Please Join Today's Polling Activity!

Text this phone number: 22333

With this message: hope

Then hit send!

- ☑ You should receive a message saying "You've joined Coalition For Behavioral Health's session (hope)."
- ☑ You only need to join the poll *once*.
- ☑ It's *free*!
- ☑ You can *leave* the session after the survey.

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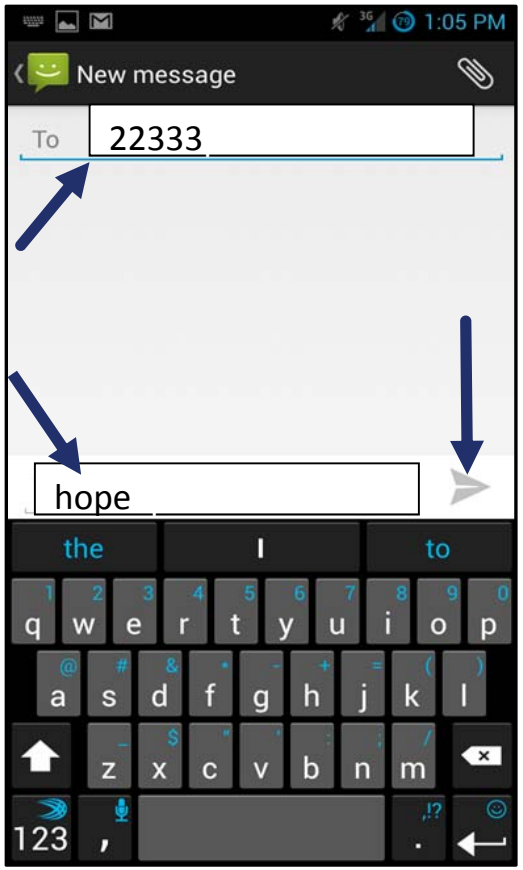

Which Seinfeld Character Are You?

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The Person at the Center of Person-Centered Recovery Planning (PCRP)

September 14th, 2017
NYAPRS Annual Conference: Stand Up Together for Recovery!

Amanda Saake, LMSW, CPRP
Melissa Thomas, LCSW

The Center for Rehabilitation & Recovery
www.coalitionny.org

The Coalition for Behavioral Health

At the Conclusion of This Workshop, Participants Will Be Able To:

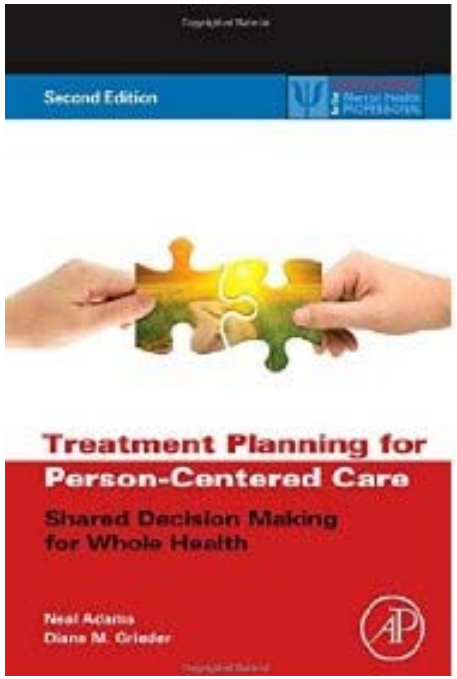
1. Articulate the core principles of establishing a person-centered, recovery-oriented plan.
2. Connect the elements of a well-constructed person-centered plan (i.e. writing of goals, objectives, and skills-focused interventions) that are both meaningful to the individual and satisfy charting requirements.
3. Identify strategies & resources to utilize to further develop knowledge, skills, and abilities in the person-centered approach to recovery planning

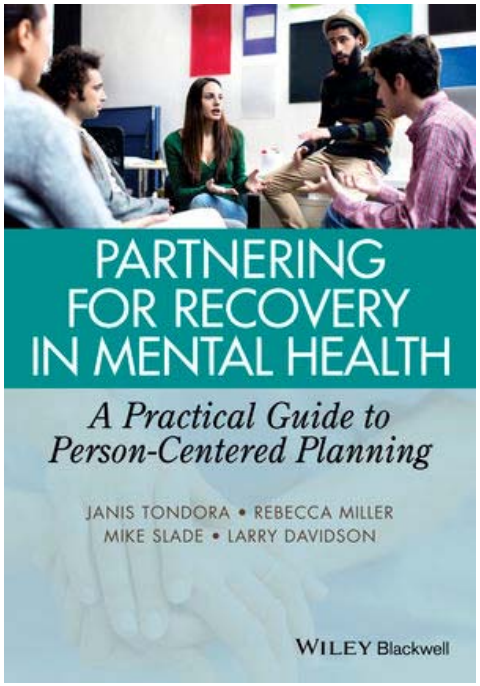
The Coalition for Behavioral Health

Foundations For This Workshop…

Treatment Planning for Person-Centered Care by Neal Adams & Diane Grieder

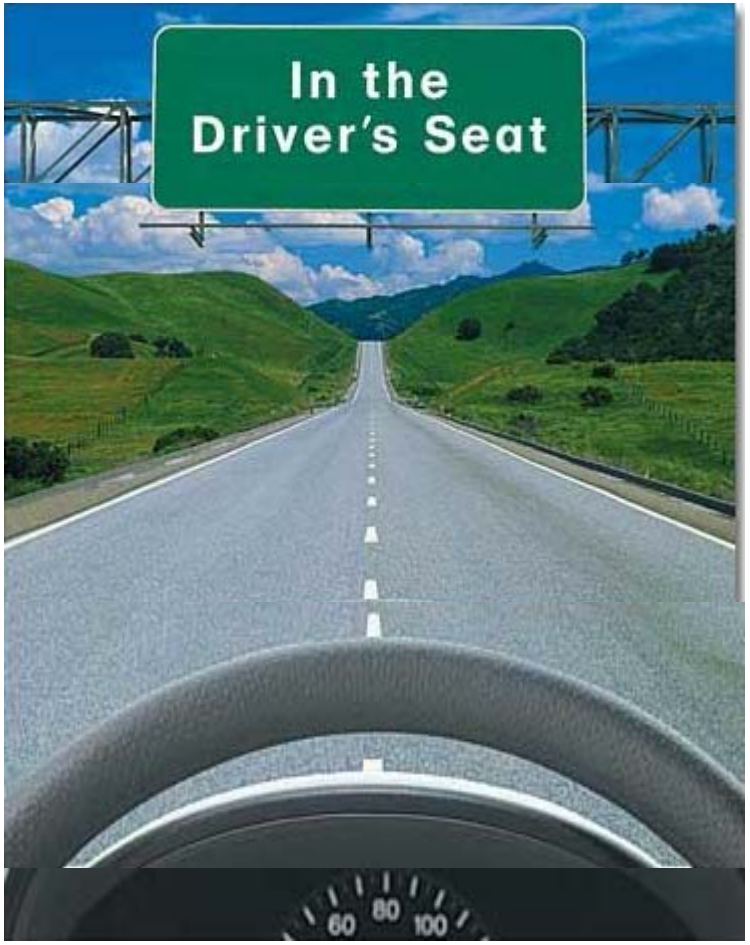
Guidance from Dr. Janis Tondora, Yale University





PCRP: A Roadmap to Recovery

- Is a collaborative process resulting in a recovery-oriented plan
- Is directed by the individual served and produced in partnership with care providers for treatment, services, and recovery
- Respects the person's right to be in the driver's seat, but also recognizes the value of professional co-pilot(s) and natural supports.



Using an assessment to understand & summarize your story

Deciding on priorities

Setting long-term goals and your vision for the future

Figuring out strengths & barriers

Creating short-term goals (objectives)

Deciding which professional services would be helpful

Capturing the steps of your plan in a written PCRP

Monitoring progress to make sure things stay on track

It's a Process!

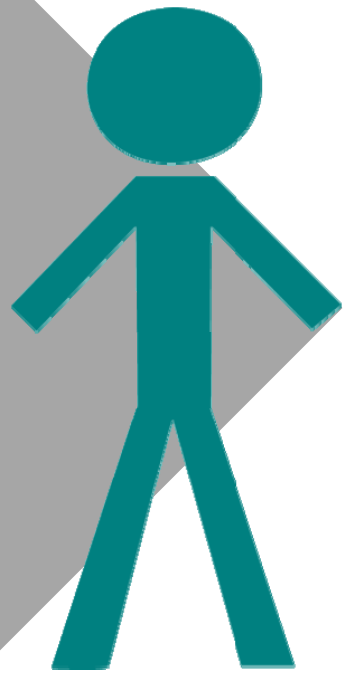
PCRP Approach: How Is It Different?

Traditional

- Outcomes focus on clinical stability
- Following providers' instructions is valued
- Problems list drives the plan

Person-Centered

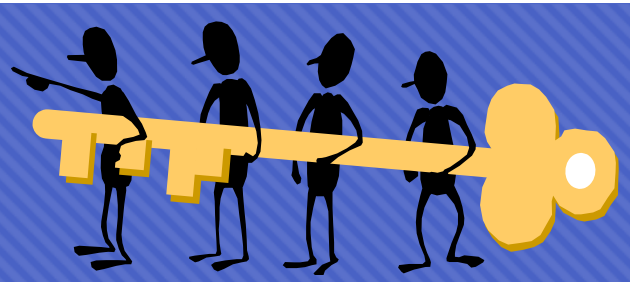
- Outcomes include quality of life & recovery
- Many different supports are valued and included
- Personal goals drive the plan



What we hope for **THEM**	What we value for **US**…
✓Compliance with treatment	✓Building a life worth living
✓Psychiatric stability	✓Being a good
✓Increased insight into illness	mom…dad…daughter
✓Medication adherence	✓A home to call our own
✓Decreased hospitalizations	✓A career
✓Residential stability	✓Love…intimacy…sex
✓Improved judgment	✓Spiritual connection
✓Increased functioning	✓Spending time with friends
✓Increased socialization	✓Financial security

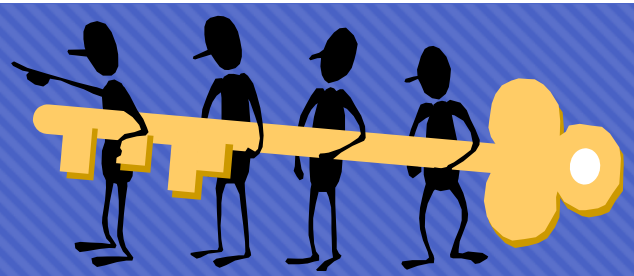
*Adapted from: Tondora, Janis. (November 21, 2013). *Person-Centered Recovery Planning: Can we honor the PERSON & satisfy the CHART?* NJPRA Annual Conference.

The Process of PCRP:
Key Practices



- Person is a partner in scheduling & planning activities/meetings
- Person has reasonable control over logistics (time, invitees, location, etc.)
- Education/preparation regarding the process and what to expect
- Agreed upon goals, tasks, participation, and roles
- Person offered a written copy
- **All of the above are critical to engagement-focus is making person feel comfortable and in control of the process**

The Process of PCRP:
Key Practices



- The ***practice*** of PCRP can only grow out of a ***culture*** that fully appreciates recovery, understands and supports self-determination
- Value community inclusion & real life - **"while" not "after"**
- Recognize the range of contributors to the planning process (e.g., peers, natural supporters)
- **4 Essential Ps:**
  - ✓ **Philosophy** – core values
  - ✓ **Process** – new ways of partnering
  - ✓ **Plan** – concrete roadmap
  - ✓ **Purpose** – meaningful outcomes

Big Picture View of PCRP Elements

GOAL

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

Strengths/Assets to Draw Upon

Barriers /Assessed Needs That Interfere

Narrative Summary/Formulation

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

Interventions/Methods/Action Steps

- Professional/"billable" services
- Clinical, rehabilitation & peer support
- 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 Involvement
I want to get back to church.
Health/well-being
I want to lose weight.

Housing
I want my own apartment
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.

To be part of the life of the community…

And NOT Just Traditional Treatment Plan Goals…

- **Goal:**
  - **Maintain psychiatric stability and sobriety from alcohol**
- **Objectives**
  1. **Compliance with meds**
  2. **Attend appointments with primary care provider**
  3. **Attend all psychiatric appointments as scheduled**

Characteristics of Recovery Goals

Important and meaningful

- What would achieving this goal mean to me?
- How would it change my life?
- What would be better if?

Constructive not "eliminative"

- Things that one is **GOING TO DO**, such as "attend college"
- Things that one is **NOT GOING TO DO,** such as "stop feeling depressed"

Goal Development – It's a Process!

- Not everyone can easily articulate recovery goals; process takes time!
- Goals unfold through reflective listening that highlights what's important to the person
- People are often ambivalent about goals
- Goals often change

Grieder, Diane, M.Ed., AliPar, Inc. and Tondora, Janis, Psy.D, Yale Program for Recovery and Community Health.
OMH PROS NYC Initiative PowerPoint presentation on March, 2011

Overcoming the "No Goal" Conundrum

- **Start with strengths identified in assessment**
  - Visualize an "ideal day" - what would this look like? What would you be doing? Who would you be with?
- **If the focus starts on goals about symptoms (e.g., I want to feel less depressed),**
  - Ask "If you were less depressed, what might you be doing? How would you spend your time? How would life be different for you?

Active Use of Assessed Strengths

- Focus on **strengths and assets** that can be leveraged in the person's recovery plan
- Strengths are not meant to **"sit on a shelf"**
  - A person who loves music might benefit from listening to music with headphones as a way to relieve anxiety on the subway
  - An individual with a strong leadership skills might work on communication skills by serving as president of a participant advisory board

Barriers/Assessed Needs

- Challenges/roadblocks experienced as a result of mental health condition/substance use issue
- What is getting in the way of the person achieving their goal?
  - need for skills development
  - intrusive symptoms
  - lack of resources
  - need for assistance / supports

PCRP Lightning Round

Round One:

Goals, Strengths, & Barriers

d on information from the profile, whic
be the MOST appropriate statement for Brian's recovery goal?

Brian will learn to live on his own.	A
"I want my family to be proud of me."	B
"I want control of my own life (aka: my housing, my money, and my meds.)"	C
ill successfully live on his own for three months.	D

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2. As reflected in the profile, which ngth/ability/asset could have the MOST influen supporting Brian's overall recovery goal?

Brian has a natural aptitude for hands-on work

Brian has had a period of housing stability over the past twelve months

Brian has his GED

rian has a positive relationship with a thrift store owner

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flected in the profile, which barrier preventi
chieving his overall recovery goal seems to b
vant to the delivery of residential rehabilitation servi

Cognitive disorganization and "nerves" that interfere with his relationships with neighbors and his attention to household chores and personal care

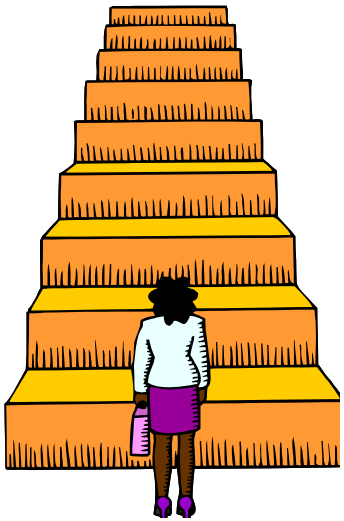
Brian's impatience with transition to his own apartment

History of being homeless and having multiple psychiatric hospitalizations

Unstable glucose levels

Short-term Objectives:
What Do They Do?

- Most active and dynamic part of the individualized recovery planning process
- Incremental & manageable steps the individual takes to achieve the larger goal
- Address the identified challenges/barriers the participant needs to overcome to achieve their life role goal
- Encourage the person to try new skills



Effective Objectives

- Contain one targeted outcome per objective
- Are constructive vs. eliminative
- Meaningful to the individual
- Easily understood by any reader
- “Proof” you are getting closer; function as markers for assessing progress
- Send a hopeful message we believe things can, and will, be different for the better!

Objectives Should be SMART

S = Simple, Straightforward, Specific

M = Measurable, Meaningful

A = Attainable, Action-Oriented

R = Relevant (to goal and stage of change)

T = Time-framed

Litmus test for measurability - read objective aloud and ask: At the end of 1 month, etc., will you definitively be able to say yes / no that the objective was accomplished?

Formula for Crafting Objectives

Within_____**(amount of time), (insert name)**_____
will have improved **(insert documented mental health barrier from formulation)**_____, as evidenced by_____. **(insert a meaningful change in functioning/ behavior or action step that is related to the 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.

Objective "Work Sheet"

Goal: "I want to get back to being active at my church and teaching bible study."

Barriers the objective is intended to overcome:

- **Anxiety, fear and distress** which increase during attempts to speak with her pastor or return to church-"I haven't taught bible study or been to church since I got sick. I am having a hard time going back."
- **Social isolation and avoidance**

Objective:

- Jill will be able to **better manage her anxiety** and **avoidance of social interactions** as evidenced by her **attending one service at her church** within the next 60 days.

Objectives Should NOT be Service Participation

- **Audrey wants to go back to work but currently, severe depression, sleep disturbance, and lack of hope is making it difficult for her to get out of bed and take steps towards seeking employment.**

- Audrey will improve depression by participating in Wellness Self-Management 2x weekly and keeping appointments with psychiatrist, in order to prepare her for work.

- This objective is about service participation. People can participate in services for years and not achieve the intended benefits!

PCRP Lightning Round

Round Two:

Short-Term Objectives

ch of the following objectives meets all SMART criteria?

Over the next three months, Brian will be doing his household chores.

Within three months, Brian will demonstrate an ability to accurately self-administer his morning dose of psychiatric medications for 2 consecutive weeks as evidenced by nursing service reports.

In the next six months, Brian will reconnect with his mother.

will get along better with his roommate.

Interventions & Services:
aka Methods

- Interventions serve as a contract for who is responsible for what actions (including person & natural supports)
- Services include interventions which…
  - Are tailored to the stage of change/recovery
  - Describe medical necessity by clearly identifying how recommended services can help individual overcome specific barriers
  - Are connected to a specific objective & recovery goal

Interventions & Services-"5 W's"

- **WHO:** will provide the service, i.e., name and job title
- **WHAT:** The NAME of the service, e.g., basic living skills training AND the modality in which the service will be provided e.g., individual sessions or in group
- **WHEN:** The SCHEDULE of the service, i.e., the time and day(s)
- **WHERE:** the service is being provided
- **WHY:** The intent and purpose of the service/intervention (anticipated outcome)

Action Steps by The Person In Recovery & Natural Supporters

- Traditionally, interventions in a plan include only those performed by staff.
- The recovery model, however, emphasizes the responsibility of a person to participate actively in his or her own care as well as the benefits of seeking contributions of "natural supports" (e.g., family, friends, advocates, & community supporters)
- For each objective, consider specifying:
  - **"Personal Actions"** (this promotes a sense of self-agency and helps to activate people in their recovery)
  - **"Natural Support Action"** (to help the person build/expand their natural recovery network as a supplement to professional services)

Interventions from natural supports are not services

Formula for Crafting Interventions

Staff will provide_____ **(name of service)** in_____**(modality to be used)** at_____**(location)** for_____**(frequency and duration)** for the purpose of_____.

Examples of Service Interventions

- Dr. Oz, Psychiatrist, will meet with Mary 1x per month at ACME PROS for 30 minutes for the next 6 months to adjust medications for purpose of reducing isolation and avoidance of social situations.
- Will Swanson, Care Manager, will meet with Mary at least 1x per week in her home for the next 6 months to teach anxiety reduction strategies to use in social interactions.

Examples of Self-Directed & Natural Support Actions

- Mary's sister, Edythe, will take her to the Senior Center 1X per month to sing with the Senior Choir for the purpose of increasing social interactions.

PCRP Lightning Round

Round Three:

Interventions/Services/Natural Support Actions

Which professional service reflects a well-writ
ion that includes all of the technical element

Connie Clayton, residential counselor, will provide weekly MMT for 30 minutes over the next 3 months in order to assist Brian in effective use of medications to decrease symptoms & to build medication self-administration skills.

Connie Clayton, residential counselor, will talk with Brian about the pros and cons of taking his medications.

Connie Clayton, residential counselor, will work with Brian regarding personal hygiene and household chores.

Brian will wash his clothes.

hich natural support action reflects a well-wr
tion/service/support that includes all of the
elements?

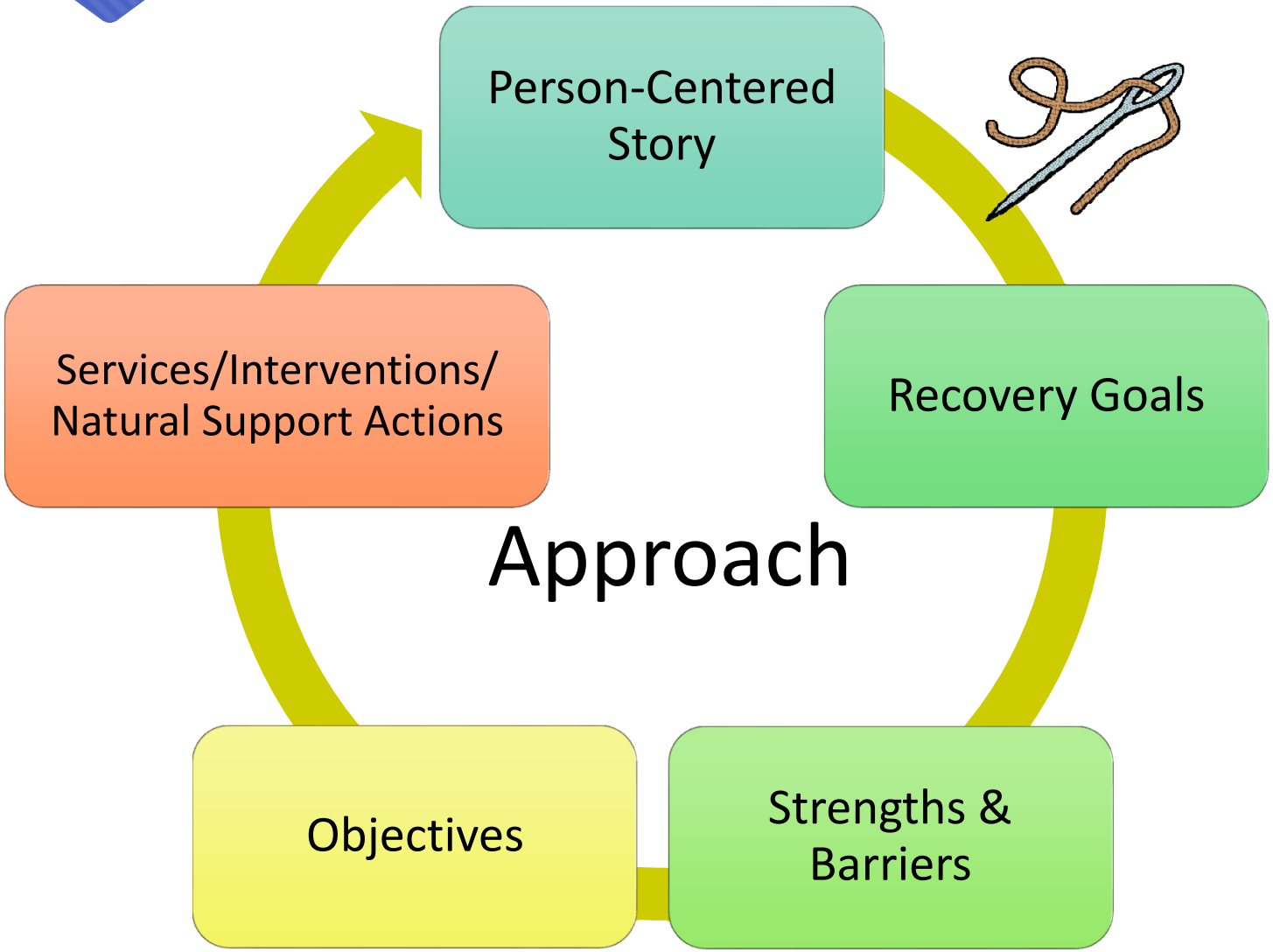
Brian will contact his thrift store owner friend regarding working at his store.

Brian's cousin, Ronnie, will text him every morning for the next three months to remind Brian to take his morning dose of medications.

Brian's mother will call him weekly over the next three months to affirm Brian's strengths and assets for living on his own.

Primary care physician, Dr. Bowen, will meet with
onthly at his office for the next six months in
o monitor and regulate glucose levels and its
im

How Do the Pieces Come Together?



Medical Necessity & PCRP Are NOT Incompatible!

Goal

- Person directed/own words
- Big picture/life role

Objective

- Written to **overcome MH/SA barriers** which interfere with goals to address symptoms/functional impairments as a result of diagnoses
- Reflect a **change** in behavioral/status/level of functioning to improve; **beyond maintenance**

Interventions

- Paid/professional services to help person achieve the specific objective
- **Tip:** Read your plan from the "bottom up" to ensure the intervention is directly linked to the objective above
- **Tip:** Document WHO provides WHAT service WHEN (frequency/duration/intensity) and **WHY (individualized purpose/intent as it relates to the linked objective.**
- Natural support/self-directed supports to help person achieve the specific objective

Tools & Resources

Recently Released Web-based Video Overview of PCP in Behavioral Health

See: https://youtu.be/IuNYB9Prnk0

Tondora & Davidson (YALE) and Rae, & Kar Ray (CAMBRIDGE)

- **CT Department of Mental Health and Addiction Services**
  - http://www.ct.gov/dmhas/cwp/view.asp?q=456036
- **New York Office of Mental Health, PCRP Resource Page**
  - https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/
- **Adams & Grieder, 2014. *Treatment Planning for Person-Centered Care, Second Edition: Shared Decision Making for Whole Health (Practical Resources for the Mental Health Professional) 2nd Edition.***
  - http://www.amazon.com/Treatment-Planning-Person-Centered-Second-Edition/dp/0123944481
- **Tondora, J., Mathai, C., Grieder, D., & Davidson, L., 2014. When the rubber hits the road: From (2013). *Best Practices in Psychiatric Rehabilitation, 2nd Edition.* Psychiatric Rehabilitation Association.**
  - http://www.amazon.com/Practices-Psychiatric-Rehabilitation-Patricia-Nemec/dp/0615962653/ref=sr_1_sc_1?ie=UTF8&qid=1460118992&sr=8-1-spell&keywords=best+practice+in+psychiatric+rehabilittion
- **Tondora, Miller, Slade, & Davidson, 2014. *Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning***
  - http://www.amazon.com/Partnering-Recovery-Mental-Health-Person-Centered/dp/1118388577/ref=sr_1_1?ie=UTF8&qid=1459255392&sr=8-1&keywords=partnering+for+recovery+in+mental+health

Thanks for participating!

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