

Person-Centered Recovery Planning:

What does it REALLY look like in practice?



Yale PRCH & DMHAS PCRП Consulting Team
Connecticut Mental Health Center
September 10–11, 2009

Agenda for AM – 1st Day

9:00 – 9:30	Introductions/overview/exercise
9:30 – 10:00	Federal & State Context Top Ten Concerns
10:00 – 10:30	Key Practices: Part I (Language)
10:30 – 10:45	Break
10:45 – 11:15	Key Practices: Part II (Community)
11:15 – 12:00	Summary, Preview Sample Plan Q & A

Agenda for PM – 1st Day

1:00 – 1:30	Logic Model thru Formulation
1:30 – 2:00	Ingrid Exercise: Part I
2:00 – 2:30	Logic Model: Plan Components
2:30 – 2:45	BREAK
2:45 – 3:30	Ingrid Exercise: Part II
3:30 – 4:30	Group Report Out/Critique Q&A
4:30	Adjourn

Agenda for AM – 2nd Day

9:00 – 9:30	Complete Report Outs PRN De-brief Day 1
9:30 – 10:00	Review & common mistakes
10:00 – 10:45	Objectives Booster Exercise
10:45 – 11:00	Break
11:00 – 12:00	Exercise: Strengthening Skills: Develop plans from Vignettes

Agenda for PM – 2nd day

12:00 – 1:00	Lunch
1:00 – 2:00	Large group report out/critique, Plans from vignettes
2:00 – 2:45	Brainstorming barriers & strengths; Committing to a next step
2:45 – 3:00	Wrap- up/evaluation

Training Objectives

- ▶ Identify how a strengths-based, person-centered framework differs from past and current practice
- ▶ Understand the importance of a clinical formulation from assessment data
- ▶ Define the key elements of a treatment/recovery plan as a roadmap to recovery and wellness
- ▶ Practice writing plans which are person-centered while also meeting rigorous requirements, e.g., medical necessity

Recovery

- ✓ 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.

Wellness

- ✓ 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...



PCP as a tool to get beyond Us and Them

- Person-centered planning, at its core, is about recognizing that people with mental illnesses generally want the exact same things in life as ALL people.
- People want to thrive, not just survive...
- PCP is one tool the system can use to help people in this process!



Recovery

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential

National Consensus Statement, SAMHSA



SAMHSA

CT DMHAS

- Commissioner's Policy on Recovery-Oriented Care & PCP
- Highly active consumer/survivor recovery community
- DMHAS/Yale Recovery Training Institute
- Draft Policy on Individualized Recovery Planning
- Fiscal mechanisms (the "teeth")
- Links to federal SAMHSA PCP Initiative
- Bridge with children/family issues
- Ground Level Centers of Excellence
- Collaborative Research and Evaluation



**EMPOWERMENT
& CITIZENSHIP**

**MANAGING
SYMPTOMS**

**ASSUMING
CONTROL**

**OVERCOMING
STIGMA**

**REDEFINING
SELF**

**INCORPORATING
ILLNESS**

**FINDING A NICHE IN
THE COMMUNITY**

**RENEWING HOPE &
COMMITMENT**

**BEING SUPPORTED
BY OTHERS**



See: <http://www.dmhas.state.ct.us/recovery.htm>.

Where does the Treatment Plan Fit In?

▶ *A Consumer and Family Driven System...*

Recommendation 2.1

- The plan of care will be at the core of the consumer-centered, recovery oriented mental health system
- Providers should develop customized plans in full partnership with consumers

The PLAN is a window
of opportunity to promote
CONCRETE recovery-
practice change!



The State Perspective

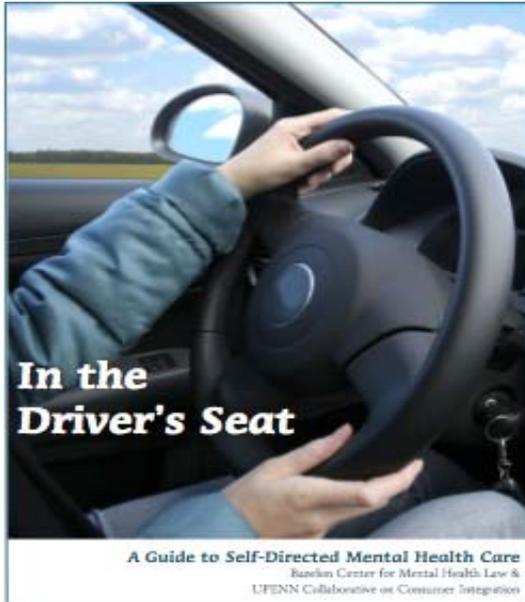
- Commissioner's Policy Statement #33, March 27, 2007
 - ...The **Plan of care shall be developed in collaboration with the person.**
 - ...**Focusing solely on deficits** in the absence of a thoughtful analysis of strengths leads to **disregarding the most critical resources an individual has** on which to build on his or her efforts to... advance in his or her unique recovery journey.
 - ...The **primary focus** of recovery planning is on what services the person desires and needs in order **to establish and maintain a healthy and safe life in the community...**

Person-Centered Planning

... a long and winding road, but a necessary journey



Why, What do we need to change?



Even though state and local agencies often include consumers and other advocates in care planning, they often allow them to have only a marginal role and fail to provide important information that could enable them to participate fully and effectively.

Bazelon Center, 2008

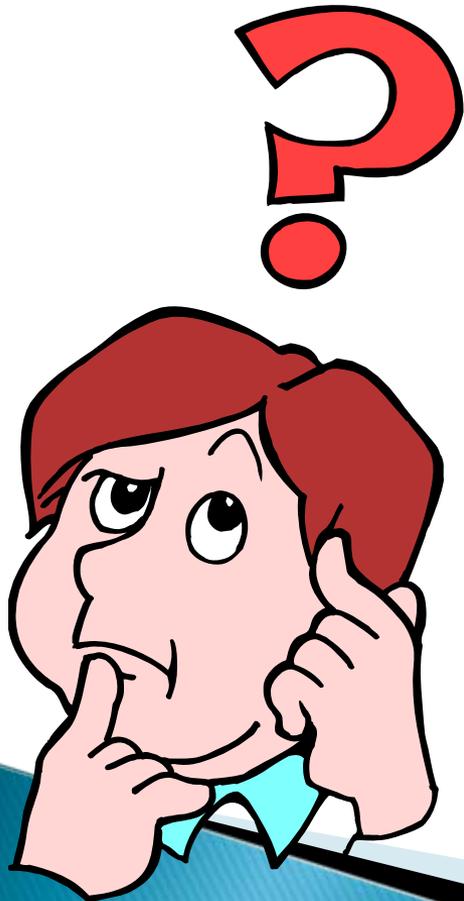
STORE CLOSING

NOW HIRING



In Other Words...

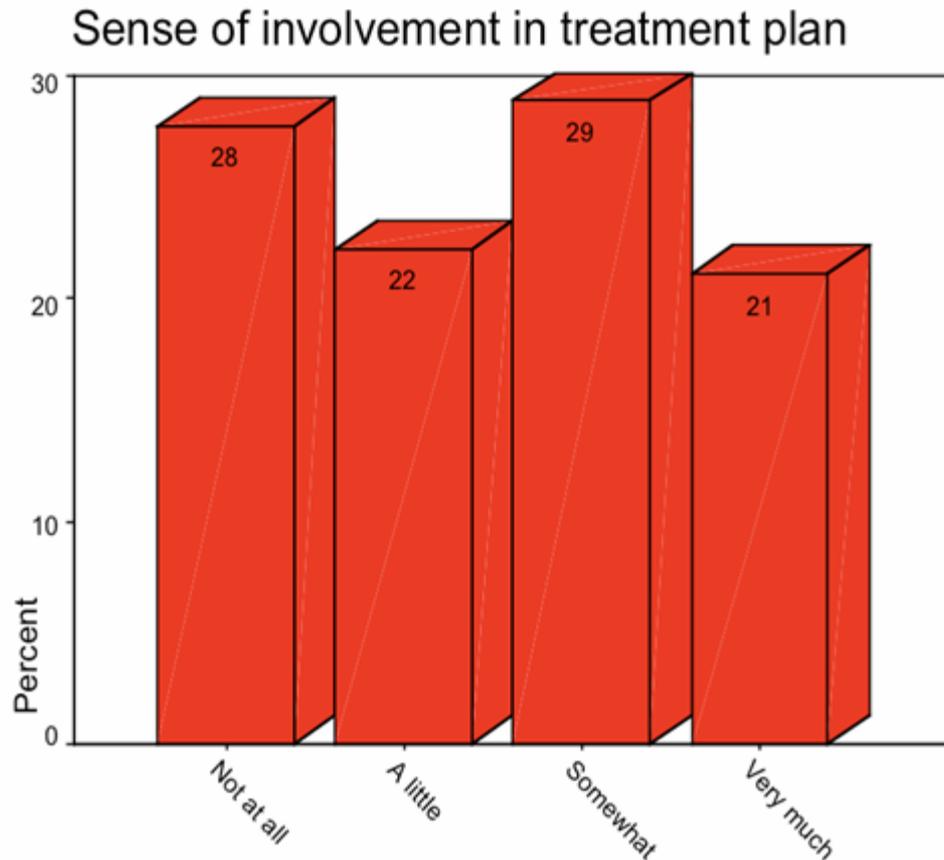
“You keep talking about getting me in the ‘driver’s seat’ of my treatment and my life... when half the time I am not even in the damn car!”



Person in Recovery as Quoted in CT
DMHAS *Recovery Practice
Guidelines, 2005*

Data from Yale Supports this Position

- 24% of sample (N=137) report NEVER having a treatment plan
- Of those who had experienced a treatment plan, half felt involved only “a little” or “not at all”.

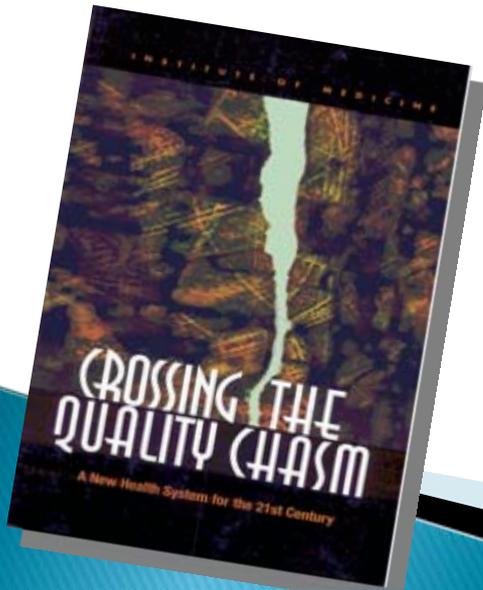


- 21% of participants report being “very much” involved
- 12% of people invited someone to their last treatment planning meeting
- Over half were not offered a copy of their plan

The Voice of Experience & the Feds

- ▶ 25 years in the DD field
- ▶ IOM Report – 2001
- ▶ New Freedom Commission – 2003
- ▶ IOM for MH/SU - 2005
 - providers must fundamentally change their approach toward patients

providers should incorporate informed, patient-centered decision-making throughout their practices, including active patient participation in the design and revision of patient treatment and recovery plans... Tondora, 2009



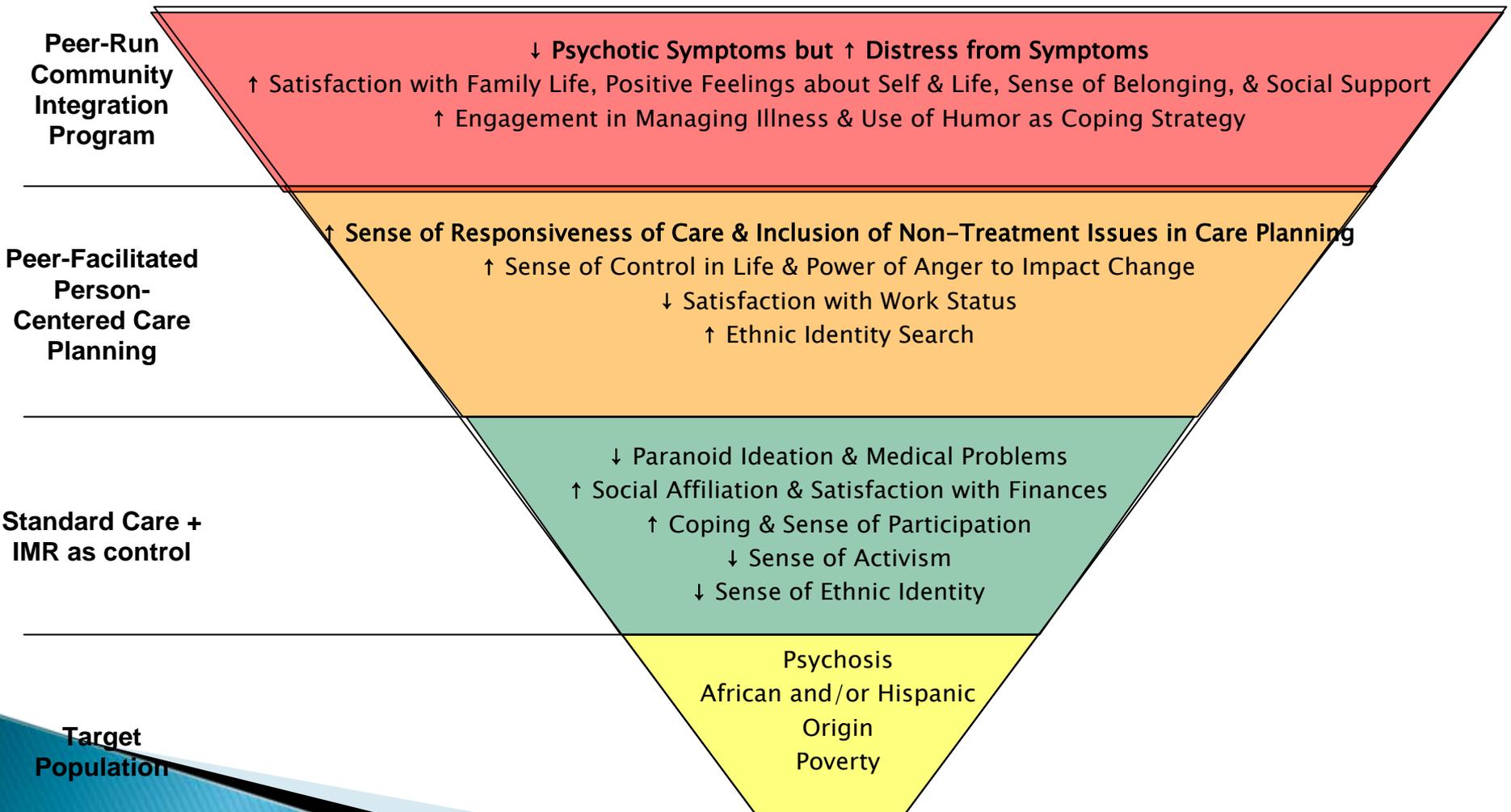
IT WORKS!!

- ▶ For example, WNYCCP (July, 2008) has achieved the following outcomes:
 - 68% increase in competitive employment
 - 43% decrease in ER visits
 - 44% decrease in inpatient days
 - 56% decrease in self-harm
 - 51% decrease in harm to others
 - 11% decrease in arrests
- ▶ Cost-effective
 - The rate of increase between 2003 and 2007 for total Medicaid costs for WNYCCP participants is LESS than rate of increase in comparison group

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Figure 1. 6-Month Process and Outcome Results for Culturally-Responsive Person-Centered Care for Psychosis Project (NIMH #R01-MH067687)



Current Thinking

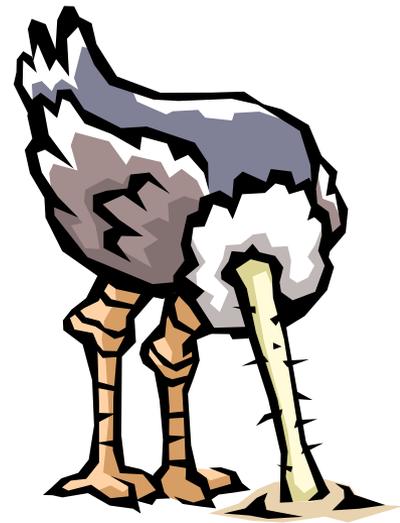


- ▶ PCP can be the bridge between the system as it exists now and where we need to go in the future
- ▶ PCPs are a key lever of personal and systems transformation at all levels:
 - ▶ Individual and family
 - ▶ **Provider**
 - ▶ Administrator
 - ▶ Policy and oversight



What might get in your way...

- ▶ Anticipate the tough questions, early on and throughout...
- ▶ Often these relate to “systemic” level issues that providers feel are beyond their control
- ▶ Align with providers.
 - *“When you pit a bad system against a good performer, the system always wins...”*
 - *(Rummler, 2004).*
- ▶ What are your “Top 10” concerns???





The one thing I have heard about PCRPs that I think is very exciting is...

I want to do my work this way because...

The one thing I have heard about PCRPs that concerns me the most is...

I don't think it will work because...

I am most confused about...



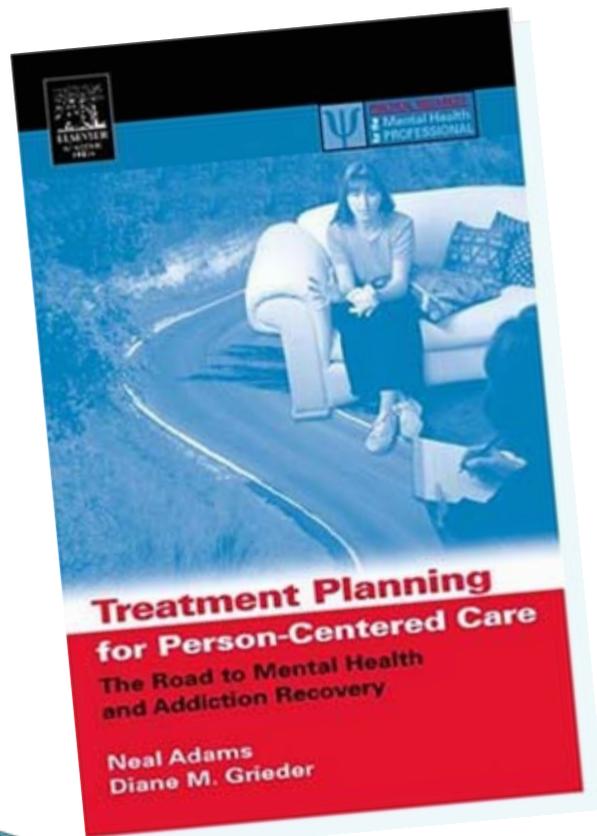


Top 10 Myths

1. If given choice, people will make BAD ones
2. Payers won't let us do this; regs prohibit this
3. The forms don't have the right fields
4. Consumers aren't interested/motivated
5. It devalues clinical expertise
6. It violates professional boundaries
7. Its what the clubhouse does...
8. Lack of time/caseloads too high
9. "My clients are sicker"
10. It doesn't fit with focus on EBPs

What is PCP?

Taking a Closer Look



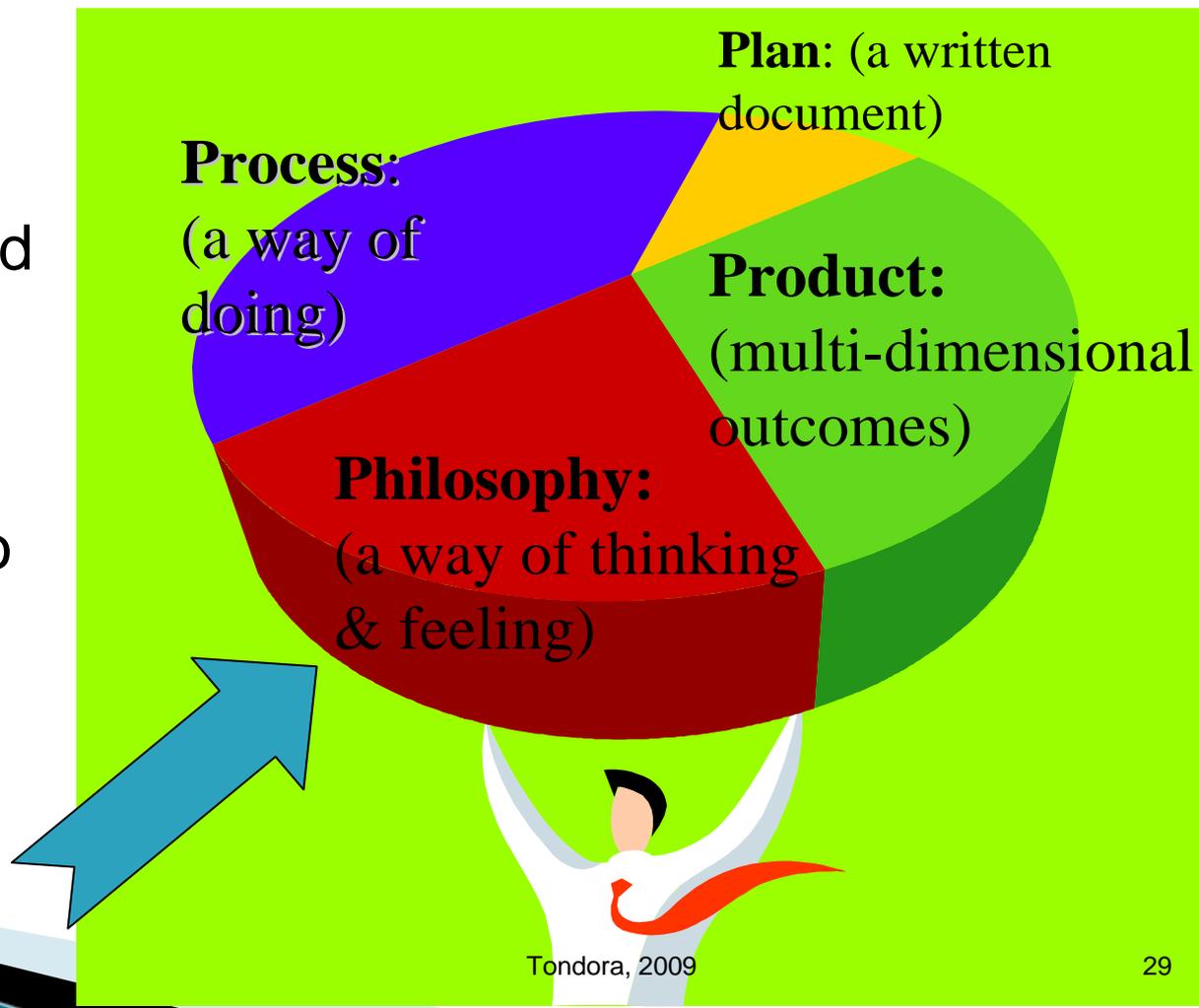
- ▶ Person-centered planning
 - is a collaborative process resulting in a recovery oriented treatment plan
 - is directed by consumers and produced in partnership with care providers and natural supporters
 - supports consumer preferences and a recovery orientation

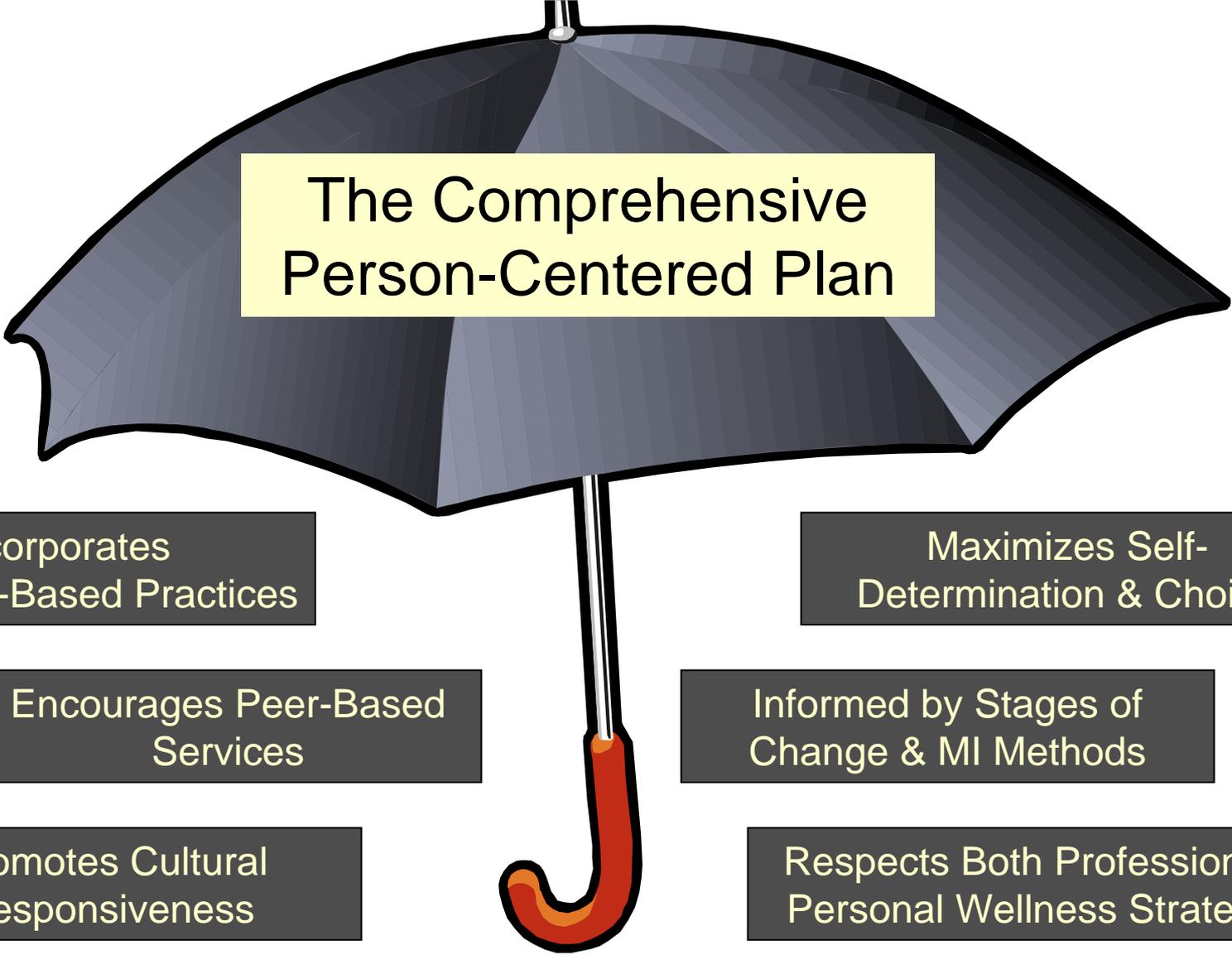
Adams/Grieder

The “Nuts and Bolts” of PCP

The *practice* of PCP 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 way people feel and think.





The Comprehensive Person-Centered Plan

Incorporates Evidence-Based Practices

Maximizes Self-Determination & Choice

Encourages Peer-Based Services

Informed by Stages of Change & MI Methods

Promotes Cultural Responsiveness

Respects Both Professional & Personal Wellness Strategies

Focuses on Natural Supporters/Community Settings

Consistent w/ Standards of Fiscal & Regulatory Bodies, e.g., CMS, JCAHO



Key Practices in Implementation

Adhere to person-centered principles in the process

- Person is a partner in all planning activities/meetings
- Person has reasonable control over logistics including invitees and location
- Person ALWAYS offered a copy
- Education about the process –Tx planning Handout **Level Of Care decisions**





Your Treatment Plan & Meeting :

Making it work for you and your recovery



What is a “treatment plan”?

A treatment plan:

- is sometimes also called a service plan or a recovery plan.
- is a document that you create with your team to help plan for your recovery and services.
- identifies goals that are important to you in your recovery and well-being.
- identifies the things that you and your team need to do to help you achieve these goals.
- is the document that your clinical team uses to get payment for the supports they provide to you.

What is a “treatment planning” meeting?

It is a meeting:

- where you work in partnership with others to create your treatment plan.
- that happens on a regular basis – usually every 6 months (although the plan can be updated as needed).
- where you have a right to invite anyone you believe is supportive of your recovery – including your recovery mentor!
- that your mentor can attend and help you speak up about things that are important to you.

What is YOUR role in this meeting?:

For this meeting, it is useful to:

- think about your priorities and goals ahead of time.
- ask for the types of support that would be most helpful to you.
- SPEAK UP and share your ideas and needs with your team!
- think about your own responsibilities in working towards your goals.

What kinds of things can I bring up at this meeting?

This is YOUR meeting. You can:

- bring up anything you think is important in your recovery
- discuss ways to pursue your goals, both clinical treatment goals and also your goals and dreams for



Key Practices in Implementation

- Conduct a strengths-based inquiry to inform the plan
 - Conducted as a collaborative process – not an interrogation
 - Solicitation of strengths from diverse areas, e.g., familial roles, cultural traditions/resilience, e.g., **New Haven**
 - Creativity is key – NOT, *What are your vocational aspirations?* BUT, *Think back when you were a kid, what did you want to be when you grew up?*
 - USE the information! e.g., **IV**



Key Practices in SBA

- Use strengths-based approaches in assessment & plans
 - Written and spoken language honors PCP values
 - Principles include things like using person-first terms, avoiding overly negative connotations, being careful not to communicate hierarchy/social control; and most important – deferring to the person “when in doubt...” – **consumer/patient/person w/**



The Power of Language in Strengths-Based Approaches:



*The Glass Half Empty,
The Glass Half Full:
Exercise and Group Discussion*

<i>The Glass Half Empty...The Glass Half Full</i>	
Deficit-based Language	Strengths-based, Recovery-oriented Alternative
A schizophrenic, a borderline	A person diagnosed with...
Clinical Case Manager	Recovery coach/guide
Front-line staff/in the trenches	Direct support staff
Substance abuse/abuser	Person living with...SA interferes with...
Suffering from	Living with/recovering from
Treatment Team	Recovery team
High-functioning vs. Low Functioning	A person symptoms/addiction interferes with the following...
Unrealistic	Idealistic, high expectations
Resistant/non-compliant	Disagrees with, chooses alternatives
Weaknesses	Barriers to change; Support needs
Maintaining clinical stability/abstinence	Promoting life worth living
Puts self/recovery at risk	Takes risks to try new things/grow
Treatment works	Person uses tx as a tool in recovery

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 psychiatrist to find a med regimen that is highly effective for her and she has been an active participant in activities at the clinic and the social club. Sandra and her supporters 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 today's clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.



Key Practices in Implementation

- Recognize the range of contributors to the planning process
- Value community inclusion





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

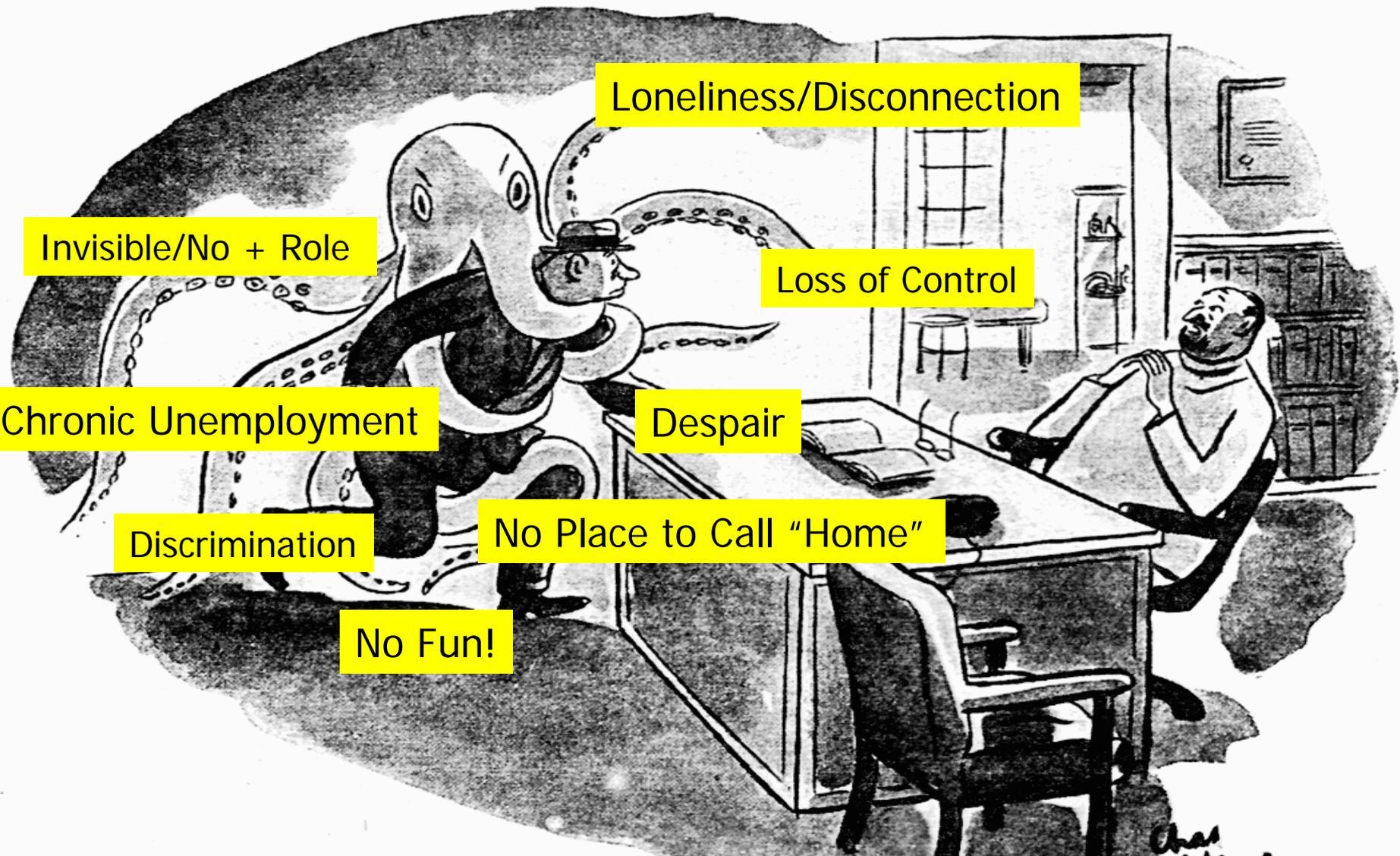
EVERYTHING! If we listen to the voice of people in recovery...

Part of healing and recovery is the ability to participate as full citizens in the life of the community. (Walsh, 1996)



To join the dance of life...

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..."



Loneliness/Disconnection

Invisible/No + Role

Loss of Control

Chronic Unemployment

Despair

Discrimination

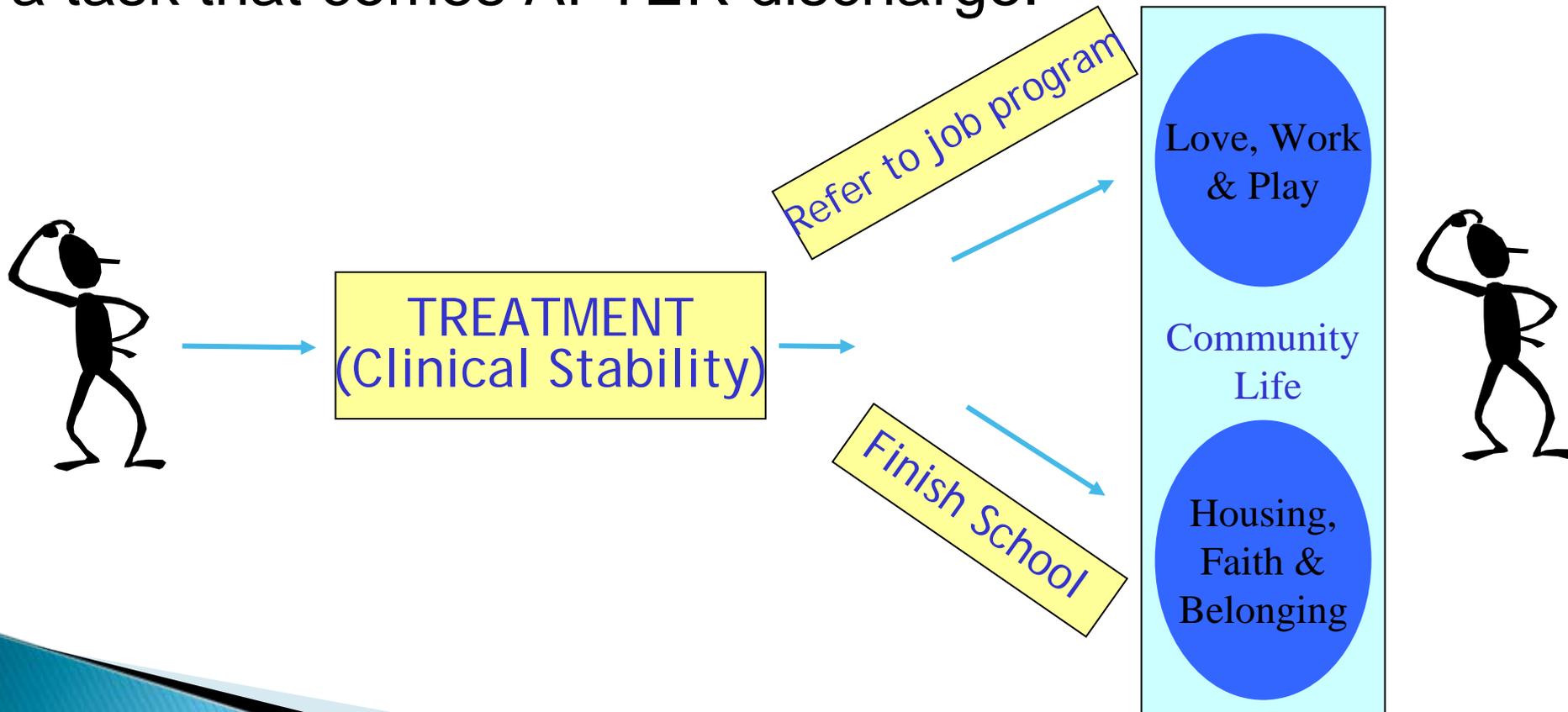
No Place to Call "Home"

No Fun!

“Now just sit down and tell me what seems to be the trouble...”

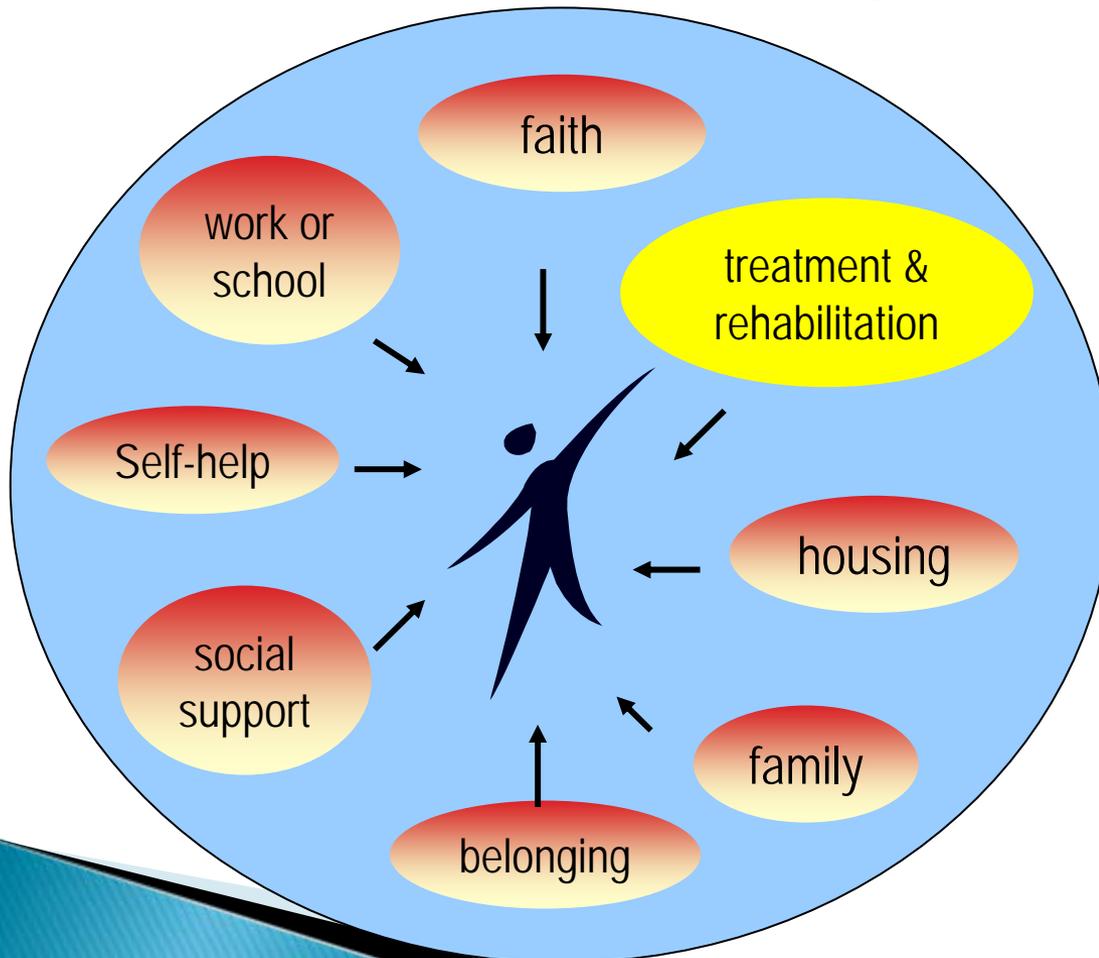
A word of caution...

Building a life in the community is NOT a task that comes AFTER discharge.



Instead...

The pursuit of meaningful community life must be at the heart of the care and planning process throughout!



**“WHILE” not
“AFTER”!**



CAUTION

A word of caution...

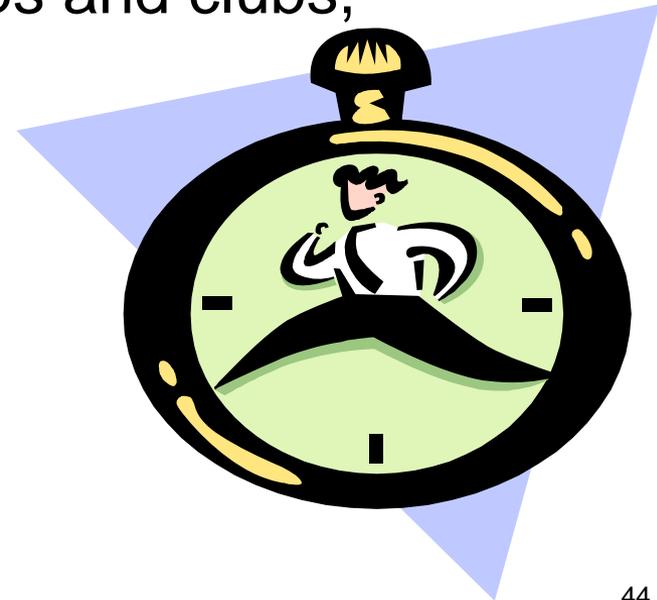


Just as community life is not what comes AFTER discharge, it is also NOT something that service systems can, or should, artificially create **FOR** people!



Think About It...

- Let's list of ALL the interventions, services, and supports that the complete CMHC system provides to service recipients.
- Think broadly and note things provided by clinical/ medical professionals, rehabilitation partners, psychosocial clubhouses, peer providers, agency committees, agency sponsored groups and clubs, social and special events, etc.
- **ANYTHING & EVERYTHING** the mental health/rehab system provides can be noted.





Think About It...

- If a person did not have a mental health issue, where would they access these various activities?
- Where do each of YOU, as community members, access these things?
- Are individuals you support encouraged to make use of these same natural community and personal resources? If not, why?
- How do you encourage creative use of natural community resources?



CAUTION

Avoid the “One Stop Shop”



Stigma/discrimination are NOT a reason to deny people access to, or to “protect” people from, the pitfalls (or potential joys) of community life.

Ask yourself: Am I about to recommend or create, in an artificial or segregated setting, something that can already be found naturally in the community?

- Sheltered workshops/real jobs for real pay
- Movie nights at the LMHA/passes to the local theatre
- Construction of fitness facilities/reduced rates to the local gym
- Internal GED classes/local Adult Education facilities
- “Current events group”/Barnes & Noble book club
- On-site medical facilities/ use of Community Health Advocates





Consider instead...



- Teaching providers to
 - collaborate with community partners
 - understand relevant disability legislation
 - recognize instances of discrimination
 - effectively utilize state/local resources
- Building this same kind of knowledge/skill within the consumer community



Key Practices in Implementation

- Demonstrate a commitment to both outcomes and process
- Understand and support human rights such as self-determination



Imminent risk vs. Responsible risk taking

- ▶ A recovery orientation in no way conflicts with risk assessment and encourages the appropriate use of this technology.
- ▶ Restrictive measures only used when there is ***imminent risk*** as narrowly allowed under statutory law
- ▶ Encourage responsible “risk taking”



Imminent risk
vs.
Responsible
risk taking



“We’ve considered every potential risk except the risks of avoiding all risks.”

“I am waiting for the day that people realize that it is just as “risky” for people to stagnate for 10 years inside the mental health system – safe but unfulfilled.”

*----Brian Phillips, WNYCCP,
Consultant, NYOMH
and NYAPSRS*

PAD and the Consumer Voice

- ▶ This time, with a PAD, I did not receive any treatments that I did not want...I really felt like the hospital took better care of me because I had my PAD. In fact, I think it's **the best care that I've ever received**.
- ▶ [P]eople can have you committed and you don't have a say about anything. **At least this way you have some say in your treatment**, if it's read, people see it and it's legal.



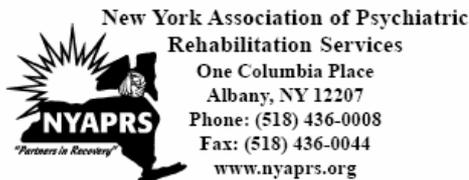
I told **my therapist** that I had done a PAD and wanted to bring a copy to her to see what she thought -- and she **thought it was great**. She thought it was wonderful that I had gotten very specific about my treatment preferences.

Duke University Medical Center, PAD Research Project

PLANNING FOR YOUR MENTAL AND PHYSICAL HEALTH CARE AND TREATMENT

- ▶ Combines user friendly Q&A
- ▶ Includes BOTH a Health Care Proxy and a Living Will form
- ▶ Wallet card for alert to proxy/will
- Many logistical and legal questions remain
 - Despite this, PADs have substantial therapeutic utility as a R-O risk-management tool

THE ADVANCE DIRECTIVE PROVIDER TRAINING PROJECT



This Document was created by The Resource Center, Albany, NY.

Recovery-oriented *AND* Clinically Therapeutic

E. PREFERENCES REGARDING PHYSICAL CONTACT BY STAFF:

C. APPROACHES THAT HELP ME WHEN I'M HAVING A HARD TIME:

If I am having a hard time, the following approaches have been helpful to me in the past. I would like the staff to try to use these approaches with me:

- | | |
|--|---|
| <input type="checkbox"/> Voluntary time out in my room | <input type="checkbox"/> Listening to music |
| <input type="checkbox"/> Voluntary timeout in quiet room | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sitting by staff | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Talking with a peer | <input type="checkbox"/> Pacing the halls |
| <input type="checkbox"/> Having my hand held | <input type="checkbox"/> Calling a friend |
| <input type="checkbox"/> Going for a walk | <input type="checkbox"/> Calling my therapist |
| <input type="checkbox"/> Punching a pillow | <input type="checkbox"/> Pounding some clay |
| <input type="checkbox"/> Writing in a journal | <input type="checkbox"/> Deep breathing exercises |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Taking a shower |
| <input type="checkbox"/> Talking with staff | <input type="checkbox"/> Exercising |

Breaking down the PCRP Process

1. Orientation and Intake to the Team

2. Pre-Planning: Education and Preparation

3. Strengths-based Assessment to Inform the Plan

4. Enhancing Forms/Templates

5. The Planning Meeting

6. Co-creating the Plan

7. Evaluating Progress

8. Maintaining the Record



6. Co-Creating the Plan:

a) Goals

- Strengths/Barriers

b) Objectives

c) Interventions



Putting the Pieces Together in a Person-Centered Plan

GOAL

as Defined by Person

Strengths to Draw Upon

Barriers Which Interfere

Short-Term Objective

- Behavioral
- Achievable
- Measureable

Interventions/Action Steps

- Professional/"Billable" Services
 - Clinical & Rehab
- Action Steps by Person in Recovery
- Roles/Actions by Natural Supporters

GOAL

Goals should be stated in the individual's or family's own words, and include statements of dreams, hopes, role functions and vision of life. For each individual and family and/or setting, completion of all three sub-goals may not be necessary or appropriate.

I am lost without my God. I want to get back to my Baptist Church. But I am so ashamed.

Barriers

Describe the challenges as a result of the mental illness or addictive disorder that stand in the way of the individual and family meeting their goals and/or achieving the discharge/transition criteria. Identifying these barriers is key to specifying the objectives as well as services and interventions in the following section of the plan.

Anxiety/intrusive thoughts which increase during attempts to return to church or speak with pastor – “All eyes are on me. My head spins. They won’t take me back.

Estrangement from Pastor – “He betrayed me. He’ll never understand.”

Need for illness self-management strategies – “I have no control – how can I stop this from happening again?”

OBJECTIVE

Using action words, describe the specific changes expected in measurable and behavioral terms. Include the target date for completion.

Ingrid will attend, and sit through, one 90 minute church service of her choice within 90 days in order to reconnect with her Baptist faith and community.

INDIVIDUAL/FAMILY STRENGTHS

*Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to **help accomplish this***

Supportive sister; Strong faith/belief system; History of active involvement in volunteer activities at church; Caring and compassionate; well-liked by fellow parishioners; strong connection to peer recovery mentor at mental health center

INTERVENTIONS

*Describe the specific activity, service or treatment, the provider or other responsible person (including the individual and family), and the **intended purpose or impact as it relates to this objective**. The intensity, frequency and duration should also be specified.*

Psychiatrist to meet with Ingrid 1 time monthly for 30 minutes for the next 3

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Psychiatrist to meet with Ingrid 1 time monthly for 30 minutes for the next 3 months to adjust medication and decrease symptoms

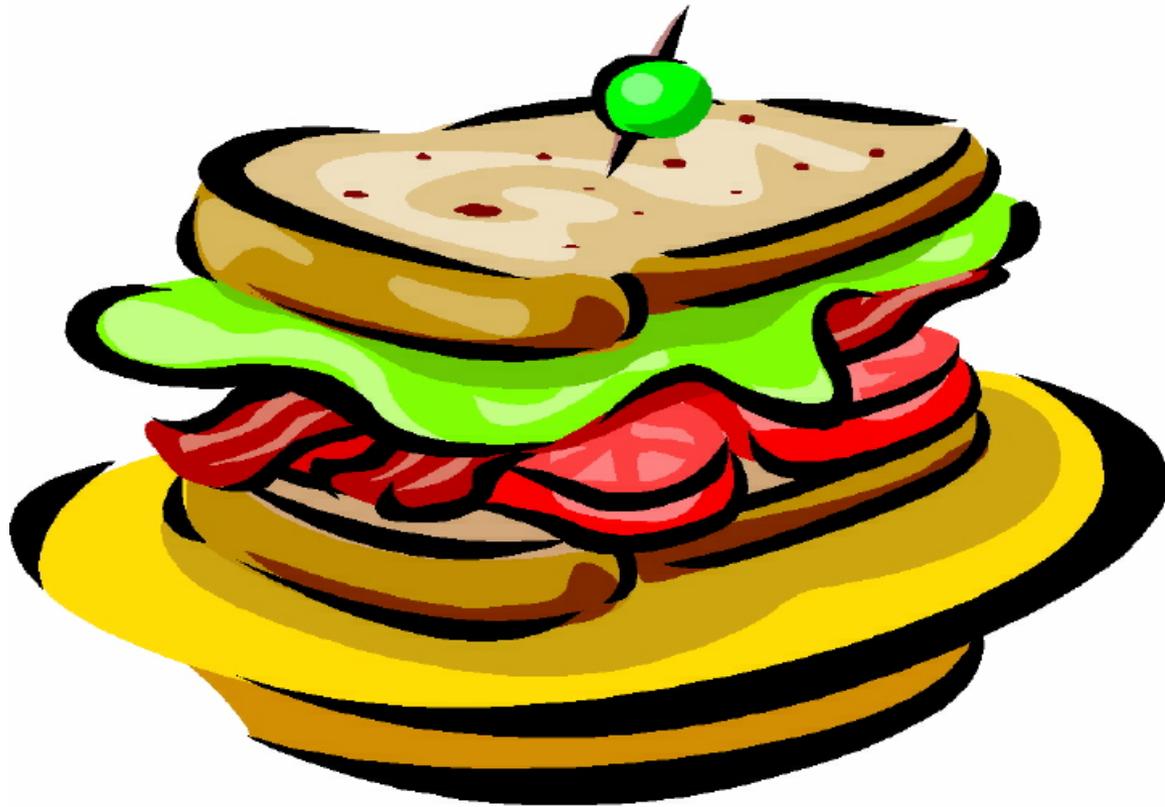
Primary clinician, LCSW, to meet weekly with Ingrid for 45 minutes for 3 months to provide CBT coping strategies (e.g., thought stopping, visualization, deep breathing) to help manage her symptoms which increase when she is in church

Case Manager to provide support to Ingrid by walking with her weekly to church while practicing CBT strategies, for 3 months.

Sister, a respected elder in the church, to meet with Pastor and Ingrid within one month to re-connect, heal the rift, and talk about how to help in the future if needed.

Ingrid to participate in bi-weekly Wellness Recovery Action Planning group (facilitated by her peer recovery mentor) for purpose of developing simple, safe, and effective strategies for maintaining her wellness and increasing her

Lunch!



Taking a Closer Look

There is a logic model for creating comprehensive, person centered recovery plans...

Building a Plan



A plan is only as good as
the *assessment*.



The Assessment

- ▶ Initiates helping relationships
 - Ongoing process

- ▶ Comprehensive domain based data gathering - attending to cultural factors throughout

- ▶ Identifies strengths
 - Abilities and accomplishments
 - Interests and aspirations
 - Recovery resources and assets
 - Unique individual attributes

- ▶ Considers stage / phase of change process

The Assessment ...

- **Explores the question of culture with the person**
 - Race
 - Ethnic identity
 - Religion
 - Socio-economic status of the person and his/her family
 - Disability status
 - Family structure
 - Family values
 - Sexual identity
 - Education
 - Spirituality
 - Gender
 - Age/Developmental

Sample Inquiries

- How do you identify culturally/racially/ethnically? What is your culture? Where are you from?
- How long have you been living here?
- Who do you include as family? Who do you trust?
- Does most of your family live here? If not, where are they?
- What does your culture/family say about mental health problems? How does your family respond to you?
- What do you call your problem? What caused it?

Sample Inquiries

- What is it like for you as a Black woman/Latino woman/Korean man living with mental health challenges?
- Are you a member of a faith community now? If so, would you like the Rabbi, Priest, Pastor, Imam, etc. involved in your team?
- Are you now going, or have you ever gone, to an Indigenous Healer for help with your problem? Would you like that person involved as part of your recovery team?
- Have you ever experienced racism, police brutality, discrimination and/or other forms of oppression?



Strengths–Based Assessment Process

- Takes time and a trusting relationship
- Must be a reciprocal dialogue – not an interrogation
- Explore strengths beyond the individual
- Expand what we value as a “strength”
- Explore what has worked for them (or peers) in the past, e.g., WRAP
- Be creative in HOW we ask questions

Sample Inquiries

- ▶ ***Personal Strengths:*** e.g., What are you most proud of in your life? What is one thing you would not change about yourself?
 - ▶ ***Interests and Activities:*** e.g., If you could plan the “perfect day,” what would it look like?
 - ▶ ***Living Environment:*** e.g., What are the most important things to you when deciding where to live?
- 

Sample Inquiries

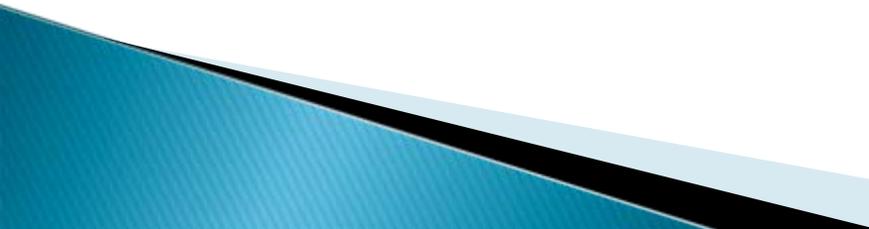
- ▶ **Employment:** e.g., As a kid, what did you dream of being “when you grew up”?
- ▶ **Learning:** e.g., What kinds of things have you liked learning about in the past? What was your favorite subject in school?
- ▶ **Financial:** e.g., Would you like to be more independent with managing your finances? If so, how do you think you could do that?
- ▶ **Lifestyle and Health:** e.g., Do you have any concerns about your overall health? Tell me a bit about your mental health: What does a good day look like? A bad day?

Sample Inquiries

- ▶ **Choice-Making:** e.g., What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?
- ▶ **Transportation:** e.g., How do you currently get around from place to place? What would help?
- ▶ **Faith and Spirituality:** e.g., What type of spiritual or faith activities do you/would you like to participate in?
- ▶ **Relationships ;:** e.g., Who is the person in your life that believes in you? Who counts on YOU?



Strengths-Based Assessment: Recommendations

- Goals are broken into small, meaningful steps that have a high probability of success.
 - Goals and tasks are written positively; something the person will do, not what they will not do, e.g., power struggles
 - Target dates are set for the accomplishment of each task (not “on-going”)
- 

*RECOVERY MAY BE A JOURNEY;
BUT IF YOU NEVER GET ANYWHERE,
IT CAN EASILY BECOME A TREADMILL.*

*Joe Marrone, Institute for
Community Inclusion*



Assessment Considers Stage of Recovery and Treatment

Ohio	Village	Prochaska & DiClemente	Stage of Treatment	Treatment Focus
Dependent unaware	High risk/ Unidentified or Unengaged	Pre-contemplation	Engagement	<ul style="list-style-type: none"> ■ outreach ■ practical help ■ crisis intervention ■ relationship building
Dependent aware	Poorly coping/Engaged/ not self-directed	Contemplation /preparation	Persuasion	<ul style="list-style-type: none"> ■ psycho-education ■ set goals ■ build awareness
Independent aware	Coping/Self responsible	Action	Active Treatment	<ul style="list-style-type: none"> ■ counseling ■ skills training ■ self-help groups
Inter-dependent aware	Graduated or Discharged	Maintenance	Relapse Prevention	<ul style="list-style-type: none"> ■ prevention plan ■ skills training ■ expand recovery

Importance of Understanding

- ▶ Data collected in assessment is by itself *not sufficient* for service planning
- ▶ Formulation / understanding is essential
 - Moves from **what** to **why**
 - Sets the stage for **prioritizing** needs and goals
 - The role of culture and ethnicity is critical to true appreciation of the person served
- ▶ Recorded in a chart narrative
 - Shared with person served
 - ▶ Is the BRIDGE between the data/assessment and the plan!

CARF's Interpretive Summary

- ▶ Central theme of the person
 - ▶ Interrelationships between sets of findings
 - ▶ Needs, strengths, limitations
 - ▶ Clinical judgments regarding the course of treatment
 - ▶ Recommended treatments
 - ▶ Level of care, length, intensity of treatment
- 

Culturally Appropriate Formulation as per DSM-IV (Appendix I):

- *Cultural Identity*: cultural reference groups; language (s): cultural factors in development; involvement with culture of origin
- *Cultural explanations of illness*: idioms of distress; meaning of symptoms in relation to cultural norms; perceived causes; help-seeking behavior

Culturally Appropriate Formulation as per DSM-IV (Appendix I):

- *Cultural factors related to psychosocial environment and levels of functioning:* social stressors; social supports; level of functioning/disability
- *Cultural elements of the clinician-patient relationship:* clinician's ethnocultural background; language; knowledge of patient's culture

The 10 Ps

- ▶ **P**ertinent history (*brief*)
- ▶ **P**redisposing factors
- ▶ **P**recipitating factors
- ▶ **P**erpetuating factors
- ▶ **P**resent condition / presenting problem
- ▶ **P**revious treatment and response
- ▶ **P**rioritization by person served
- ▶ **P**references of person served
- ▶ **P**rognosis
- ▶ **P**ossibilities

Prioritization by Person Served

- ▶ What comes first?
 - Personal / family values need to be considered
 - Cultural nuances are significant
- ▶ Must be the driving force
 - Consistent with concerns / perspective of person served (and family *as appropriate*)
 - Builds upon the person's own expertise

What is important **TO** the person?

Provider Perspectives in Prioritization

- ▶ Basic health and safety
 - Reduction of clinical sx
 - Maslow's basic needs
 - Harm reduction

What is important **FOR** the person?

- ▶ Legal obligations and mandates
- ▶ Community Safety

Important **TO**



Important **FOR**

Small Group Exercise – Formulation/Summary



- ▶ *Ingrid*
- ▶ Prepare an interpretive summary using the assessments and format provided
- ▶ Use team expertise
- ▶ Be prepared to
 - Talk about how you answered the questions
 - Discuss any problems you encountered

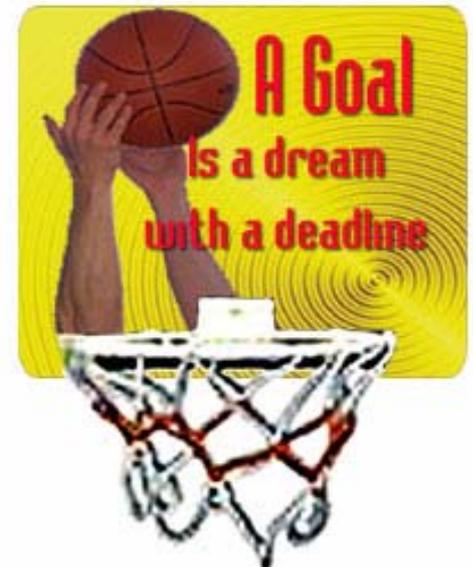
Goals

- ▶ Long term, global, and broadly stated
 - the broader the scope the less frequently it needs to change
- ▶ Life changes as a result of services
 - focus of alliance / collaboration
 - readily identified by each person
- ▶ Linked to discharge criteria and needs
 - describes end point of helping relationship



Goals *continued*

- ▶ Person-centered
 - Ideally expressed in person served's / family's words
 - Easily understandable in preferred language
 - Appropriate to the person's culture
 - reflect values, life-styles, etc.
 - Consistent with desire for self-determination and self-sufficiency
 - may be influenced by culture and tradition



Goals *continued*

- ▶ Essential features

- Attainable

- Written in positive terms

- **built upon abilities / strengths, preferences and needs**

- embody hope/alternative to current circumstances

- They are about recovery, not maintenance, per the proposed CMS regulations for rehab option



The Right Balance

Let client do what
he/she wants

Get client to do
what I want



Neglect

*Recovery
Zone*

Control



Common Ground

- ▶ Dignity of risk and right of failure
- ▶ Providers as advocates
- ▶ Clients are not abandoned to suffer “the natural consequences” of their choices
- ▶ Provider or client not a failure if choice results in failure
- ▶ Use reinforcers to support client choice
- ▶ Assure true choice over a wide range of options

Barriers

- ▶ What is keeping the person their goals?
 - need for skills development
 - intrusive or burdensome symptoms
 - lack of resources
 - need for assistance / supports
 - problems in behavior
 - challenges in activities of daily living
 - threats to basic health and safety
- ▶ **Challenges / needs as a result of a mental and/or alcohol/drug disorder**





Objectives

Work to remove barriers and/or
build on strengths

Expected near-term changes
to meet long-term goals

divide larger goals into manageable tasks

provide time frames for assessing progress

maximum of two or three per goal
recommended

Objectives



- ▶ Essential features
 - behavioral
 - achievable
 - measurable
 - time framed
 - understandable for the person served
- ▶ ***Services are not an objective!!***
- ▶ **SHORT-TERM ACCOMPLISHMENTS; PROOF YOU ARE MOVING CLOSER TO THE GOAL**

Objectives – Technical

- ▶ **Non-behavioral:** Client will decrease social isolation.
- ▶ **Behavioral:**
 - Client will participate in a minimum of 1 social activity outside of their home each wk. for next 90 days AEB self report.
 - Within 30 days, client will identify 3 ways in which he / she can begin to make acquaintances @ time of session w/ worker.

Objectives – Technical

- ▶ **Non-behavioral:** Client will decrease frequency & intensity of substance use.

- ▶ **Behavioral:**
 - Client will identify a min. of 2 adverse effects that substance use has on his/her recovery within 30 days AEB self-report.

 - Client will be substance-free for 6 months as evidenced by results of tox screen.

Objectives

▶ TEST:

- At the end of 3 month / 6 months, etc., can you definitely say yes / no that the objective was accomplished.
- WITHOUT differences of opinion around the table!

Services are not objective...

- *Gary will come to group consistently and demonstrate interest in the activities.*
- *Gary will demonstrate increased engagement in care as evidenced by his attendance at IMR group 75% of groups over the next 3 months. (Assumes pre-contemplative!)*
- *Or... as evidenced by Gary completing 75% of his homework assignments over the next 3 months. THEN...*

Services are not objective...

- AFTER Gary is engaged/more active – do not default to this place!
- *Question to now ask is: What do you want him to get out of group / how do you want him to change as a result of coming to IMR??*
 - **Decreased symptoms AEB...**
 - **Improved social relations AEB...**
 - **Better behavioral control AEB... etc.**

Objectives – Wording

- ▶ *“Within X days... The individual / family will ...”*
- ▶ *As a result of services and supports, Mr./Ms. X will....., as evidenced by.....”*
- ▶ **changes in behavior / function / status**
 - described in action words
- ▶ *Be careful of using the word “and”*

Objectives

- ▶ Ideal is short-term, **OUTCOME-ORIENTED** objectives, e.g., Goal = Graduate from college
 - **Outcome-oriented objective** = Within 6 months, Joan will complete one course at local CC with minimum grade of “C”
 - Versus...

Objectives

- ▶ Versus: more **PROCESS-ORIENTED** steps, e.g.,
 - Joan will file complete financial aid application
 - Joan will call college advisor
- Consider adding THESE steps to your interventions section as Joan's personal "Action Steps" if, based on functioning/severity of illness/stage of change, the phone call or application is realistically the most ambitious first-step that can be taken

*RECOVERY MAY BE A JOURNEY;
BUT IF YOU NEVER GET ANYWHERE,
IT CAN EASILY BECOME A TREADMILL.*

*Joe Marrone, Institute for
Community Inclusion*



Objectives

- ▶ Versus: more **LEARNING OBJECTIVES:**
 - Joan will verbally identify 3 sources of school-related anxiety in session with staff.
 - Joan will verbally identify 3 positive coping strategies in session with staff.
 - Consider expanding, to Joan will positively apply coping strategies as evidenced by her ability to attend class over the next 3 months without experiencing a panic attack.

Remember to Raise Bar Over Time!

- ▶ *Audrey will work on her resume 3 times during the next 30 days.*
- *Over the 30 days, Audrey will spend 30 minutes for 3 times working on her resume.*
 - *Within 3 months, Audrey will have completed a draft of her resume*
 - *Within 6 months, Audrey will be working 5 hours per week in community!*

Objectives – Summary

- Generally, outcome-oriented objectives are more meaningful to the person than process-oriented steps
- Rule of thumb in writing objectives:
 - Start where person is at no matter how small a step it might be BUT
 - Be as ambitious as possible (i.e., don't default in objectives to phone calls, applications, interviews, etc.)
- Another example:
 - Outcome-oriented objective: Within 6 months, John will be working a minimum of 5 hours per week in a competitive job in the community.
 - Process-oriented mini-step: Within 6 months, he will do his resume, have 3 interviews, etc.

- Rule of thumb in writing objectives:
 - Start where person is at no matter how small a step it might be BUT
 - Be as ambitious as possible (i.e., don't default in objectives to phone calls, applications, interviews, etc.)
- Another example:
 - Outcome-oriented objective: Within 6 months, John will be working a minimum of 5 hours per week in a competitive job in the community.
 - Process-oriented mini-step: Within 6 months, he will do his resume, have 3 interviews, etc.

Objectives – Summary

- ▶ What change in behavior would you see if the client is responding to the treatment / services being provided?
- ▶ What change in behavior would you see if he / she becomes less depressed (or paranoid, anxious, etc.?)
- ▶ What is the concrete “proof” they are moving closer to achieving the LT goal?

Interventions

- ▶ *Actions* by staff, family, peers, natural supports
- ▶ Specific to an objective
- ▶ Respect consumer choice and preference
- ▶ Specific to the stage of change/recovery
- ▶ Availability and accessibility of services may be impacted by cultural factors
- ▶ Describes medical necessity

Five Critical Elements

- ▶ Interventions must specify
 - provider and clinical discipline
 - staff member's name
 - **modality**
 - frequency /intensity / duration
 - **purpose / intent / impact**
- ▶ Include a task for the individual as well as family, or other component of natural support system to accomplish



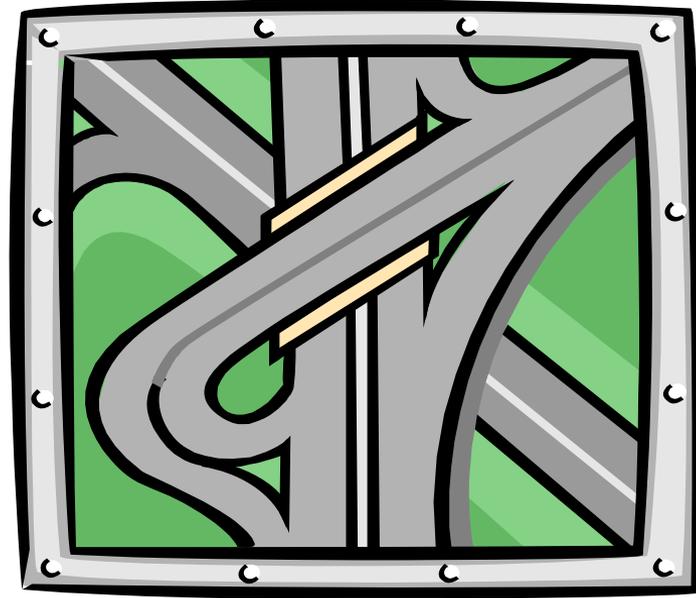
Writing a Recovery Plan Exercise

- ▶ Write Ingrid's Plan:
 - One group member can role play Ingrid to get more information
 - Each team/group needs a spokesperson and a recorder
 - In your small group teams, utilizing the written narrative summary, complete the form - write at least one goal, one objective and several interventions for your example
 - Write your plans on the transparency form provided
 - Large group review and discussion

Summary of Day

Topics that were covered during this day:

- Context and demand for PCRP
- Key Practices
- Introduction to a comprehensive assessment
- Interpretive summary writing practice
- Incorporating assessment findings into treatment plans
- Components of a person-centered treatment plan
- Putting it all together/writing the plan exercise

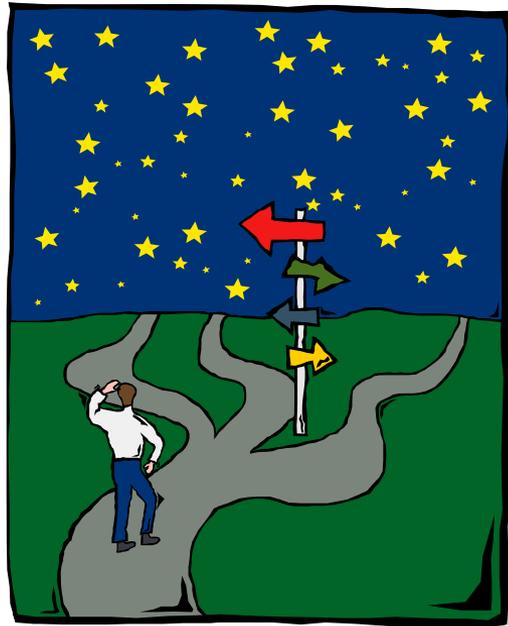


“If you don’t know where you are going, you will probably end up somewhere else.”

Lawrence J. Peter

Person-Centered Recovery Planning:

What does it REALLY look like in practice?



Yale PRCH & DMHAS PCRPP Consulting Team
Connecticut Mental Health Center
September 10-11, 2009

Agenda for AM – 2nd Day

9:00 – 9:30	Complete Report Outs PRN De-brief Day 1
9:30 – 10:00	Review & common mistakes
10:00 – 10:45	Objectives Booster Exercise
10:45 – 11:00	Break
11:00 – 12:00	Exercise: Strengthening Skills: Develop plans from Vignettes

Agenda for PM – 2nd day

12:00 – 1:00	Lunch
1:00 – 2:00	Large group report out/critique, Plans from vignettes
2:00 – 2:45	Brainstorming barriers & strengths; Committing to a next step
2:45 – 3:00	Wrap- up/evaluation

ILLITERATE?

WRITE FOR FREE HELP.

ILLITERACY FOUNDATION
806 MAIN STREET

ILLITERACY

www.StrangeCosmos.com



Building a Plan



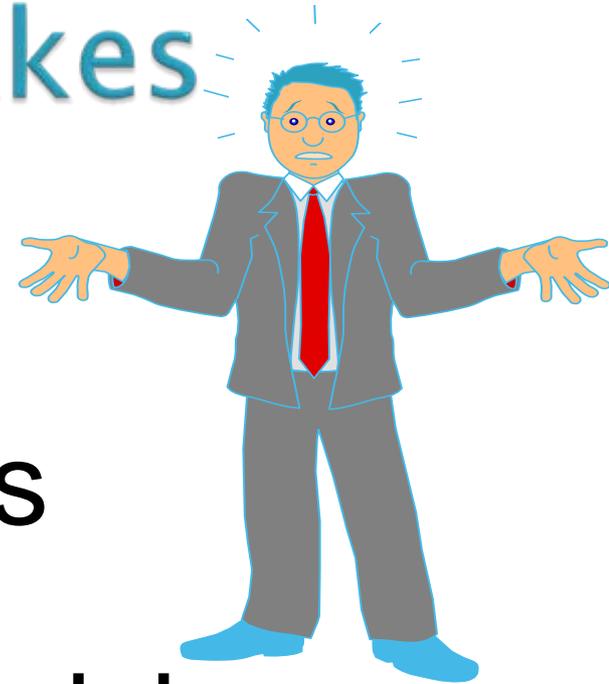
Common Mistakes

▶ Assessment

- Do not use all available information resources
- Not culturally appropriate / sensitive
- Not sufficiently comprehensive
- Neglect of stage of change
- Lack adequate understanding



Common Mistakes



▶ Goals

- Not global
- Not directed towards recovery
 - Only striving, not thriving
- Not responsive to need
- Not strengths based
- Too many

What Do People Want?

- ▶ Commonly expressed goals of persons served
 - Manage their own lives
 - Social opportunity
 - Activity / Accomplishment
 - Transportation
 - Spiritual fulfillment
 - Satisfying relationships
 - Quality of life
 - Education
 - Work
 - Housing
 - Health
 - Love

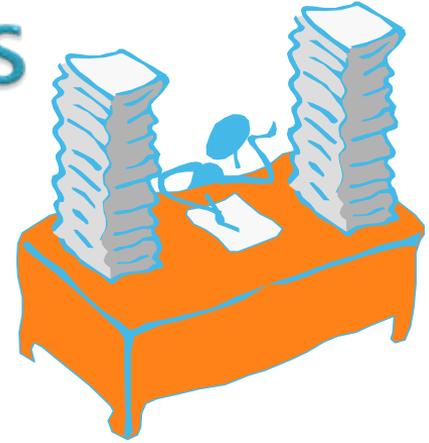
... to be part of the life of the community

Example

▶ Goal

- ***“will receive the support, training, supervision and community services needed to achieve her greatest level of independence while remaining healthy and safe in the community.”***

Common Mistakes



- ▶ Objectives
 - Don't support the goal
 - Not measurable or behavioral
 - Interventions become objectives
 - Not time framed
 - Too many simultaneous objectives



Example

▶ **Goal**

- ***Decrease depression***

▶ **Objectives**

- ***improve finances***
- ***develop appropriate vocational goals***



Example

▶ Goal

- ***Maintain psychiatric stability***

▶ Objectives

- 1. Attend appointments with PCP**
- 2. Donna will attend psychiatric appointments**

Common Mistakes

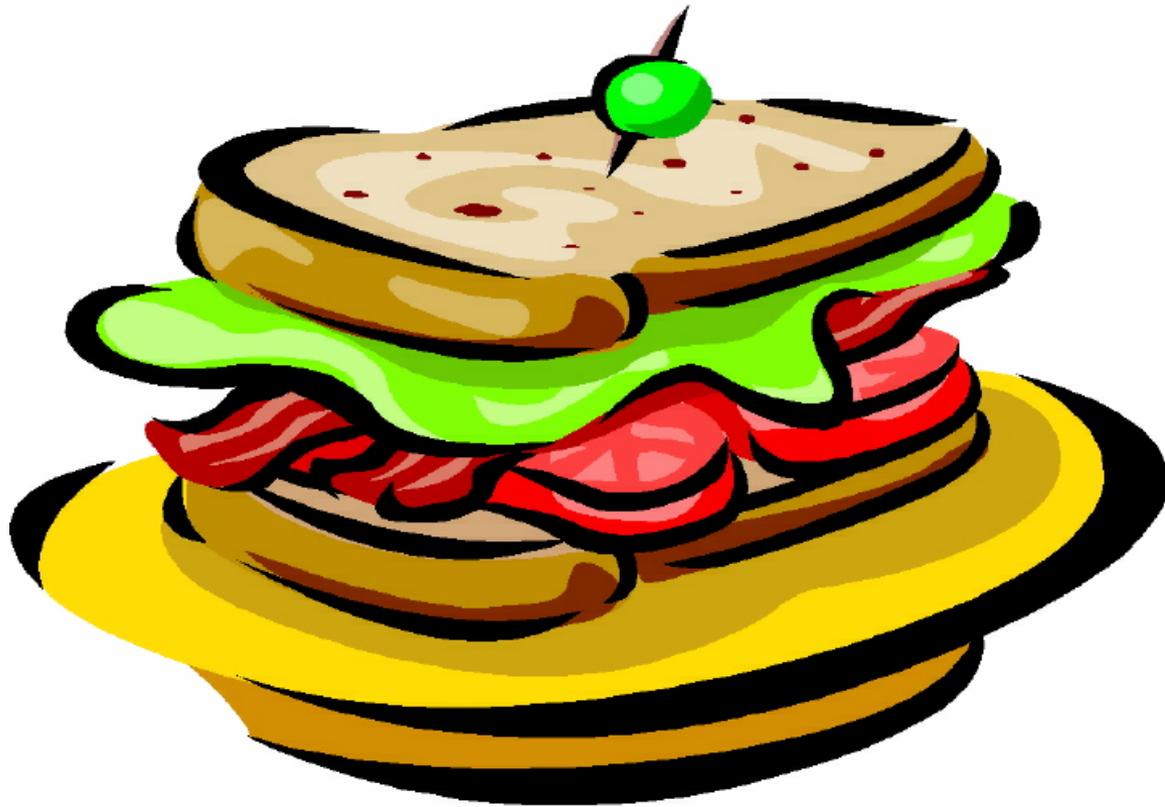
- ▶ Interventions
 - Purpose not included
 - Frequency, intensity, and duration not documented
 - Too few
 - Don't reflect multidisciplinary activity
 - Leave out role for person and/or natural supporters



Writing a Recovery Plan Exercise

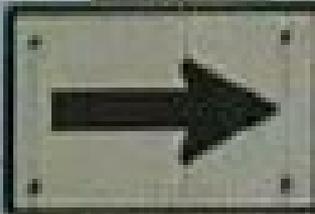
- ▶ Using the vignette provided
- ▶ Select one group member to role play the consumer
- ▶ Each team/group needs a spokesperson and a recorder
- ▶ In your small group teams, write at least one goal, one objective and several interventions for your example
- ▶ Write your plans on the transparency form provided
- ▶ Large group review and discussion

Lunch!



Writing a Recovery Plan Exercise

- ▶ Using the vignette provided
- ▶ Select one group member to role play the consumer
- ▶ Each team/group needs a spokesperson and a recorder
- ▶ In your small group teams, write at least one goal, one objective and several interventions for your example
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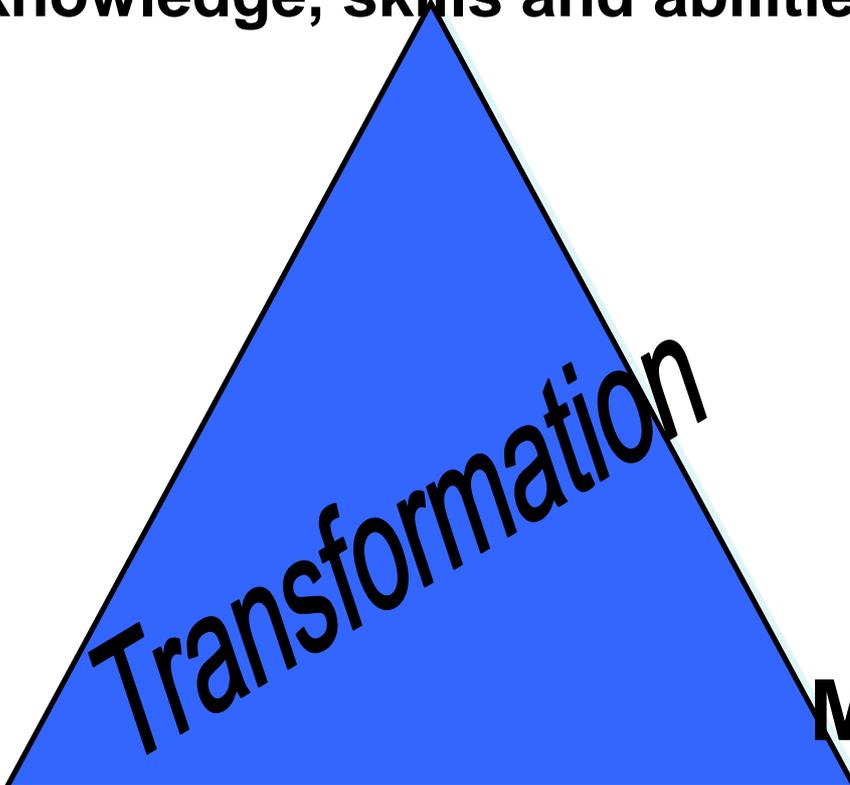


Change Model

Competency

knowledge, skills and abilities

Transformation

A blue triangle with a black outline, positioned centrally. The word 'Transformation' is written diagonally across the triangle in a bold, black, sans-serif font.

Change Management

behavior and attitude

Project Management

work / business flow

Brainstorm System Barriers & Strengths



Consider the following:

- ▶ What is the point of entry in your specific agency?
 - ▶ Who can be the champion(s) and help push the PCP agenda forward?
 - ▶ Stakeholders: Who needs to be on board?
 - ▶ Where are the pockets of resistance to PCP?
 - ▶ How will you build consensus/spread the word?
 - ▶ What type of training/skill-development do you need?
 - ▶ How will you involve people in recovery in change efforts?
- 

Commit to a next step...

- ▶ **As an INDIVIDUAL** what are some things you will commit to change to make your planning processes more person-centered?
- ▶ **As an AGENCY/TEAM**, what steps will you commit to take to move the PCP agenda forward?



TOOLS AND RESOURCES

Practice Guidelines for Recovery-Oriented Behavioral Health Care



**Connecticut Department of
Mental Health and Addiction Services**



TOOLS AND RESOURCES

Center on Mental Health Services Research and Policy

UIC University of Illinois
at Chicago
Department of Psychiatry

[UIC CMHSRP Home](#) | [UIC RTC on Self-Determination](#) | [UIC EIDP](#) | [UIC Publications](#) | [Search](#)

SAMHSA
Substance Abuse and Mental
Health Services
Administration



NIDRR
National Institute of
Disability and Human
Resources

Search P/FCP pages

National Consensus Initiative on Person/Family-Centered Planning

/ INTRODUCTION

The purpose of this initiative was to plan and convene a consensus meeting on December 8, 2005 to identify model approaches to individualized, person/family-directed planning. The initiative targeted approaches that facilitate recovery and resiliency for children and adults with mental health problems. [Presentations made at this meeting and final papers commissioned for the initiative are now available](#). A series of recommendations on how to implement and monitor quality individualized recovery and resiliency planning for youth and adults will be posted to this website. The initiative is sponsored by the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#), [Center for Mental Health Services \(CMHS\)](#).

To find out more about the Initiative, click on one of the links below.

[HISTORY AND BACKGROUND OF THE NATIONAL CONSENSUS INITIATIVE ON PERSON/FAMILY-CENTERED PLANNING](#)

[CONFERENCE PLANNING COMMITTEE MEMBERS](#)

[CONFERENCE PAPERS, PRESENTATIONS, AND PRESENTER BIOS](#)

[PERSON/FAMILY-DIRECTED PLANNING RESOURCES](#)

[PRESIDENT'S MENTAL HEALTH COMMISSION FINAL REPORT](#)

[NATIONAL CONFERENCE AGENDA: NOTES AND RECOMENDATIONS](#)

www.psych.uic.edu/uicnrtc/cmhs/pfcphome.htm



TOOLS AND RESOURCES



New ways of
working for psychiatrists:
Enhancing effective,
person-centred services
through new ways of working in
multidisciplinary and multi-agency
contexts

Final report 'but not the end of the story'

Royal College of Psychiatrists
National Institute for Mental Health in England
Supported by the Changing Workforce Programme

October 2005

TOOLS AND RESOURCES



Keystones for Collaboration and Leadership: Issues and Recommendations for the Transformation of Community Psychiatry

The American Association of Community Psychiatrists
Pennsylvania Psychiatric Leadership Council
Allegheny County Office of Behavioral Health
Coalition of Psychiatrists for Recovery

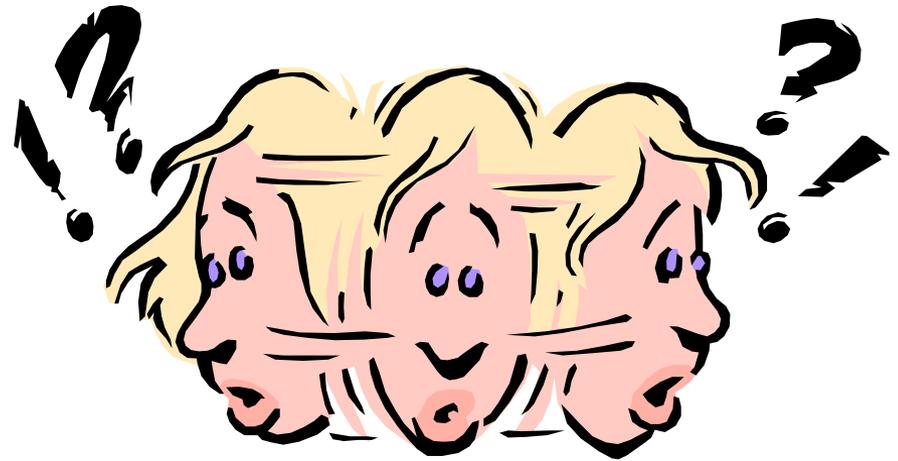
Edited By
Wesley E. Sowers, MD, and Kenneth S. Thompson, MD

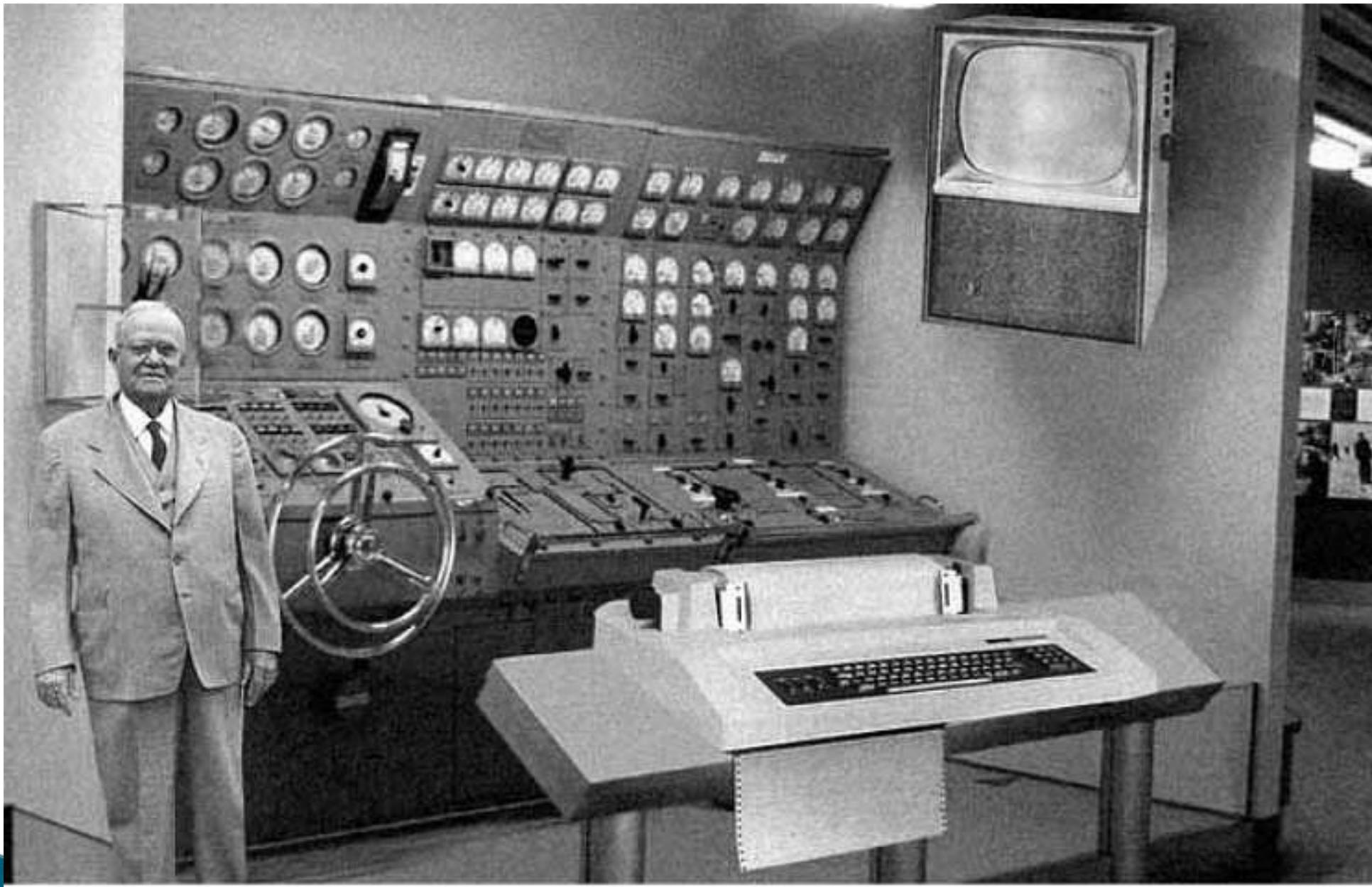
Last Chance for Q&A



- ▶ What do you need to know...
- ▶ Need support with...

- ▶ From
 - ▶ each other,?
 - ▶ SEMHA Admin.,?
 - ▶ our team?
 - ▶ Central Office?





Scientists from the RAND Corporation have created this model to illustrate how a "home computer" could look like in the year 2004. However the needed technology will not be economically feasible for the average home. Also the scientists readily admit that the computer will require not yet invented technology to actually work, but 50 years from now scientific progress is expected to solve these problems. With teletype interface and the Fortran language, the computer will be easy to use.