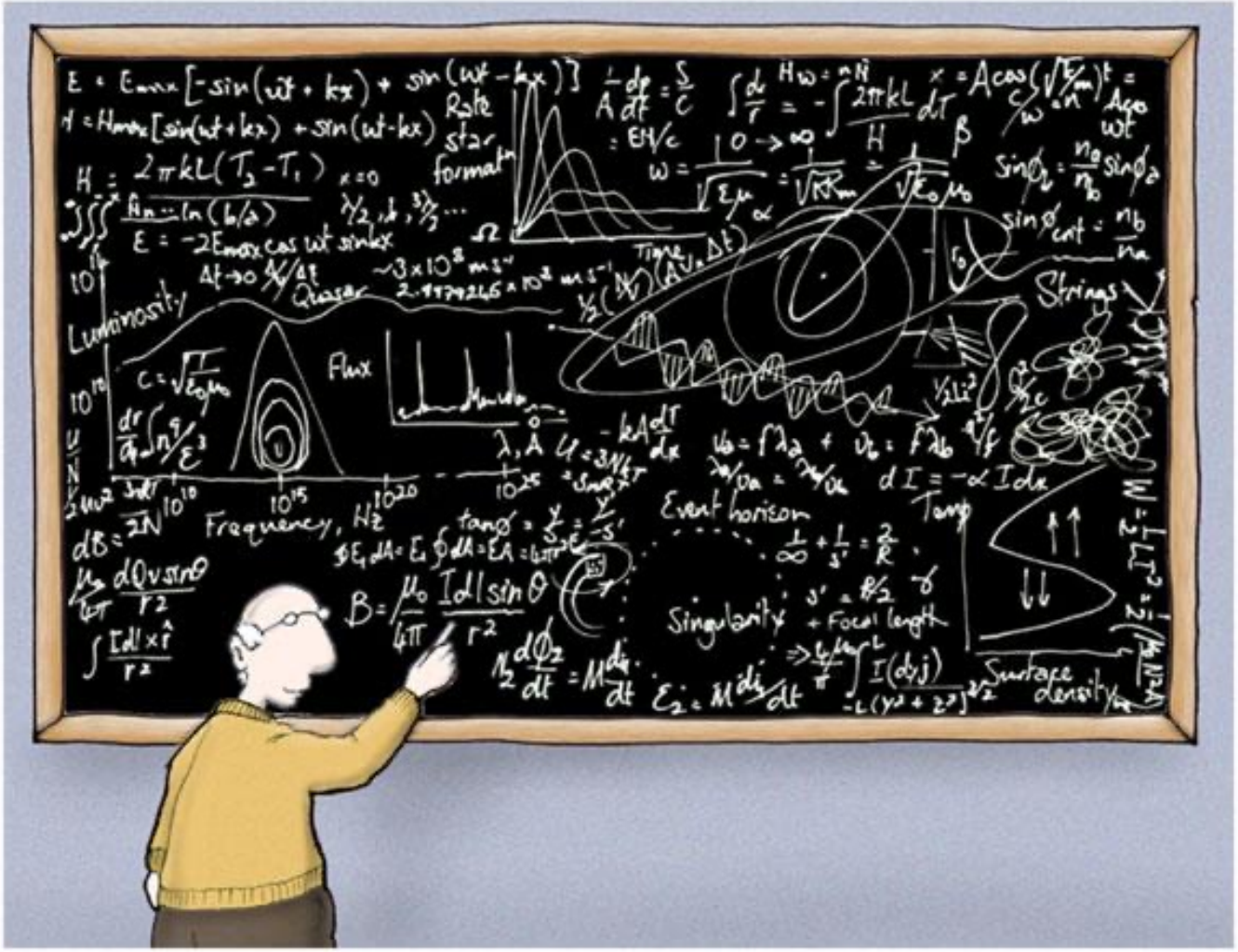
- *Note: Items often refer to the "team" or team meeting but just as readily apply to 1:1 planning activities*

Video Reflection:
PCRP Process:

"I'm on the team!"

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

… without creating plans so detailed, no one uses them?!



PCRP Documentation: Big Picture

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

Strengths/Assets
to Draw Upon

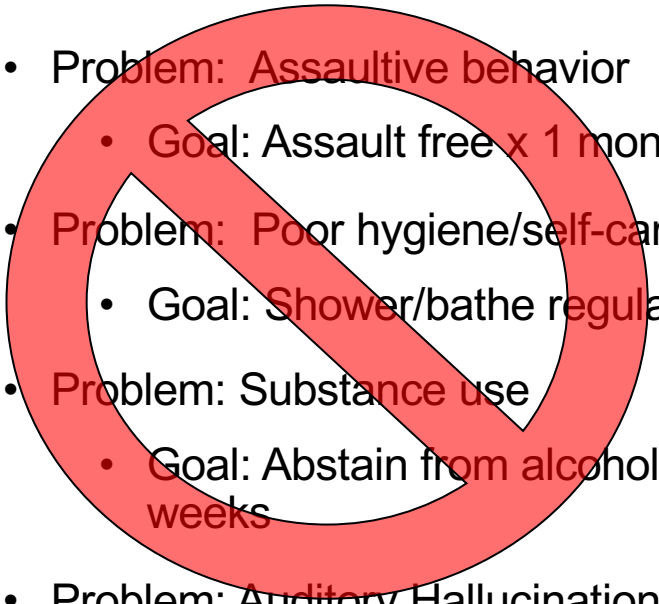
Barriers/Assessed Needs
that Interfere

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

A Marked Departure from Traditional Treatment Plans

Problem-Centered
One Goal for Every Problem as Identified in the Assessment



- Problem: Assaultive behavior
  - Goal: Assault free x 1 month
- Problem: Poor hygiene/self-care
  - Goal: Shower/bathe regularly
- Problem: Substance use
  - Goal: Abstain from alcohol x 2 weeks
- Problem: Auditory Hallucinations
  - Goal: Increase reality testing

Person and Goal-Centered
Goal of the PERSON and How Barriers Interfere

I want my job back so I ... my kids.

- Loss of ... ysical conflict with co-work... *...out when I felt uns...*
- Self... present well in job inte... *for the interview.*)
- Subst... ...bsenteeism and job loss (*I ... ...d got let go.*)
- Auditory hallu... ...make it difficult to interact with customers. (*My voices really bother me at work.*)

Learning Through Roma's Story

Roma: Assessment and Background Information

History, Demographics, and Presenting Issue

Roma is a 29 year old, Puerto Rican female who has been treated on and off in the XYZ system of care for 15 years due to problems associated with her diagnosis of major depression, post-traumatic stress disorder, and poly-substance use. She was incarcerated for a year for drug-related offenses (possession of cocaine, theft, prostitution) and risk of injury to a minor (repeated DUI with children in her car; leaving children unattended during drug use). During this time, her children (currently a 14 year-old daughter and a 9 year old son) were in the custody of her cousin who is a supportive influence in Roma's life and recovery. Upon her release from prison 6 months ago, Roma began living with her cousin and kids. At some point, Roma started drinking and then stole money from her cousin to buy alcohol. During one incident, the cousin had left the kids overnight in Roma's care so she could attend an out-of-state funeral. When she returned, Roma was passed out on the couch and she did not know where her 9-year-old was. It turned out that the 9-year-old was playing basketball at the local community court, but Roma later admitted that she had left the kids unsupervised as she was drinking with neighbors. In addition, Roma's cousin tells you that Roma had been having great difficulty setting limits with the children, and that she relates to them more as a friend than a maternal figure. In addition, there were frequent verbal "blow-outs" with her teenage daughter, and on one occasion, Roma slapped her across the face when she was drunk. Roma's cousin is very concerned about Roma's continued alcohol use and her volatile relationship with her daughter, so she asked Roma to leave the apartment until she "cleaned up her act."

The Department of Children and Families (DCF) has been involved in Roma's case for several years given her previous charges and difficulties taking care of the kids. When Roma had to leave her cousin's apartment, her DCF worker suggested she seek temporary housing and services at a local transitional shelter. In addition, they would like Roma to connect with a variety of community-based health services including primary care and outpatient mental health and addiction services. She has been at the shelter now for 4 weeks, and she makes it clear that she wants to work toward re-gaining custody of her children with the help of her various healthcare providers. Her cousin is willing to let Roma visit with the kids provided that she sees Roma is taking steps to get her life back on track. Roma has been enrolled in your Case Management program to help her do this and to take advantage of the range of services available to her.

Family Background/Early Childhood

Born in Puerto Rico, Roma is the 4th of 5 children. Her mother reportedly suffered from serious mental illness and abandoned the children when Roma was 6 years old. She was then raised by her maternal grandmother for two years until the age of 8 when the grandmother passed away suddenly. She moved in with her biological father, who sexually abused Roma until Roma became pregnant by him at the age of 14. Roma ran away from home, and with the help of neighbors, she contacted extended family in the U.S. and re-located to Connecticut to live with a maternal aunt and uncle. The aunt and uncle are now deceased, but Roma continues to be close with her cousin who currently has temporary custody of her children.

Education/Employment

Upon re-locating to Connecticut, Roma enrolled in high-school while her aunt and uncle assisted with child care responsibilities for her children. She was an average student, but an avid reader who also excelled in creative writing and arts classes. However, she quickly became involved in a number of abusive relationships, and turned to drugs and alcohol as she became increasingly depressed. Roma dropped out of school mid-way in her Junior year. She has worked off/on as a housecleaner for the past decade; however, difficulties with

Meet Roma: Recap

- 29 year old Puerto Rican female and loving mom of 2 teens
- Survivor of childhood abuse and multiple ACES
- Long history of polysubstance use, major depression, and PTSD
- Intermittent homelessness and incarceration
- Medical issues (Hep C) but “refuses” to go to the doctor
- Many strengths, including her a supportive cousin, creativity, work history
- Released from prison 6 months ago
- Began living with a cousin who had temporary custody of her children
- Asked to leave 1 month ago due verbal and physical “blowouts” with daughter and relapse on substances
- Clinician referred Roma to a local transitional shelter
- Doing well volunteering in reception but admits to “slips” with drinking
- Roma is open to case management/care coordination and highly motivated to get her kids back

“Traditional” Roma Service Plan

Roma Traditional Treatment Plan:

Problem #1: Chronic psychiatric issues (depression and PTSD; noncompliance with treatment and medications; impulse control issues and poor judgment in parenting role); unable to live independently or manage activities of daily living on her own due to co-occurring disorder

Goal: Achieve and maintain psychiatric stability; reduce risk behaviors in family

Objectives:

1. Roma will be med-compliant for the next 90 days.
2. Roma will have increased insight into her symptoms and behavior
3. Roma will display improved anger management with daughter

Interventions:

1. Case Manager will communicate with shelter staff to verify Roma’s compliance with medication.
2. Therapist provide twice monthly depression treatment to address Roma’s irritability and aggression.
3. Psychiatrist will provide medication evaluation and management and monitor response.
4. Rehab skills counselor will provide anger management group 2x monthly to address Roma’s outbursts with her daughter.
5. Case manager to refer Roma to local parenting class and support group

Problem #2: Long history of poly-substance use (can become aggressive when under the influence; abuse and neglect of children led to their removal of children by DCF; not attending 12-step as directed; minimizes role of substances in her life despite Hepatitis C illness)

Goal: Abstinence from all drugs including alcohol

Objectives:

1. Roma will attend AA/NA meetings 3x per week
2. Roma will stay home at night and try to sleep throughout the night without use of substances
3. Roma will submit to weekly urine screens to her Probation Officer
4. Roma will comply with all medical appointments (including hepatologist) and follow treatment as prescribed

Interventions:

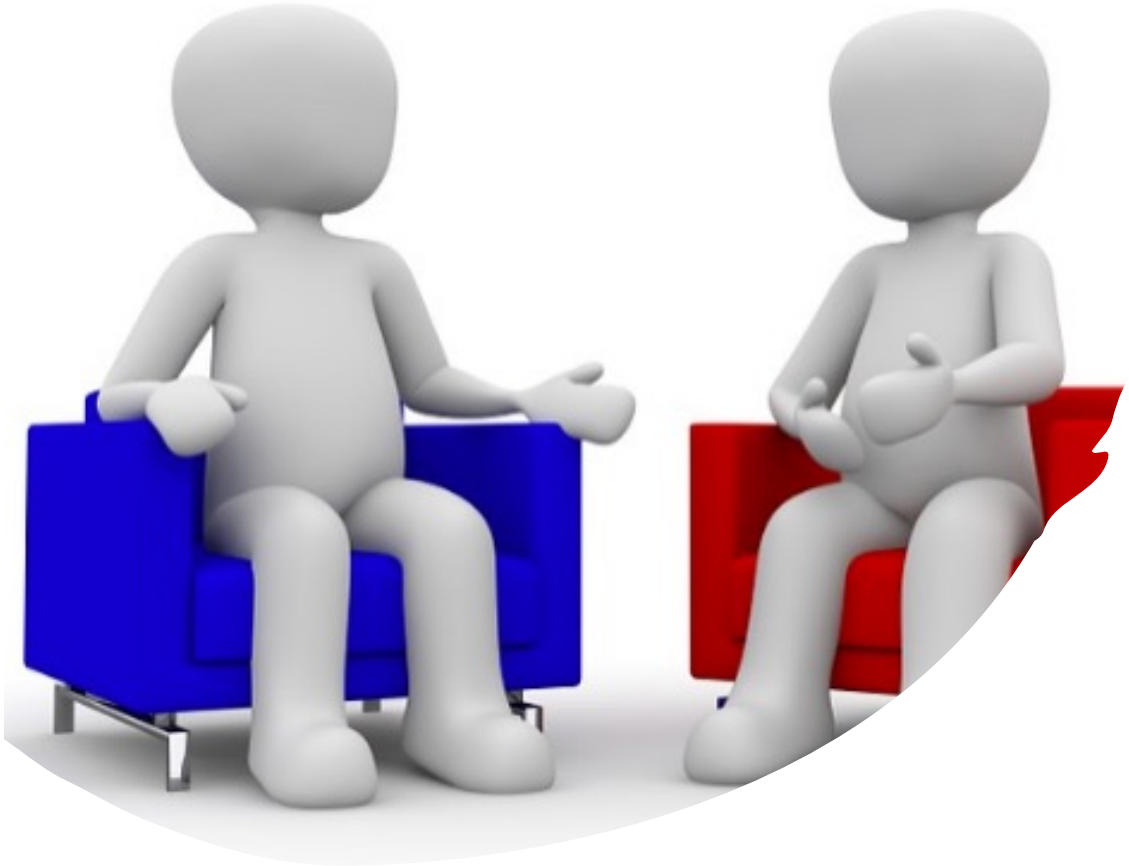
1. Case Manager will monitor Roma’s attendance 12 step meetings and secure urine screens for her P.O.
2. Substance Abuse Counselor will provide weekly relapse prevention meetings and report absences to PO
3. Psychiatrist will prescribe Antabuse to deter Roma’s drinking and remind her of dangers of continued drinking due to her liver damage.

Traditional Plan

I'm here to return YOUR goals.
You left them on MY plan!

- Comply with meds
- Increase insight
- Reduce assaults
- Get sober/ no "dirty" urines
- Follow shelter rules
- Go to PCP

"You keep talking about me getting in the driver's seat of my recovery and my life but half the time I am not even in the damn car…"



Person-Centered Plans are Grounded in Person-Centered Assessment

- Assessment is <u>enhanced around commonly neglected areas:</u>
  - strengths/interests
  - cultural preferences and treatment implications
  - stage of change/readiness
  - AND concludes with an integrated summary/formulation that goes beyond the data!

Integrated Summary: Moving From the "WHAT" to the "WHY"

- Moves from the **"what"** (facts only) to the **"why"** (i.e., how you make sense of the data
  - "Hypothesis" or best-guess as to what is going on
  - Informed by both the person's understanding as well as by your professional opinion
  - Information in summary should have a direct impact on the plan
  - Recorded in a chart narrative – in the "integrated summary"
  - "shared" with person served

An Example: WHY do individuals choose not to use medication at times?

Person is concerned about side-effects
Exploration of medications with different side effect profiles, consultation with nutritionist to get support to off-set weight gain, family-based interventions to help couples deal with sexual side-effects
Person has a culturally-informed preference to use alternative healing strategies
Collaboration with faith-based or cultural healers, integration of alternative strategies into recovery plan
Person becomes disorganized and struggles with keeping track of complex medication schedule
Cognitive remediation, skills training, compensatory strategies to promote organization

Roma's Integrated Summary

Roma is a 29-year-old Puerto Rican woman, and a deeply loving mother. Through the years, she has drawn on the support of a cousin to provide for her minor age children as she struggled to manage a serious trauma history and subsequent mental health and addiction issues (major depression, PTSD, and poly-substance abuse). She was recently referred to Care Coordination by a representative from DCF after she was asked to leave her cousin's apartment, with whom she had been living, due to frequent volatile arguments with her 14-year old daughter and a suspected relapse on alcohol. *Roma's daughter is currently at the same age that Roma was when she became pregnant with her as a result of sexual abuse at the hands of her own father. Unresolved trauma issues appear to be triggering an increase in symptoms, and making it particularly difficult for Roma to parent her daughter and manage her recovery. In addition, Roma has been reluctant to f/u on treatment for her hepatitis C which may be due to her trauma history and discomfort with male providers.*

Roma is living in a Transitional Shelter, and while she is feeling very overwhelmed and distressed by her situation, she is hopeful regarding your program and has made it clear that her priority goal is to work toward re-gaining custody of her children. She motivated to work with her providers to develop the stability and skills needed to be the best mother she can be. Priority assessed needs include connecting her to specialty medical services and developing parenting and communication skills, symptom management/coping skills, and ADL skills associated with household management (e.g., budgeting).

Roma's Story and Hypothesis

- Roma has a number of strengths and interests to draw upon in her recovery. She is a devoted mother who has demonstrated significant resilience having survived multiple traumas and losses in her life. Consistent with her culture of origin, she places a high value on family support, has benefitted from a close relationship with her cousin, and may prefer natural supports to formal treatment services. Roma is highly creative and artistic and has found refuge in painting, which she uses as a coping skill.

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.

And NOT just the territory of traditional treatment plans…

- Goal:
  - Maintain psychiatric stability
  - Achieve abstinence
- Objectives
  1. Compliance with meds
  2. Attend appointments with primary care provider
  3. Attend all appointments as scheduled

POLL:

Which is the best goal statement for Roma's PCP?

- I don't want to lose control anymore.
- Roma will better manage distress without drinking.
- I want to be a better mother for my kids and work on getting them back.
- Roma will attend the anger management group.
- Roma will attend all appointments as directed by Protective Services.

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?

- Remember:
  - Like ALL parts of the PLAN, the development of the barriers is a partnership. This means that you START with the person's perspective on what is getting in the way and add your professional perspective

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 to the valued goal
- 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…?

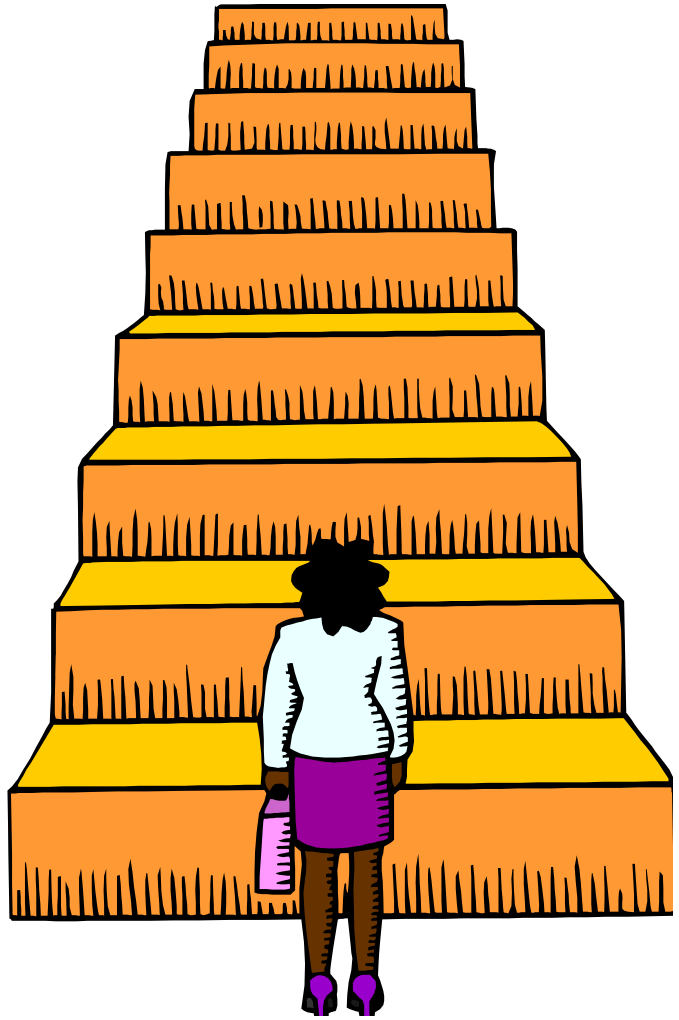
Technical Formula for Crafting Objectives

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.

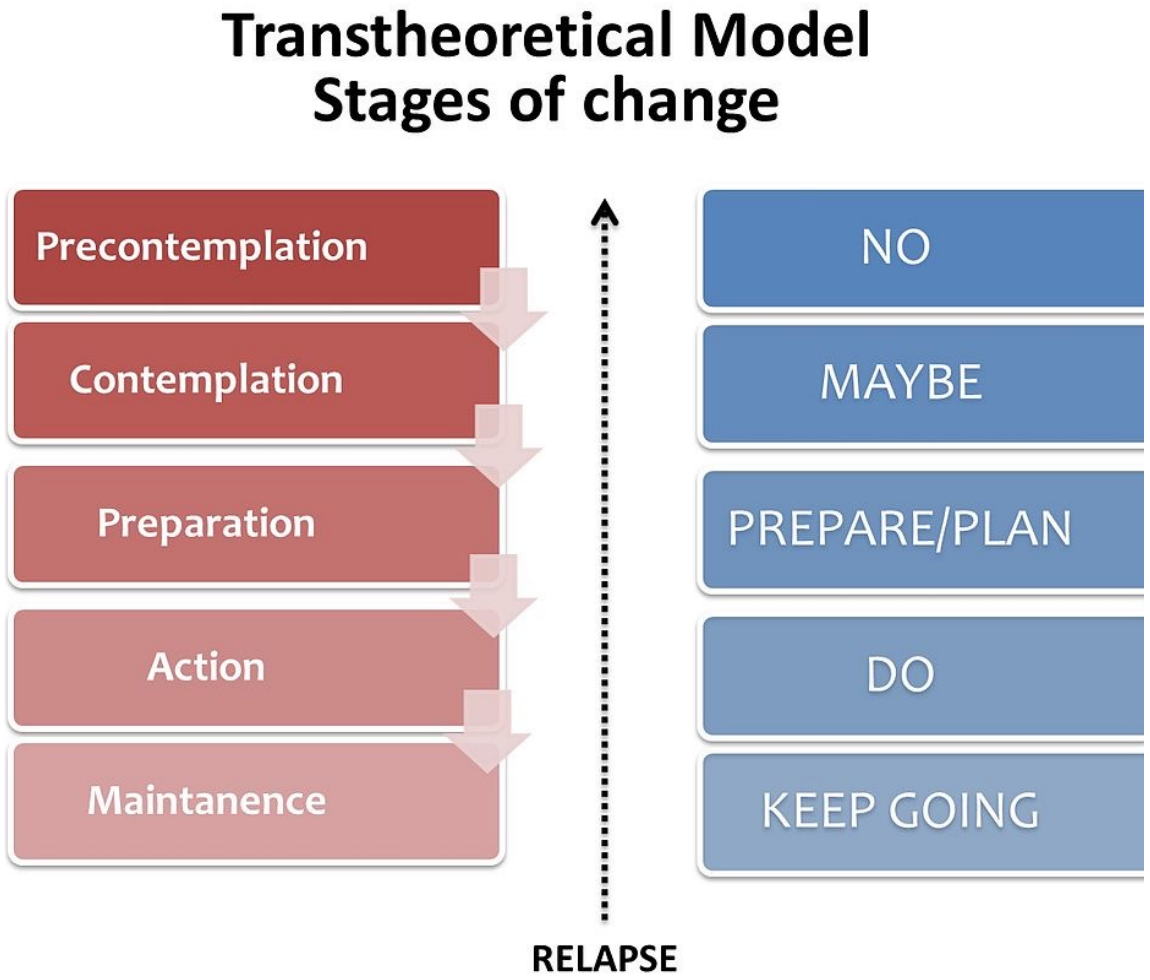
Objectives Build Over Time

BARRIER: Audrey is currently unable to work, because severe depression & sleep disturbance is making it difficult for her to get out of bed.

- “Within 90 days, Audrey will overcome isolation due to depression, as evidenced by getting out of bed by 10am at least 4 out of 5 days, M-F.”
- Update: “Within 3 months, Audrey will have completed a draft of her resume, as the result of less depression.”
- Update: “Within 6 months, Audrey will have part-time employment, because of better managed depressive symptoms.”

Objectives – Stage Responsive

- Joe will identify a min. of 2 adverse effects that substance use has on his/her recovery within 30 days (pre-contemplative)
- Joe will be substance-free for 6 months as evidenced by self-report (action-oriented)



Assume her goal is:
I want to be a better mother for my kids and work on getting them back.

Which of the below is the <u>best</u> objective for Roma's PCRP?

Care Coordinator will refer Roma to community parenting group within 1 week.

Roma will have 3 successful visits with her daughter (without outbursts) as evidenced by her self report and cousin's report.

Roma will demonstrate improved anger management.

Roma will attend all appointments with her mental health providers.

Roma will take all medications as prescribed and have no dirty urines.

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

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

Examples of Interventions

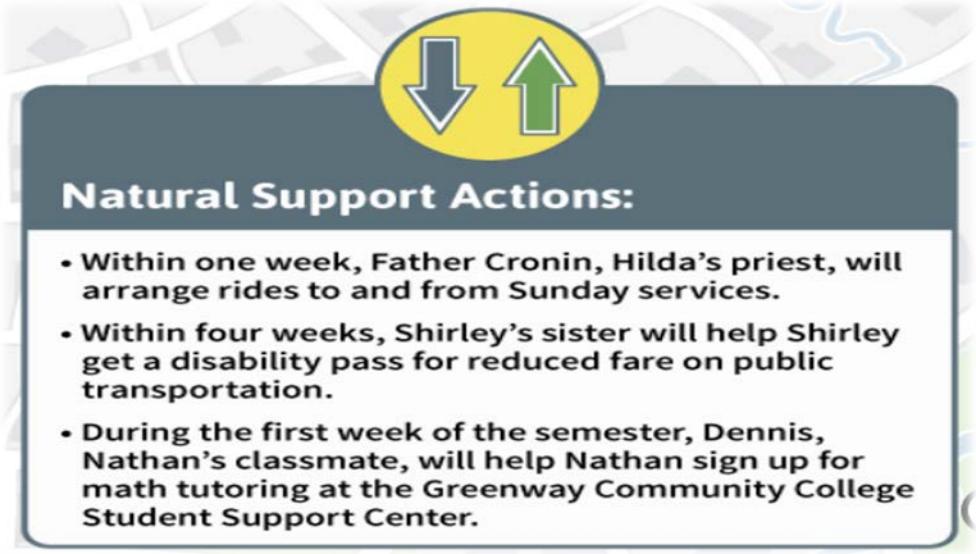
Psychiatrist will provide Med Management 1x per month for 30 minutes for the next 6 months to adjust medications to reduce symptoms, including Mary's tendency to isolate and avoid social situations.

PSC will provide Community Integration support at least 1x/week for the next 6 months to help Mary learn skills necessary to use ACCESS and go into the community by herself. Anxiety reduction techniques and social skills training will also be provided in vivo.

Holly Baker, Addictions Counselor, will provide Motivational Enhancement interventions during weekly home visits over the next 90 days for the purpose of encouraging Oliver to decrease substance use.

Interventions:
Self Directed and Natural Support Actions

- **Self-directed** actions are a reminder that the person, 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.



Assume her objective is:
Roma will have 3 successful visits with her daughter (without outbursts) as evidenced by her self report and cousin's report.

Which of the below is the best intervention statement for Roma's PCRP?

Shelter Coach will provide Money Management group weekly so that Roma can learn to be more responsible with her money.

Care Coordinator will meet with Roma weekly for the next 3 months.

Sally Rodriquez, Clinician, will provide trauma-informed individual therapy 2x/monthly for 3 months to assist Roma in managing symptoms which interfere with her relationship with her daughter.

Roma will submit to weekly urine screens to verify her abstinence and care coordinator will report progress to probation office.

Care Coordinator will communicate with shelter staff to make sure that Roma is complying with all medications.

How does it all come together in the PCRP?

Roma Re-envisioned…
A word of warning about “samples”

Person-centered planning cannot be implemented as though it were some simple thing like inserting “Tab A” into “Slot B.” Our emphasis on “nuts and bolts” should by no means be taken to suggest this. In fact, such a rigid or mechanistic adherence to a single model or set of standards would be antithetical to the core premises of person-centered planning!

Nonetheless, there are underlying principles that suggest what it is, and what it is not, and we will articulate these to offer guidance (not directives) for well-intentioned providers who ask the question—as they so often do—“What can we do differently today when we sit down with Tisha to do her treatment plan?” We will review innovative best practices in an effort, in the words of O’Brien (2002), to “encourage the flowering of diverse methods…that express the many different gifts of those people who accept responsibility for the work” and the responsibility to walk beside people on their unique paths to recovery, wellness, and better lives.

Tondora et al, 2005

Roma Person-Centered Recovery Plan:

There are many possible ways that a quality PCRP might come together. This sample is organized around Roma's overarching life goal of being a better mother and getting her kids back with certain components (e.g., trauma-induced altercations with her daughter, alcohol use, medical issues, money management, etc.) integrated underneath this goal as shorter-term objectives. There is no single "right" way to develop a person-centered recovery plan!

Recovery Goal
"I want to be a better mother for my kids and work toward getting them back."

Strengths

Deep love for children; recognizes need for skill development to interact appropriately; cousin is very supportive and willing to provide practical support and negotiate supervised visitation; has safe temporary housing at the shelter; beginning to understand the relationship between trauma, substance use, and sleep disturbance; recent commitment to substance use recovery and one month sober; positive relationship with care team; creative and "artsy" – loves books and painting; recognizes need for skill development to take care of kids and run a household

Barriers/Assessed Needs
Frequent verbal and physical altercations with daughter; in need of skill development in areas of communication, parenting, and conflict resolution; mental health symptoms (irritability, severe depression, unresolved trauma experience) exacerbate parenting difficulties; daughter's adolescence triggering Roma's abuse history and teen pregnancy due to incest at hands of her father; vivid nightmares; has not slept through night in months; tends to sort to drinking to sleep and relieve trauma distress/"Numb out"; chronic hepatitis C associated with past IV drug use; symptoms of depression and trauma have also led to difficulty with some independent living skills, e.g., Roma has neglected bills in the past and failure to pay rent has led to eviction proceedings and instability in housing for her and children

***Objective* 1 (targeting trauma-induced conflicts with daughter)**

Roma will have a minimum of 3 successful supervised (by cousin) visits with her daughter within 30 days as evidenced by cousin's report that Roma visited without verbal or physical altercations

Interventions and Action Steps

1) Sally Rodriquez, Primary Clinician, will provide Dialectical Behavior Therapy one-time weekly for the next 3 months in order to assist Roma in understanding trauma-related conflict in her relationship with her daughter and teach alternative coping strategies, e.g., mindfulness, distress tolerance, etc.

2) Bob Smith, Rehabilitation Specialist, will provide twice monthly anger management group for 3 months in order to teach Roma conflict resolution and positive coping strategies to manage stressful situations which arise with daughter.

3) Audrey Jenkins, Peer Community Connector, will meet with Roma two times over the next two weeks in order to help Roma to identify and access parenting-support groups/organizations in the community so she can develop a healthy peer network with which to share her parenting concerns and receive support. In addition, Ms. Jenkins will assist Roma in learning about arts-related events/activities in the local community that Roman and her daughter might attend together on their visits.

Client Self-Directed Wellness and/or Natural Support Actions:

4) Within 2 weeks, Roma will develop a list of preferred arts-related activities she'd like to engage in with her daughter in order to help structure visits and draw upon their shared passion for the arts and creative expression

5) Roma's cousin will work with Roma and shelter staff in order to schedule visits, and will report back to Team re: Roma's progress toward the above objective. Roma's cousin will also participate in NAMI-sponsored Family-to-Family program to receive education and support re: Roma's issues with depression and post-traumatic stress

Objective 2: (targeting alcohol use which complicates serious medical issues)

Roma will maintain abstinence for the next 3 months as evidenced by bi-weekly urine screens which are collected by her probation officer

Interventions:

1) John Casey, Substance Abuse Coordinator, will provide one-time weekly Relapse Prevention group in order to teach Roma positive coping skills to deal with cravings and manage stressors/symptoms without substance use

2) Anthony Sells, M.D., will make a referral to a female hepatologist (given her discomfort with male providers due to trauma history) within the next 2 weeks, so that Roma can get connected to the medical care she needs for her Hepatitis C.

3) Audrey Jenkins, Peer Community Connector, will accompany Roma to scheduled appointment with hepatologist to support her follow-through as she is uncomfortable attending alone due to her past sexual abuse. Hepatologist will provide evaluation/ treatment and educate Roma about the dangers of continued drinking on her liver functioning to increase motivation for recovery.

Client Self-Directed Wellness and/or Natural Support Actions:

4) Roma to attend a minimum of 3 local AA/NA groups within two weeks to explore if 12-step program can be helpful source of support in learning positive ways to manage stressors and sleep disturbance without substance use
5) Roma's cousin will buy her a writing journal and book of poetry readings within 2 weeks in order to help Roma in practicing her preferred relaxation strategies daily before bed (as an alternative to drinking).

Objective 3 (targeting ADL of budgeting)

Roma will manage her monthly budget successfully as evidenced by her paying her Transitional Housing rental fee in full by the 5th of every month each month for the next 6 months. ("I need to learn how to stretch my money and pay my bills so I can show DCF I can keep a roof over my kids' heads.")

Interventions and Action Steps

1) Anthony Sells, M.D., to provide medication evaluation and monitoring two times per month for the next 3 months for purpose of identifying possible medications to address Roma's complaints of inability to focus/disorganized thinking during periods of depression.

2) Mary Tomason, Rehab Specialist, to provide skill-building once a week for the next 6 months in order to build Roma's independence in managing her personal budget, e.g., providing instruction re: the process of writing checks and tracking balances in her check register.

<u>Client Self-Directed Wellness and/or Natural Support Actions:</u>

3) Within 1 week, Roma will identify any preferred priorities she has for limited "spending" money (e.g., art and painting supplies) so that she and her cousin can accurately report income to Rehab Specialist assisting with budgeting skills.

4) Within 2 weeks, Roma's cousin has agreed to help her outline and bring in records of her bills in order to assist Roma and Rehab Specialist in creating a budget to cover all expenses with available income.

PCRP Honors Both Professional Expertise and the Wisdom of Lived Experience

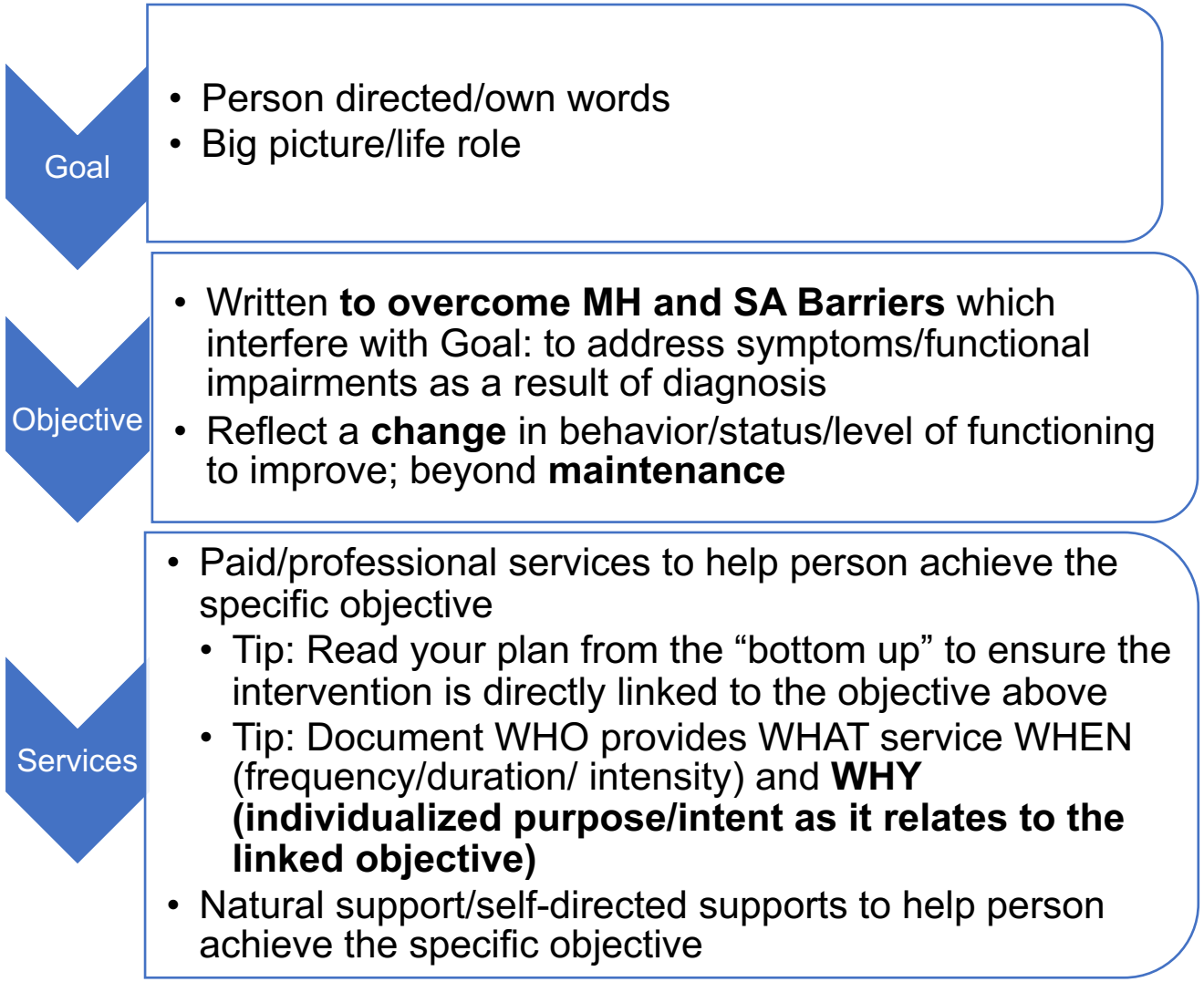
Important *TO the Person*

- Meaningful relationships
- A place of my own
- Valued social roles
- Independence
- Freedom to Make Choices
- Cultural and personal preferences
- Faith and spirituality
- A job, a career

Important *FOR the Person*

- Basic health and safety
- Management of clinical symptoms
- Maslow's basic needs
- Harm reduction
- Management of risk
- Legal obligations and mandates

Golden Thread of Medical Necessity

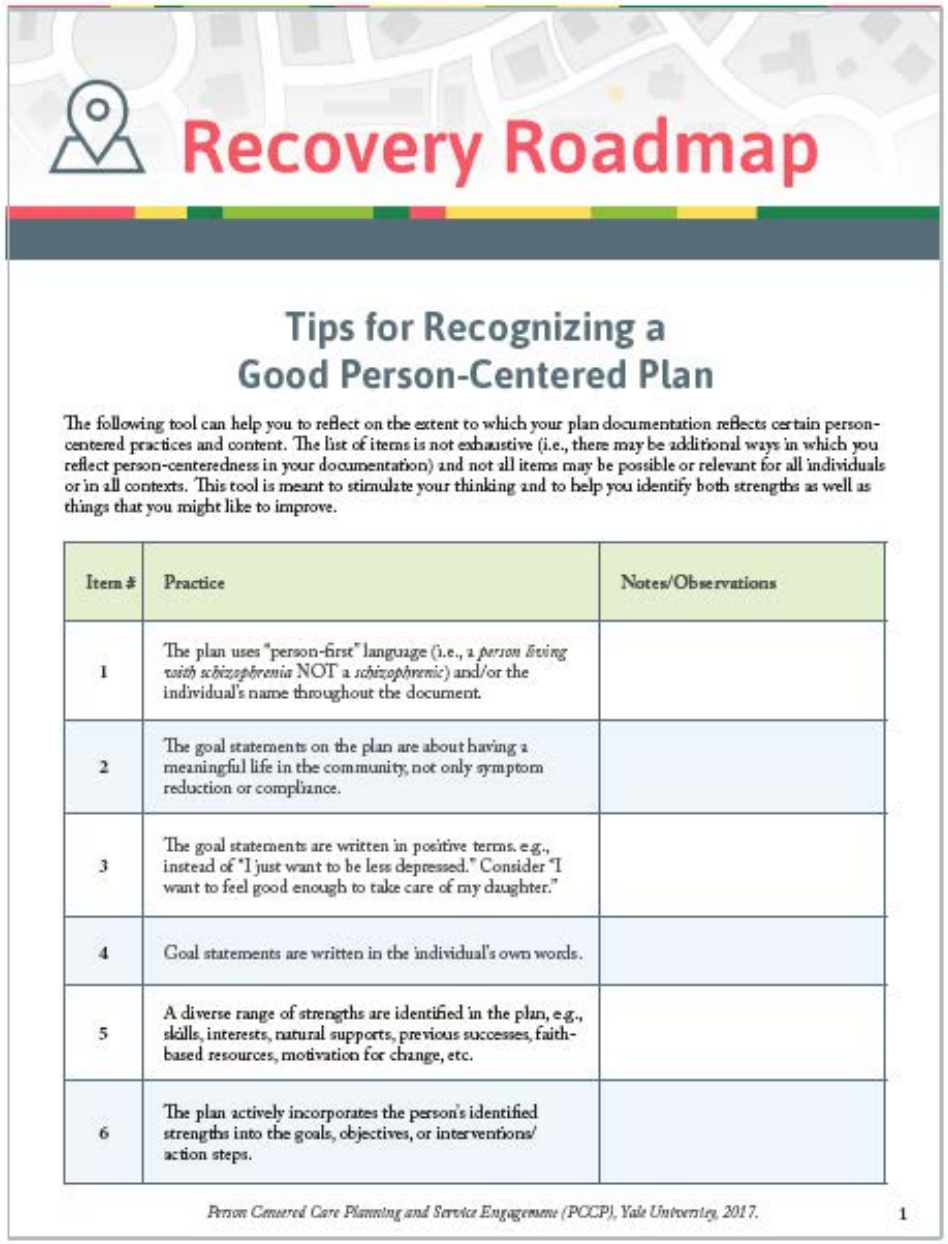


A Parting Thought

- 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

Recovery Roadmap Resource: 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

BUT IS A PERSON-CENTERED, APPROACH AT THE LEVEL OF SERVICE DELIVERY ENOUGH?

Even the most competent and committed of person-centered, employees will not be able to fully actualize their competency in practice in the absence of systems characteristics

- …that align in support of recovery-oriented services AND…
- that promote staff wellness and growth through employee-centered organizational strategies
    - PARALLEL WORLDS ALIGN!!
    - It is a BOTH/AND not EITHER/OR approach to person-centered transformation

STAY CONNECTED

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Closing Q&A… Your Thoughts and Ideas