South Southwest (HHS Region 6)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

New England (HHS Region 1)
MHTTC Mental Health Technology Transfer Center Network
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Person-Centered Recovery Planning Webinar Session 2

yale program for recovery and community health

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
School of Social Work

Acknowledgement

Presented in 2024 by the Mental Health Technology Transfer Center (MHTTC) Network.

This presentation was prepared for the South-Southwest Mental Health Technology Transfer Center (MHTTC) and the New England Mental Health Technology Transfer Center (MHTTC) Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed in the presentation are the views of our speakers and do not reflect the official position of the Department of Health and Human Services or SAMHSA.

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Presented 2024

MHTTC

Mental Health Technology Transfer Center Network

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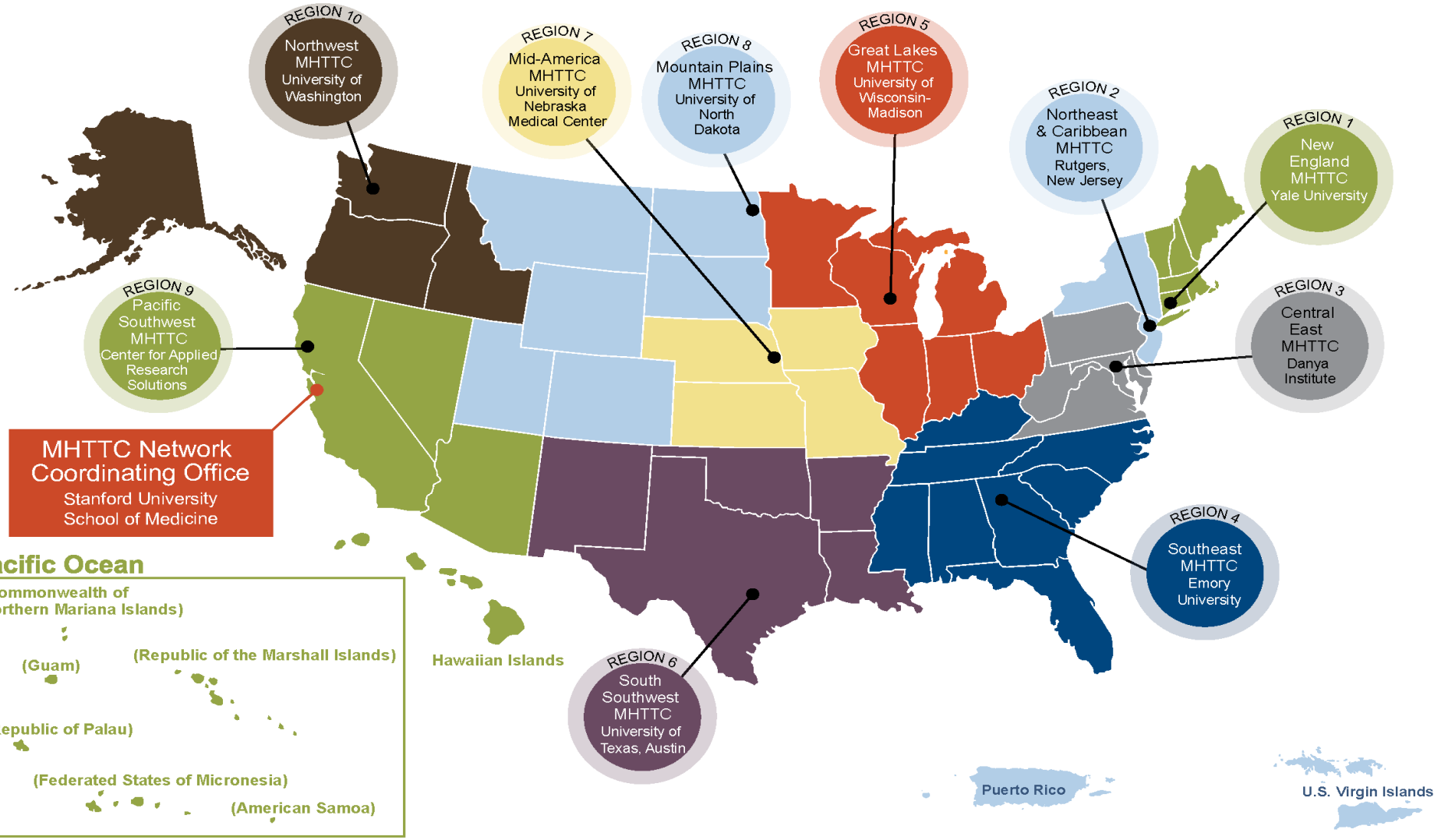
MHTTC Network



The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Housekeeping Items

- We have made every attempt to make today's presentation secure. If we need to end the presentation unexpectedly, we will follow-up using your registration information.
- Attendees are able to unmute and share.
- Have a question or comment? Use the Chat and direct to EVERYONE.
- This session will be recorded.
- A confirmation email will be sent from our South-Southwest email address containing a link to download your CEU certificate.
- CEUs are contingent upon your participation for the full duration of the event based on our Zoom participation logs.
- Registrants are responsible for checking with their licensing or credentialing board to ensure acceptance of the CEUs issued.

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Facilitators

Janis Tondora, Psy.D., (she/her), is an Associate Professor in the Department of Psychiatry at the Yale School of Medicine. Her work involves supporting the implementation of person-centered practices that help people with behavioral health concerns and other disabilities to get more control over decisions about their services so they can live a good life as they define it. She has provided training and consultation to over 25 states seeking to implement Person-Centered Recovery Planning and has shared her work with the field in dozens of publications, including her 2014 book, *Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning.* Outside of work, you may find Janis enjoying the great outdoors with her family (human and furry!) on a paddleboard, in the mountains, or at the beach.

Amanda Bowman, LCSW-S, PSS (she/her) is a clinical social worker, certified peer specialist supervisor, and WRAP® facilitator, using her professional and lived experience with mental health challenges to promote person-centered practices in behavioral health care. Coming from direct social work practice and administrative leadership within the public mental health system, she joined Via Hope in 2013, where she served as Recovery Institute Director until 2023. In this role, she oversaw the development and delivery of organizational change programs, which included statewide initiatives to support the implementation of person-centered planning, peer support services, and trauma-responsive work environments. As the owner of Sidecar Consulting, Amanda now facilitates collaborative learning events and serves as a subject matter expert for programs designed to support change within and across agencies. Outside of work, you may find Amanda with her family hiking the Barton Creek Greenbelt or enjoying live music.

How about you? What hat(s) are you wearing today?

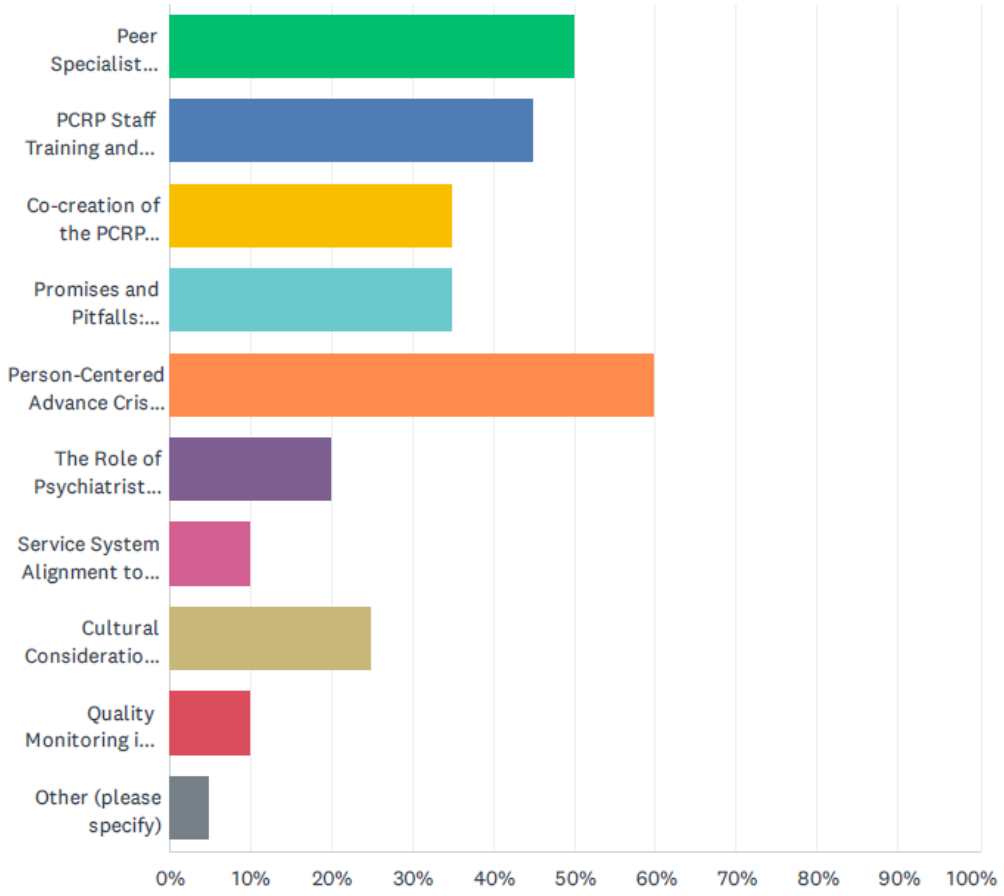
Audience Participant Poll
(Multiple Hats Allowed)

- Direct support practitioner
- Peer support specialist
- Supervisor/team leader
- Family member/natural support
- Guardian/conservator
- Leadership/administration
- Managed Care/Funder
- *Service recipient/person with lived experience
- Advocate
- Other (_____)

*A note on our use of terms: *Service user/participant, client, person in recovery, patient, person with a disability, psychiatric survivor, person with lived experience, person in distress, consumer.* ***Always honor individual preferences and when in doubt, ASK!***

You spoke, We are doing our best to listen!
Consultation Corner Session Calendar

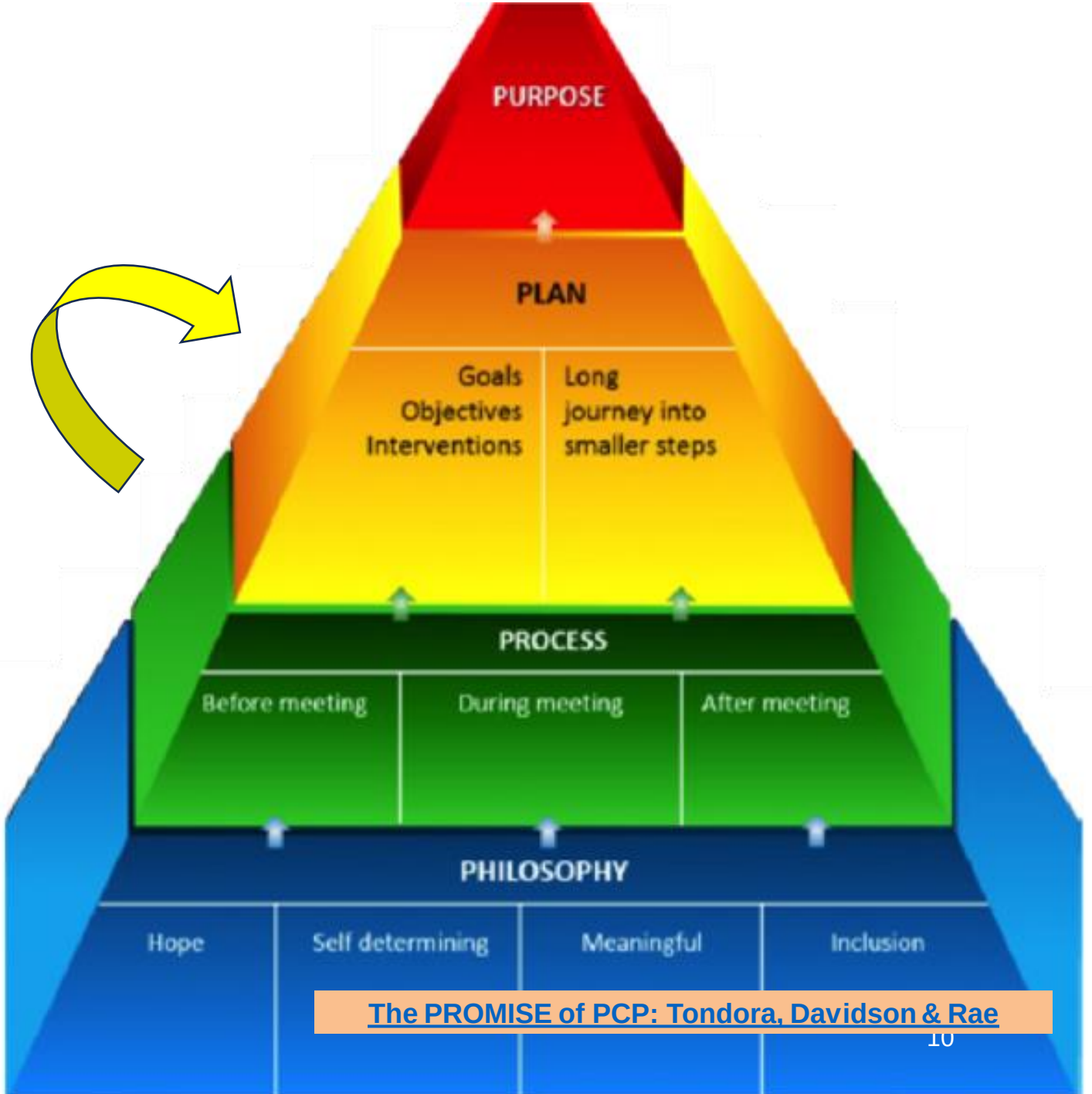
Date Event (2-3:30pm EST)	Webinar Topic/Title
Webinar March 27th	PCRP Consultation Corner: Overview and Launch
Webinar April 17th	Co-creation of the PCRP Document: Partnering, Goal Discovery, and Emphasizing Real-life Results
Webinar May 15th	Peer Specialist Roles in PCRP: Aligning with Peer Ethics and Values
Webinar June 19th	Promises and Pitfalls: Designing Electronic Health Records to Support PCRP
Webinar July 17th	Person-Centered Advance Crisis Planning to Maximize Choice and Control
Webinar August 21st	How to Reinforce PCRP in Practice: PCRP Staff Training, Supervision and Quality Monitoring



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

Person-centered quality often goes awry when moving from PROCESS to PLAN DOCUMENTATION



The PROMISE of PCP: Tondora, Davidson & Rae

Aren't we already co-creating Person-Centered Plans?

What we hope for THEM…

- ✓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.

What we value for US…

- ✓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…

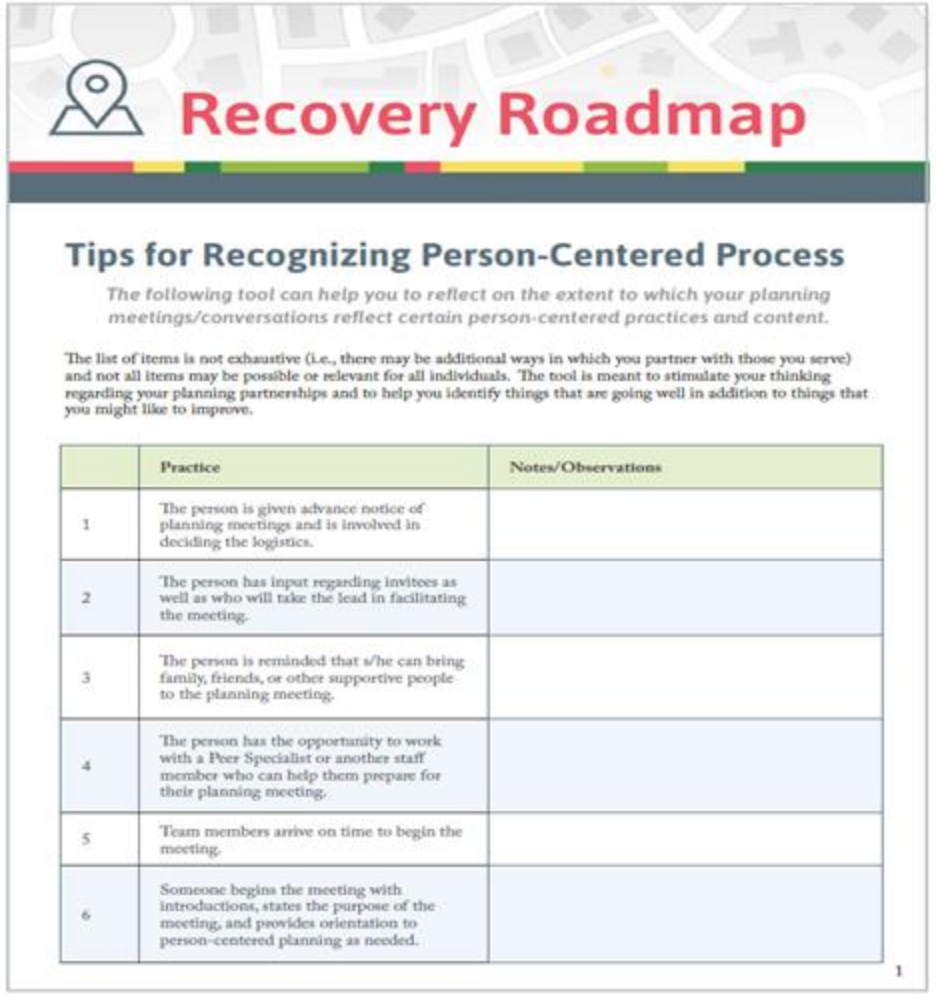
Just imagine…

Beyond *US and THEM*

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

The Quality of the PLAN is only as good as the Quality of the PROCESS Behind It

- Practical training on the documentation of person-centered plans is needed to address marked confusion in the field and **because the plan is a tool of accountability**
- But…no plan (no matter how well written on paper or in an EHR) should be taken as a proxy for the person's experience
- The quality of the plan ("crossing Ts and dotting Is) is meaningless unless it is authentically based on a quality person-centered process as its foundation.



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

What kinds of key person-centered processes are needed to co-create a quality plan?

- Person is a partner in all planning activities/meetings
- Person has reasonable control over logistics (e.g., time, invitees, etc.)
- Person offered a written copy/transparency
- 1:1 or team meetings look different (shift in structure/roles)
- Person/family is educated about PCRP to promote activation
- Team may be expanded based on person's preferences/chosen circle
- Self-determination is seen as a universal right
- Community inclusion is not something which is "earned" through clinical stability
- Strengths-based approaches are seen in conversation, assessments, and plans
- Cultural factors that impact preferences n care and planning are respected

If you did not join us for our first PCRP webinar, a more detailed conversation around these person-centered processes is available in the Session 1 recording here.

Person-Centered Process Looks and Feels Different:

“I’m on the team!”

Could a greater miracle take place than for us to look through each other’s eyes for an instant?...

- Henry David Thoreau

Sounds great… but how do you continue to honor the person while ALSO maintaining the necessary rigor required in plan documentation?

Meet Gerry

Gerry is a 42 year old single, white man who is living with a diagnosis of disorganized schizophrenia. He has had numerous lengthy hospitalizations and is currently living in a residential group home with 24-hour supports. Gerry is well-liked by his peers; and has a good sense of humor; a supportive and involved brother; and a wide range of interests (e.g., music, Chinese restaurants) he enjoys participating in and sharing with others when he is feeling well enough to do so. But his experience of feeling confused and fearful of others has been increasingly distressing to him and he is lonely and isolated. He used to go to the downtown jazz fests and meet lots of people, but now he feels like a "zombie." He is not getting out of the house to do much of anything other than come to the Center. He wonders if this is due to his meds or his stress when voices are very active. Although Gerry would really like to start dating and have a girlfriend, he admits to being "terrified" to get out in community and meet women, and states that it's been 10 years since he dated anyone. He wouldn't know where to start…He is currently unable to take the bus and is afraid to go anywhere alone because he gets confused at times and fears others might try to hurt him.

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

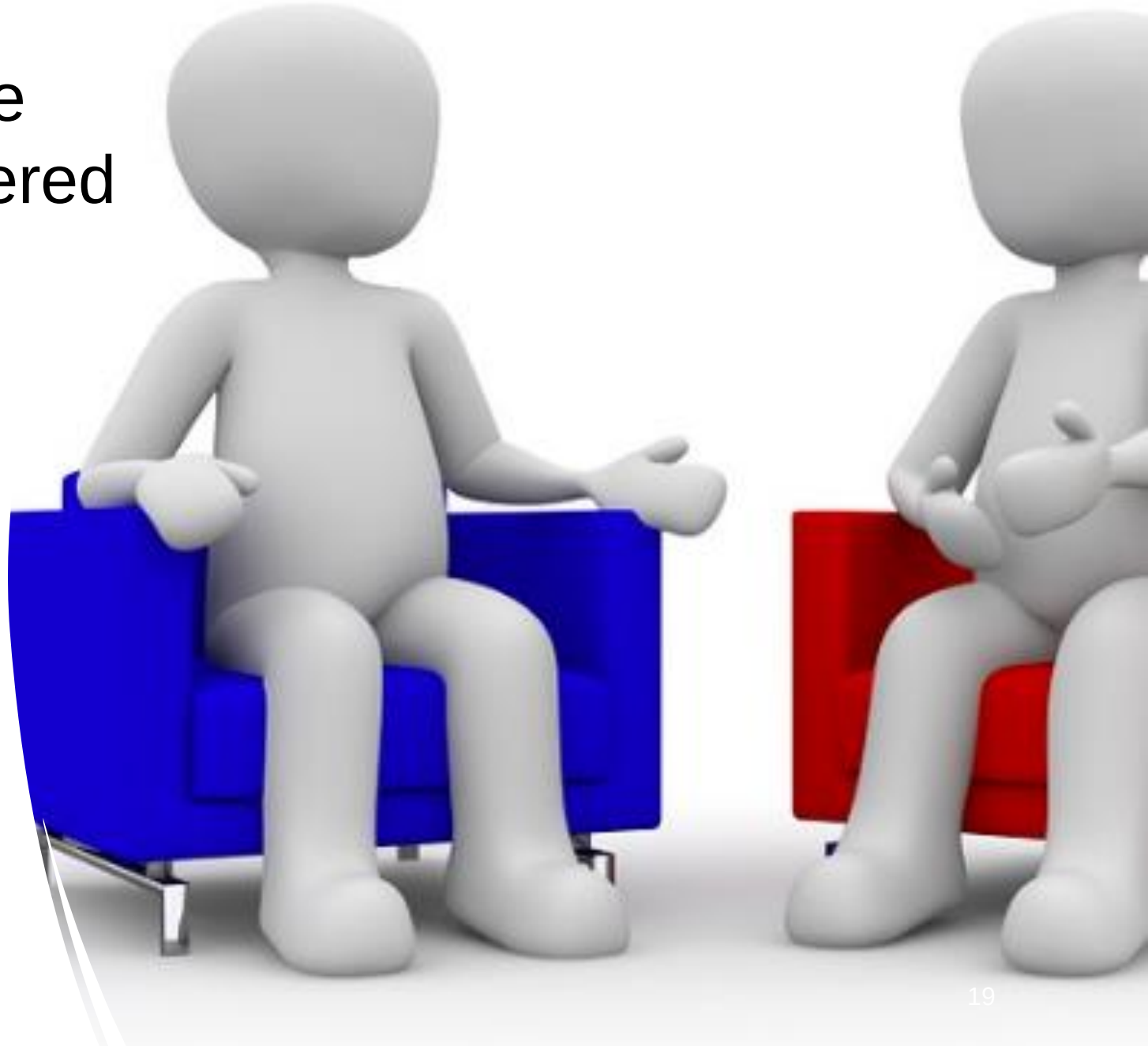
Short-Term Objective
S-M-A-R-T

Services/Action Steps
- Professional/“billable” services
- Clinical & rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters

Person-Centered Plans are Grounded in Person-Centered Assessment/Conversation

- Assessment is <u>enhanced around commonly neglected areas:</u>
  - strengths/interests
  - cultural preferences and treatment implications
  - Readiness for change

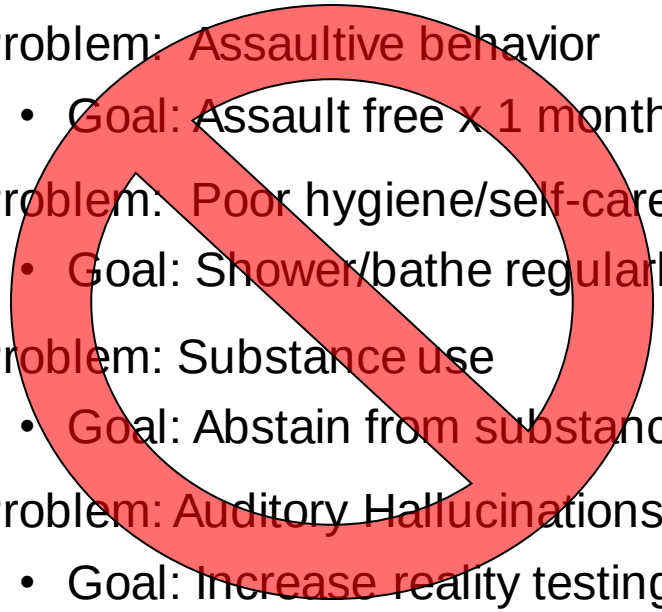
- And concludes with some type of summary of what is essential and WHY
  - Not just a repetition of the data …but how what you have learned together might inform individualized supports moving forward



A Marked Departure from Traditional Treatment Plans: PCRPs are NOT Organized Around a PROBLEM List

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 substances
- 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 can provide for my kids.

- Physical conflicts[illegible]ker led to termination. *I[illegible]y let me go.*
- Difficulty w[illegible] *my best at interviews*
- Substanc[illegible]d job loss *I called out*
- Distress from[illegible]ult to focus at work *I make a lot[illegible]hen my symptoms are really bothering me.*

Long-term Recovery Goals:

Definition/Qualities

WHY they are important

Documentation Tips/Examples

Holding Hope, Understanding Goals

Person Centered Recovery Planning:
"We can't know what a person needs until we first *understand* what it is that they WANT."

How do we best support people when identifying what kind of life they wish to have?

Goal/ vision statements are about movement TOWARD something desired

Make Space for Different Perspectives

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

Goals: Important TO the Person

- Owned by the person in recovery
- Person's motivation for action (and reason for engagement in services)
- Vision of recovery that guides actions by professional and natural supporters
- In community - beyond the mental health system
- Anticipated reward for their efforts
- Hope and high expectations

Sample Goal or Vision Statements

- “I want to get my kids back.”
- “I want to be a mechanic.”
- “I want a girlfriend.”
- “I want to have my own place to live.”
- “I want to swim with the turtles in Hawaii.”

Understanding a Person's Goal: The Conversation

- It's NOT our role to judge a person's motivation for change.
- It *is* our responsibility to seek understanding and to facilitate a conversation that conveys respect and genuine interest in what that person values.
- Sometimes inquiry leads to a process of self-discovery for the person being supported, which can take time

What are your hopes and dreams for the future?

Goals: Take Time for the Conversation!

Person's Answer	Follow Up Question
"I'd be able to stay out of hospital"	**"If you were able to stay out of the hospital, what would life look like for you?"**
"I just want the voices to be quiet"	**"If they were quiet, how might your life be different?"**
"I want to be a professional basketball player."	**"What do you think life as a professional basketball player is like? What part of that lifestyle would you like best?"**
"I want to go to college."	**"How might life be different if you went to college?" When you think about college, what parts are you most looking foirward to?**

POLL: So, what do you think?

Which would be the best goal statement?

1. “I don’t want to feel like a zombie.”
2. Gerry will better manage distressing symptoms of paranoia.
3. “I want a girlfriend…someone to share my life with.”
4. Gerry will attend the Social Skills Group.
5. “I just want to be happy.”

Strengths and Barriers:

Definition/Qualities

WHY they are important

Documentation Tips/Examples

The Role of Strengths in the Plan

- Identify aspects of the person's life that they can draw from to move toward a specific goal
- Promote engagement and communicate a message of hope and confidence in the person's abilities
- Captures the person's unique identity, resources, interests
  - best personal qualities/character traits
  - strategies already utilized to help, self-directed wellness
  - most valued accomplishments and skills
  - cultural traditions and connections
  - community activities and interests
- NOT defaulting to "strengths" of "medication compliant, adheres to program rules, insight into illness" etc.

Capitalize on Strengths in the Plan

- A person with a love for books might be engaged by asking them to help out in the agency resource library…
- A person who loves music might benefit from access to CDs/headphones as a way to quiet voices…
- A spiritual person with thoughts of suicide might want support from a Spiritual Director…
- An animal lover struggling with their weight due to medication side effects might walk a dog regularly.

Barriers

- Reminder: 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.
- 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?

The Value of Descriptive Barriers

WEAK EXAMPLES

- Anger Issues
- Depressive Symptoms
- Substance Use

STRONG EXAMPLES

- Conflicts with neighbors
- Lacks the energy to take care of household tasks/ living space
- Substance use at apartment has led to police calls and risk of eviction

Short-term Goals (Objectives):

Definition/Qualities

WHY they are important

Documentation Tips/Examples

So how will we know if we're making progress?

Why Talking about Results Matters

- Explicitly makes the connection between potential action steps – treatment recommendations or their own commitments – to expected real life benefits they care about
- Supports ongoing motivation & engagement
- Helps maintain momentum toward longer-term recovery
- Demonstrates accountability by the service provider; includes education about expected outcomes

Short-term Goals/ Objectives

- Anticipated RESULTS that will be meaningful to the person
- **Description of concrete changes in person's behavior, expected to happen once immediate barriers are overcome**
- "Proof" that personal action steps + services are helping them make progress toward their goal (i.e., life worth living)
- **Developed WITH the person: "What are some small but meaningful ways your life could look different in a month or so that will be closer to your goal?"**

Myth: Getting rid of symptoms is always the solution

- Often times, people learn to live with experiences/"symptoms" rather than getting rid of them altogether.
- Psychoactive medication isn't always the (primary/only) solution to experiences that are disturbing or interfere with the person's functioning.

Tune in during our May 8th TA Session for more on this topic, including an interesting video by the Hearing Voices Network & vignettes to demonstrate how reorienting AWAY FROM SYMPTOM REDUCTION can open up new opportunities for recovery!

Short-term Goals/ Objectives Examples

- Phillip will have increased social interaction as evidenced by meeting a friend for coffee at Dunkin' Donuts at least 3 times over the next 30 days.
- Within the next 2 months, Jo Ann will be able to take the bus by herself to the library 4 times, due to feeling more comfortable around strangers.
- Within the next 60 days, Brian will be able to sleep a minimum of 6 hrs per night for an entire week, as the result of feeling safer in the home.

Objectives should be SMART

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

SIMPLE (straight forward)

MEASURABLE (quantitative or qualitative)

ATTAINABLE (possible for that person)

RELEVANT (for that person's goals)

TIME FRAME (date for completion)

Technical Tips for Crafting Objectives

Within_____ **(amount of time),** _____ **(Name)** will have improved _____ **(documented barrier)**, as evidenced by_____
(a meaningful change – to THEM - in their functioning/ daily life/ activities that moves them closer to their long-term recovery goal)

Examples:

- Phillip will have increased social interaction, as evidenced by meeting a friend for coffee at Dunkin' Donuts at least 3 times over the next 30 days.

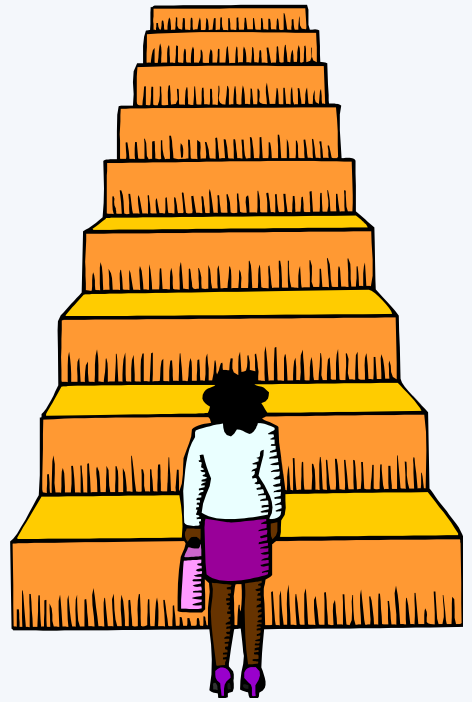
- Within the next 60 days, Brian will feel safer in the group home, as evidenced by sleeping a minimum of 6 hours per night for an entire week.

Objectives: NOT about Service Participation!

People can participate in services for years and not achieve the intended benefits!

NO: *Wanda will attend CBT group 2x weekly.*

Reminder:
objectives describe expected **results** of actions steps and services to benefit the person



YES: *Wanda will apply mindfulness techniques to decrease the frequency of self-injury to no more than one instance per week within 90 days.*

POLL: So, what do you think?

Which would be the best, meaningful SMART objective for Gerry's PCRP?

Gerry's valued goal:
"I'd like a girlfriend… someone to share my life with."

1. Case manager will refer Gerry to the local Adult Recreation Department within 1 week.
2. Gerry will participate in at least 6 chosen/preferred community activities in the next 60 days.
3. Gerry will have less distress due to paranoia.
4. Gerry will attend the Social Skills Group weekly.
5. Gerry will pay his cable bill on time each month for the next 3 months.

Services and Other Action Steps

Definition/Qualities

WHY they are important

DocumentationTips/Examples

Different Types of Action Steps

1. Professional, Billable Services
2. Personal Action Steps
3. Natural Supporter Action Steps
   (at the discretion of the person)

Services and Action Steps

The plan (and its services/actions section) serves as a contract for who is responsible for what

- Respect individual choice and preference
- May incorporate evidenced-based as well as other innovative recovery-oriented and alternative strategies
- Are individualized and specific to the person's goal/objective to help the person achieve their unique desired results
- Support medical necessity by clearly describing how services are intended to overcome that individual's barriers

Critical Elements – The “Ws”

Professional services should specify…

- WHO will provide the service, i.e., NAME or job title when specified
- WHAT: The TITLE of the service
- WHEN: The SCHEDULE of the service, i.e., the time and day(s)
- WHY: The individualized INTENT/PURPOSE of service

Examples of Formal Service Statements

Dr. Jenkins, 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.

John Perkins, Rehab Specialist will provide community integration support at least 1x/week for the next 6 months to coach/practice skills necessary to use the ACCESS system and go into the community on her own.

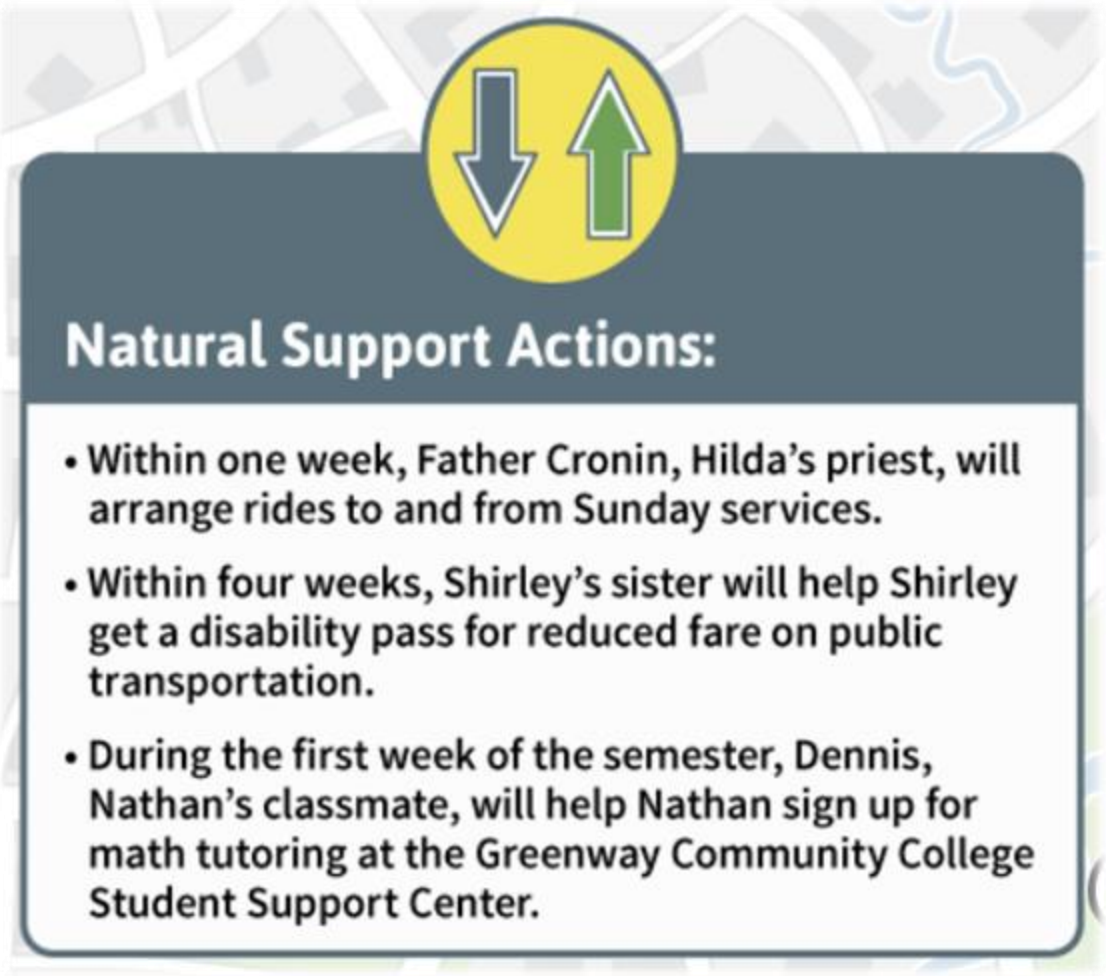
Holly Smith, Certified Peer Specialist, will offer weekly in-person community-based meetings for the next 90 days to discuss ways to self-advocate with providers, exploring recovery goals, and other needs within the peer provider role as identified.

- Add value by focusing on what the person can do right NOW
  - (whereas the objective is a growth goal)
- Build a sense of self-agency around recovery, separate from what the "system" provides
- Not a simple "flip" of a service statement, e.g., Janis will attend Social Skills group, take meds as prescribed
- Opportunity to get strengths into the plan!

- Natural supporters involved at the discretion of the person
- Opportunity to tap into/grow the informal network that supports the person's recovery over time
- Supports growth/transition by offering additional support beyond professional services
- NOT something you are "on the hook for" if there is not follow-through

Examples and Documentation Tips

- Includes enough detail to be clear (but may not include all “Ws” of formal services
- Ideally listed alongside professional services on the same plan



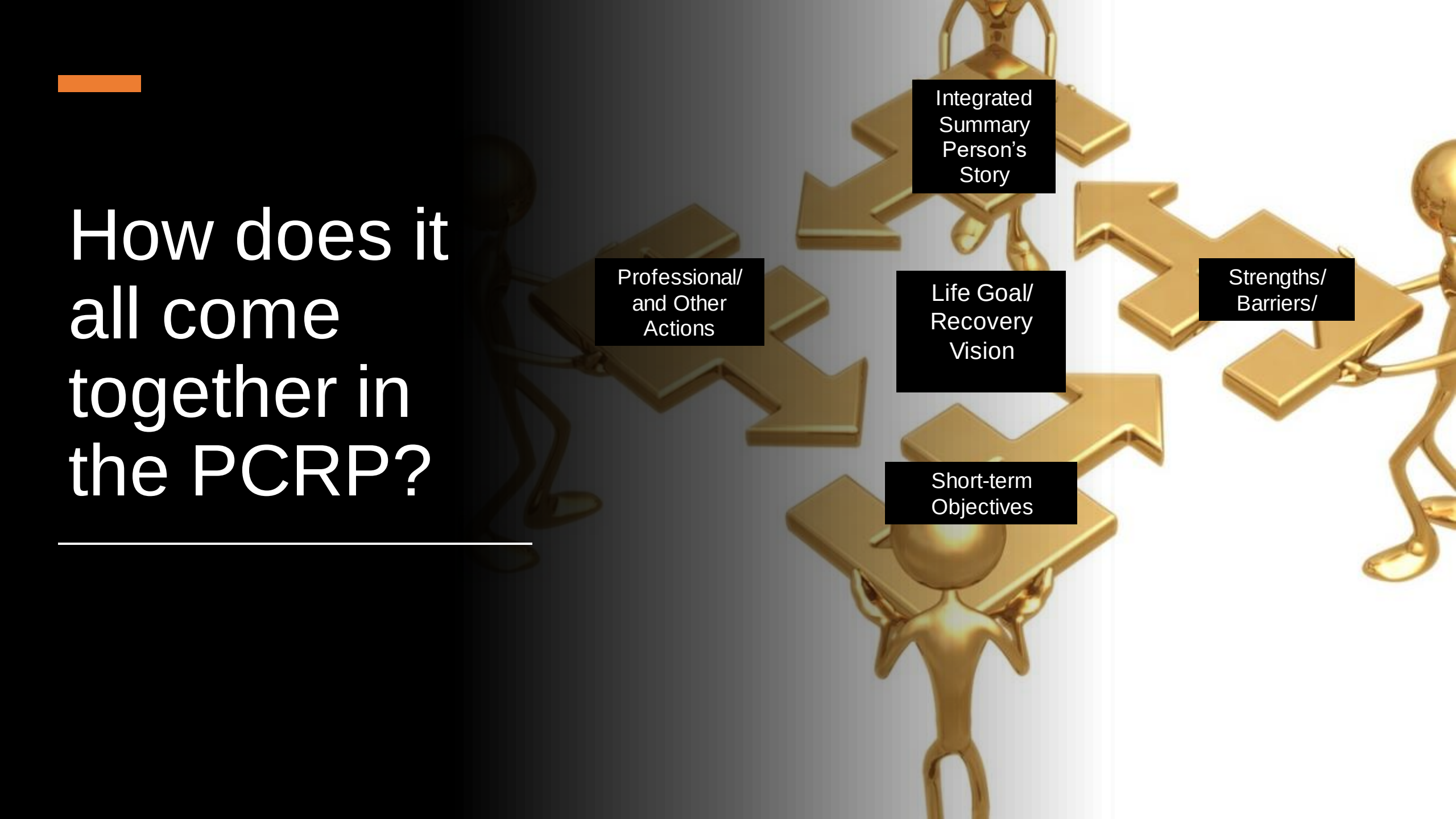
POLL: So, what do you think?

Which would be the best examples of services/action steps (*pick up to 2)

Gerry's short-term goal/objective:
Gerry will participate in at least 6 chosen/preferred community activities in the next 60 days.

1. Residential Coach will provide Money Management group weekly for 3 months
2. John Smith, Rehab Specialist, John Smith, Peer Coordinator, will provide travel training 1X/wk. for 4 weeks to help him become independent with city bus.
3. Residential Coach will meet with Gerry to talk about how to manage his paranoia when he thinks others are trying to hurt him
4. Gerry's brother, Jim, will accompany Gerry on community outings over the next few months until he is more comfortable going out on his own.
5. Residential Coach will monitor med compliance daily and report non-compliance to clinical team.

How does it all come together in the PCRP?



Gerry's PCRP

Goal: "I'd like a girlfriend…someone to share my life with."

- **Strengths:**
  - Motivated to reduce social isolation; supportive brother; has identified community interests he has enjoyed in past (e.g., music, Chinese restaurants) well-liked by peers; humorous

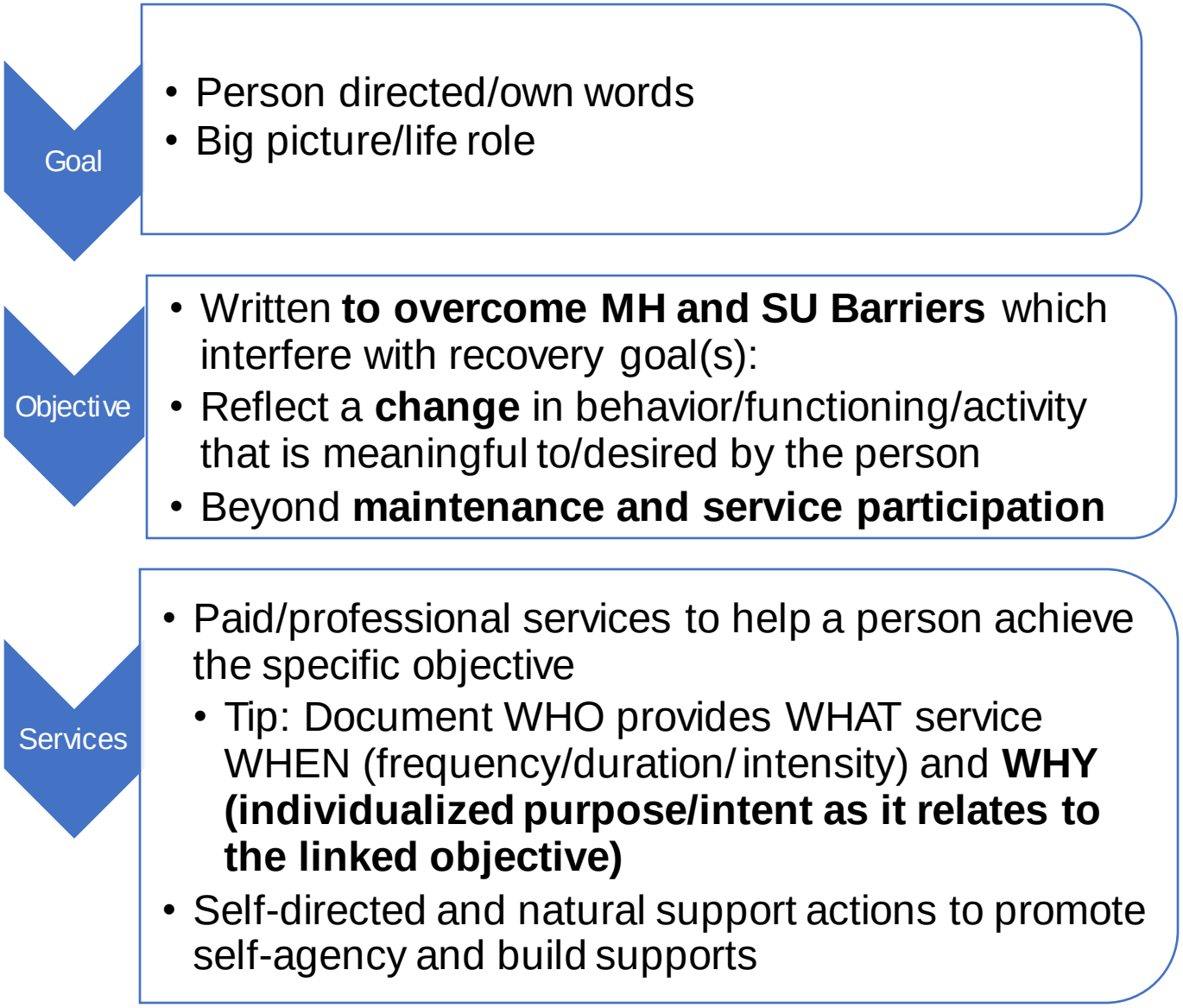
- **Barriers/Assessed Needs/Problems:**
  - Intrusive thoughts that cause him distress; can feel threatened by others in social situations; possible negative symptoms of schizophrenia and/or med side effects result in severe fatigue/inability to initiate and lead to social isolation; challenges in communication and social skills; difficulty with self care routine; gets confused/disorganized when under stress; could benefit from skill development to manage disruptive symptoms; navigate public transportation, and develop coping strategies

- **Objective:**
  - Gerry will participate in at least 6 chosen/preferred community activities in the next 60 days.

Gerry's PCRP: Services and Action Steps

- Jane Roe, Clinical Coordinator, to provide **CBT** 2X/mos. for next 3 mos. to increase Gerry's ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)
- Dr. X to provide **medication management,** 2X/mos for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning
- John Smith, Peer Coordinator, will provide **travel training** 1X/wk. for 4 weeks to help him become independent with city bus (e.g., identifying most direct bus routes, rehearsing use of coping skills, role playing conversations if confused/lost, etc.)
- **Gerry's brother, Jim,** will accompany Gerry on community outings over the next few months until he is more comfortable going out on his own.
- **Gerry** will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

Honoring the Person and Supporting Medical Necessity

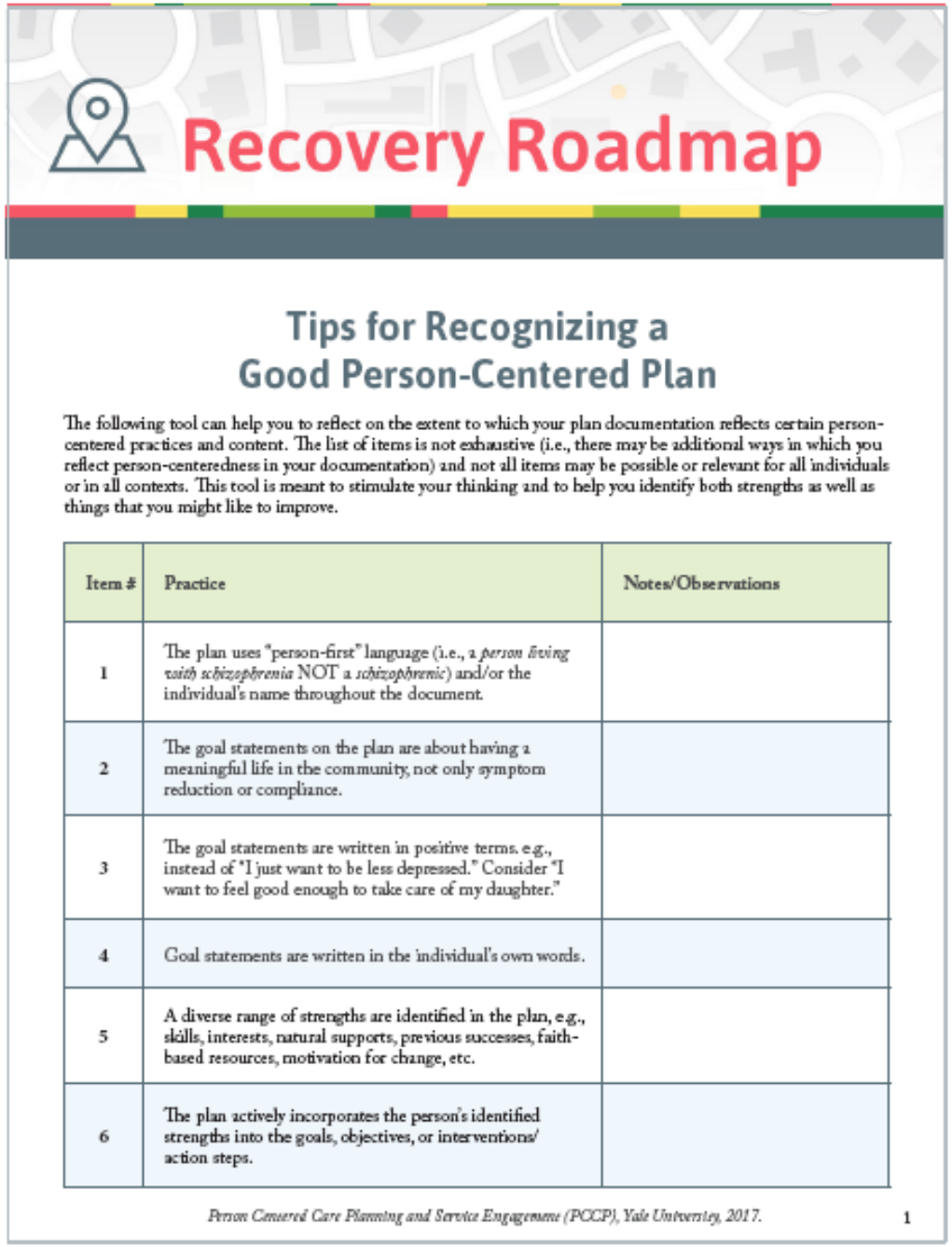


A Parting Thought

- 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!

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

PCRP RESOURCES

ENGAGING PEOPLE WHO RECEIVE SERVICES

August 2020

LINK

NCAPPS

FIVE COMPETENCY DOMAINS FOR STAFF WHO FACILITATE PERSON CENTERED PLANNING

November 2020

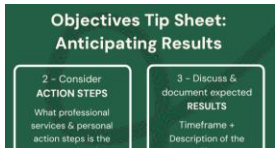
LINK

NCAPPS

OBJECTIVES TIP SHEET: ANTICIPATING RESULTS

March 2024

LINK



RECOVERY ROADMAP: PROCESS AND DOCUMENTATION QUALITY INDICATORS

March 2017

LINK

yale program for recovery and community health

Yale Program for Recovery and Community Health

Closing Q&A… Your Thoughts and Ideas

Evaluation

Scan the QR code to provide your valuable feedback through our evaluation survey. Your input helps us improve our services. Thank you for your participation!

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The MHTTC provides a comprehensive range of technical assistance services, catering to universal, targeted, and intensive needs. Our offerings encompass dynamic webcasts, informative clinical briefs, engaging podcasts, concise fact sheets, and personalized intensive consultations. We actively disseminate our wealth of resources through our user-friendly website and vibrant social media platforms, ensuring widespread accessibility and impact.