Strengths-Based Assessment and Person-Centered Treatment Planning in Recovery-Oriented Systems of Care

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Webinar Objectives

• Gain an understanding of “person-centered care” and how this differs from traditional models in behavioral health service delivery.

• Identify concrete, practical strategies that exemplify the implementation of Person-Centered Recovery Planning (PCRP).

• Learn strategies to maintain the rigor of documentation in order to meet fiscal and accreditation standards.
So what is this *Person-Centered Planning* Stuff?

Off the top of your head…

- Imagine you are out to dinner last night with a group of friends
- You tell them you have to head home because you have a webinar tomorrow on person-centered planning
- They respond: “Sounds kind of interesting, so what exactly IS person-centered planning?”
- *Using the comments box, please type in a few phrases or a brief sentence about how you would define “person-centered planning.” What is it? How is it different?*

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The Person-Centered Train: Who’s on Board?
Forces Behind Person-Centered Care

• Values-driven approach first and foremost! *Golden Rule*
• State policy and program design
• Federal/national endorsement (President’s New Freedom Commission, Substance Abuse and Mental Health Administration, Opioid Treatment Standards, etc.)
• Funders (e.g., Centers for Medicare and Medicaid Services (CMS) and other requests for proposals) and accrediting bodies (Commission on Accreditation of Rehabilitation Facilities (CARF), etc.)
• Accumulating evidence/data showing improved outcomes

Forces Behind Person-Centered Care

• Voice of service recipients:
  • *When I have a voice in my own plan, I feel a responsibility to “work it” in my recovery.*
  • It made such a huge difference to have my pastor there with me at my planning meeting. He knows me better than anyone else in the world and he had some great ideas for me.
Florida ROSC
Strengths-based, Person-Centered Focus?

- Initial Study of Recovery Services in Florida
  - Individuals often did not experience program activities as relevant to achieving life goals.
  - Individuals often experienced treatment planning as a bureaucratic rather than an interpersonal process.
  - Florida has a range of disparate service activities that are recovery oriented, but there is currently no framework to coordinate these efforts.

  - Winarski, J., Thomas, G., DeLuca, N. 2007

Florida Recovery-Oriented Systems of Care (ROSC): Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

- Treatment Domain
  - Validation of the Person
  - Person Centered Decision Making
  - Self Care – Wellness
  - Advance Directives
  - Alternatives to Coercive Treatment

http://saptrecovery.org/
Florida Recovery-Oriented Systems of Care (ROSC): Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

- Community Integration Domain
  - Access
  - Basic Life Resources
  - Meaningful Activities and Roles
  - Peer Leadership

http://saptrecovery.org/

If Person-Centered Care is so great, why isn’t it universally implemented?

1. If given choice, people will make BAD ones
2. Payers won’t let us do this; regulations prohibit this
3. The forms/templates/electronic health records don’t have the right fields
4. Consumers aren’t interested/motivated
5. It devalues clinical expertise; violates professional boundaries
If Person-Centered Care is so great, why isn’t it universally implemented?

6. It’s what the clubhouse does…Not a part of core clinical healthcare
7. Lack of time/caseloads too high/ “initiative fatigue”
8. “My clients are too sick/impaired”
9. It doesn’t fit with focus on evidenced-based practices
10. Don’t we already do it? Is it really any different?

Common Concerns/Barriers

On being strengths-based and person-centered? Don’t we already do it?

• In the experience of the persons served
• when we “take stock” of current planning practices
• and in the written recovery plan itself…

Person-Centered Care Questionnaire: Tondora & Miller 2009
**Not necessarily…Meet Mr. Gonzalez**

Mr. Gonzalez, 31, is a married Puerto Rican man and father to two boys. He recently relocated to Florida with his family after they were displaced by Hurricane Maria and forced to evacuate when their home was left uninhabitable by the storm. He is diagnosed with bipolar disorder and he has a co-occurring addiction to alcohol which he often relies on to manage distressing symptoms.

Mr. Gonzalez has been experiencing an increase in psychiatric symptoms since his relocation to Florida. During a recent period of acute mania, he was having increasingly volatile arguments with his wife in the presence of his two young sons, ages 3 and 5. On one occasion, he shoved his wife to the floor, which prompted her call to the police. When the police arrived at the home, Mr. Gonzalez was uncooperative and agitated, and he was subsequently admitted to an inpatient psychiatric facility for stabilization and later discharged to the care of a community mental health center.

His wife is open to reconciliation and she is actively involved in his treatment. However, she asked Mr. Gonzalez to leave the family home and will not allow him to see her or his boys unless he “gets things under control.” Mr. Gonzalez states that his love for his family and his faith in God keep him going in difficult times. He feels misunderstood by his treatment team but has developed a positive connection with a Peer Recovery Coach.

*How might a treatment plan come together for Mr. Gonzalez?*
## Snapshot: A Traditional Plan

- **Goal(s):**
  - Achieve and maintain clinical stability; reduce assaultive behavior; comply with medications

- **Objective(s):**
  - Pt will attend all scheduled group; pt will take all meds as prescribed; pt will complete anger management program; pt will demonstrate increased insight re: clinical symptoms; pt will recognize role of substances in exacerbating aggressive behavior

- **Services(s):**
  - Psychiatrist will provide medication management; Social Worker will provide anger management groups; Nursing Staff will monitor medication compliance and conduct random drug screens

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## Traditional Treatment Plan

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

- Take my lithium
- Increase insight
- Reduce assaults
- Remain abstinent
- Comply with group schedule
### Life Goal:

*I want to get my family back.*  
*I don’t want my boys to ever be afraid of me.*

<table>
<thead>
<tr>
<th>Strengths to Draw upon:</th>
<th>Barriers that Interfere:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devoted father; motivated for change; supportive wife; Catholic faith and prayer are source of strength/comfort; positive connection to Peer Specialist; intelligent</td>
<td>Acute symptoms of mania led to violence in the home; lack of coping strategies to manage distress from symptoms; abuse of alcohol escalates behavioral problems</td>
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### Sample Short-Term Objective(s)

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

### Services & Other Action Steps

- Center doc/APRN to provide med management to reduce irritability & acute manic sx 1x per month for 3 mos
- Psychologist to provide family therapy sessions to discuss Mrs. Gonzalez’s expectations and feelings re: future reunification every 2 weeks for 3 mos
- Rehab Specialist to provide Communication and Coping Skills training weekly to teach/coach skills that will foster successful visits with wife and children – 1x weekly for 3 mos
- CDAC Counselor, will
- Peer Specialist to promote daily wellness through the use of creating a Wellness Recovery Action Plan and self-directed strategies 2x p/w
- Local Spiritual Director to promote use of faith/daily prayer as a positive coping strategy to manage distress 1x p/w
The 4 “Ps” of PCRP

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

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

• *4 Essential Ps:
  • Philosophy – core values
  • Process – new ways of partnering
  • Plan – concrete roadmap
  • Purpose – meaningful outcomes

The Process of PCRP:

Key Practices

• Person is a partner in all planning activities/meetings; advance notice (person-centeredness)

• Person has reasonable control over logistics (e.g., time, invitees, etc.)

• Person offered a written copy/transparency

• Shift in structure/roles in planning meetings

• Education/preparation regarding the process and what to expect
Consider Your Meeting Dynamics

- Spatial set up of the room speaks volumes
- Team members arrive on time; introductions
- A range of contributors are involved in the planning process (e.g., peers, natural supporters, other community providers).
- The person is given your/the team’s full attention, e.g., cell phones are turned off; there are no side-bar conversations; team members are not completing/reading other paperwork/texting/ responding to e-mail, etc.
- The person is not “talked about” during the meeting as if they are not there.
- “What comes next” is explained to the person, including an opportunity for them to review the plan; provide input

Educate & Prepare the Person

“This toolkit can be useful for anyone – regardless of whether they have a psychiatric condition or an addiction. Everyone needs help at times setting goals, and figuring out what they want. This toolkit has some specific parts that are helpful to people with a mental illness or addiction, but could be really used by anyone.”

-Janis Tondora et al., Yale Program for Recovery and Community Health
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http://www.yale.edu/prch/research/documents/toolkit.draft.7.24.09.pdf
The Process of PCRP: Key Practices

- Capitalize on role of peers where possible
- Recognize the range of contributors to the planning process
- Understand/support rights such as self-determination
- Value community inclusion/life - "While," not "after"
- Strengths-based approach in both language and assessment/planning

PCRP Process: I’m on the Team!!
The Documentation Challenge:

How can we include enough information to create an individualized & complete view of the person that ALSO meets regulatory/fiscal requirements?

... without creating plans so detailed that no one uses them?!
...and in a way that balances the spirit of person-centered care with the rigor required in clinical documentation?

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<thead>
<tr>
<th>Regulations</th>
<th>Collaborative</th>
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<tbody>
<tr>
<td>Required Paperwork</td>
<td>Person-centered</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>Strengths-based</td>
</tr>
<tr>
<td>Compliance</td>
<td>Transparent</td>
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But, I feel like I keep trying to force a square peg into a round hole. And it just doesn’t fit!

Case Manager on trying to be “person-centered” in the context of clinical treatment planning and all the requirements that go with it...
A plan is only as good as the assessment it is based on!

**Definition of an Assessment**

- Initiates helping relationships
  - An ongoing process
  - More than just “documentation”

- It is the process of gathering information across life domains to determine
  - Eligibility
  - Extent of need
  - Direction of services

- Evaluates a person’s life from a strengths perspective, rather than through a “problem-dominated” lens

The root of the word, “assessment,” is from the Latin “assidere,” which means, “to sit beside.”
Person-Centered Assessment

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

Use Strengths as the Foundation for PCRP

• “It’s about what’s STRONG, not just about what’s WRONG!“
  --Gina, a former patient at a state inpatient hospital
Role of Strengths

- Identifies aspects of the person’s life that they can draw from to move toward a specific goal
- Captures the person’s unique identity & abilities
- Promotes engagement and communicates messages of hope and confidence in the person’s abilities

Sample Strengths-Based Assessment (SBA) 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?

- **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?
Sample SBA 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?

Don’t Let Strengths Sit on a Shelf!
Capitalize on Strengths in the Plan

• Think about where/how you are not only assessing but also are USING strengths in recovery planning in your work?

• E.g., a person with a love for books might be engaged by asking him/her to help out in the agency library....A person who loves music might benefit from access to CDs/headphones as a way to quiet voices.... A spiritual person contemplating suicide might want direction from the center’s chaplain.... An animal lover struggling with obesity due to med side effects might walk a dog regularly.

Expand Appreciation of Culture in Assessment & Planning

• Culture is central not peripheral, to recovery as culture is the context that shapes and defines all human activity.

• Begin with cultural and demographic factors
  • Clarify identity
    o "How do you see yourself?"
    o Race, ethnicity, sexual orientation, religion, color, disability reference group
Aspects of Cultural Identity

- Ethnicity
- Race
- Country of origin
- Gender/gender identification
- Age
- Socio-economic status
- Social class
- Primary language
- Prefer language
- English proficiency
- Educational background
- Acculturation level
- Spirituality/religion
- Literacy level
- Sexual orientation
- Employment
- Physical ability/limitations
- Mental ability
- Criminal justice involvement
- Political affiliation
- Immigration status
- Traditions
- Geographic location

Sample Culturally Oriented Inquiries

- How do you identify culturally or ethnically? What do you know about your culture? What were some of the messages you got about the cultures of others?
- What personal pronoun do you use? What would you like to be called? (This is especially important to transgender and gender-fluid people.)
- Who is your family? Whom do you trust?
- What do you call your challenge, and what do you think can help to heal it?
Sample Culturally Oriented Inquiries

• Have you ever been a member of a faith or spiritual community? Are you a member now? If so, would you like your faith/spiritual leader to become part of your recovery/resilience support team?

• Have you ever been a victim of police brutality, homophobia, transphobia, or other forms of oppression?

• How long have you lived in the area? Can you tell me about how comfortable (or not) you feel here?

• Could you share with me a bit about your experiences in mental health care? Have you felt understood and respected?

Personal/Cultural Preferences in PCRP Process

Individual Decision Making
- Focuses on personal agenda
- Values autonomy, self-determination, and independence
- Values partnering “as equals”
- Expects meetings to “get down to business”

Collective Decision Making
- Focuses on collective agenda
- Values family and community involvement
- Defer to family members or others in making decisions
- Values hierarchy
- Expects meetings to “build personal relationships”
Cultural Factors Directly Impact Understanding and Planning

• The PCRP process needs to validate the person’s cultural identity to ensure an accurate assessment and understanding.

• It requires the providers to have the awareness, knowledge and skills to effectively formulate an culturally meaningful plan.

Role of Stage of Change in Planning

• NOT to determine eligibility (or ineligibility!)

• Stage of change is an informed starting place from which we can best tailor plan content to meet the person where they are.

• May directly impact both objectives AND recommended interventions.

• Striving for stage-responsive planning is an opportunity to program for success!
Assessments Consider Motivation and Stage of Change

<table>
<thead>
<tr>
<th>Stages of Change; *Prochaska &amp; DiClemente</th>
<th>Treatment Focus/ Matched Intervention</th>
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<tbody>
<tr>
<td>Pre-contemplation: Unaware of the problem or do not want to fix it.</td>
<td>Outreach; practical help; crisis intervention; relationship building</td>
</tr>
<tr>
<td>Contemplation: Beginning to think change might be a good idea.</td>
<td>Psycho-education; building awareness</td>
</tr>
<tr>
<td>Preparation: Readying themselves to do things differently regarding the problem.</td>
<td></td>
</tr>
<tr>
<td>Action: Doing things differently and is actively working to fix the problem.</td>
<td>Counseling; skills training; self-help groups</td>
</tr>
<tr>
<td>Maintenance: Person has sustained identified change.</td>
<td>Relapse prevention plan/Wellness Recovery Action Plan (WRAP) /advanced Directives; skills training; Expand recovery</td>
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Assessments Conclude with an Integrated Understanding

- Data collected in assessment is by itself *not sufficient* for treatment planning

- Data must be woven together in a cohesive understanding of the whole person in the Case Formulation or “Integrated Summary”

- This requires some skill, experience, judgment, and practice!
  - Fact-finding often feels easier than interpreting/ hypothesizing!
The Summary Moves You from the “WHAT” to the “WHY”

- Moves from the “what” (facts only) to the “why” (i.e., how you make sense of the data.)
  - Informed by both the person’s understanding as well as by your professional opinion
  - Information in summary should have a direct impact on the plan
  - Recorded in a chart narrative

› A well-written integrated summary is the BRIDGE between the data/assessment and the plan!

Building a Healing Partnership

- The provider shares the formulation in an emotionally safe and supportive context of caring and understanding, communicating hope and belief in the capacity of the human spirit to succeed throughout
Why is it Important to Go Beyond the Data?

• Assessment data may have multiple references to a person not using medication effectively and the consequences of this behavior. In the Integrated Summary, we often note that a “long history of medication non-compliance in the community has led to…”

• This is NOT Formulation but rather, a mere re-stating of the data/facts. The task in Case Formulation/Integrated Summary is to try to understand WHY the person is not using meds effectively as a tool in his/her recovery.

• This formulation/understanding may take the plan in very different directions.

Example: WHY Might an Individual Chose NOT to Use Meds?

• Person is concerned re: side-effects: exploration of meds with different side-effect profiles; consultation with nutritionist to get support to off-set weight-gain; family-based interventions to help couples deal with sexual side-effects

• Person does not believe they have an illness/believes meds are poison: trust-building; motivational approaches; psycho-education; peer specialist engagement interventions; empathic understanding

• Person has religious objections to taking medications; has a cultural preference to use alternative healing strategies such as collaboration with faith-based or cultural healers; integration of alternative strategies along-side traditional treatments/me in plan
Example: WHY Might an Individual Chose NOT to Use Meds?

- Person experiences **stigma** re: use of psych meds; family/others have advised them not to take it: family-based interventions; peer support; exposure to positive recovery role models
- Person becomes **disorganized**/can't track complex med schedule: cognitive remediation; occupational therapy consult to develop compensatory strategies to promote organization

Person-Centered Documentation: Big Picture

- **Goal:** Life goal, as defined by person; what they are moving toward, not just eliminating
- **Short-Term Objective**
  - **S-M-A-R-T**
  - Interventions/Methods/Action Steps:
    - Professional “billable” services, including purposeful rehabilitation
    - Action steps by person in recovery
    - Roles/actions by natural supporters
- **Strengths/Assets to Draw Upon**
- **Barriers /Assessed Needs That Interfere**
Developing Goals and a Vision

• Goals and objectives in the recovery plan are not limited to clinically-valued outcomes reducing symptoms, increasing adherence, etc.

• Rather, goals are defined by the person with a focus on building “recovery capital” and pursuing a life in the community.

What Do People Want?

✓ Manage their own lives
✓ Social opportunity
✓ Accomplishment
✓ Transportation
✓ Spiritual fulfillment
✓ Satisfying relationships
✓ Quality of Life
✓ Education
✓ Work
✓ Housing
✓ Health / Well-being
✓ Valued roles

*To be part of the life of the community*...
Goals

- Long term, global, and broadly stated
- Life changes as a result of services
- Ideally expressed in person's own words
- Written in positive terms
- Consistent with desire for self-determination
  - may be influenced by culture and tradition

Barriers

- What is getting in the way of the person achieving their goal?
  - Why can't they do it tomorrow?
  - Why can't they do it themselves?

- Our job is helping the individual to identify and then remove/reduce/resolve/overcome barriers that occur as a result of the mental health challenges
  - symptoms
  - functional impairments
  - distress
Barriers Should Be Descriptive

Weak Examples

• Anger issues
• Depressive symptoms
• Addiction

Strong Examples

• Has had outbursts and interpersonal conflicts with neighbors
• Lacks the energy to take care of basic household tasks
• Frequent substance use at apartment has led to police calls and risk of eviction

An Example

Goal: Reduce symptoms & increase concentration
I want to get my degree in education and someday be a teacher

Barriers: difficulty concentrating due to depression, previously unable to meet attendance requirements at GED class due to lack of energy and high anxiety; difficulty remembering, tracking and completing assignments; anxiety related to taking bus to GED classes

Need to secure financial aid, difficulty obtaining affordable childcare
Recovery Happens in Small Steps

• To be an effective road-map, recovery plans need to clearly identify the smaller steps that get you to your destination
• Objectives become markers along the way
  – Offer opportunity to celebrate and acknowledge progress
• Every gain made is additional fuel for the journey!

Short-term Objectives: What do they do?

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

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

- Simple or Specific
- Measurable
- Achievable
- Realistic/Relevant
- Time-framed

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 that increase during attempts to speak with her pastor or return to church—“I am so embarrassed and angry about the way I was treated. 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 Go Beyond Service Participation

• The following objective is about service participation. People can participate in services for years and not achieve the intended benefits!
  
  • “Wanda will voluntarily attend DBT group 2x weekly.”

• Objectives are about what you hope will change for the person as a result of services. Ask yourself the question:
  
  • As a result of attending DBT groups, how do you expect her behavior/quality of life/status to change in a measurable way?

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

Objectives: From Learning to Doing

• Client will reduce assaultive behavior.
  
  • Within 90 days, Amy will identify 3 triggers to behavioral outbursts with children.
    
    • (LEARNING objective)
  
  • Within 90 days, Amy will have a minimum of one successful visit with her children AEB by report of Amy’s DCF Case Worker
    
    • (BEHAVIORAL objective)
"Just Right Fit" Objectives

Continuum of Functional Abilities and Stage of Change

Current Functioning

Too Easy

Goal

Too Hard

Objectives – Stage Responsive

- *Client will decrease frequency & intensity of substance use.*
  - Joe will identify a minimum of 2 adverse effects that substance use has on his/her recovery within 30 days (pre-contemplative)
  - Joe will be substance-free for 6 months as evidenced by self-report (action-oriented)
Interventions & Action Steps

• Serves as a contract for who is responsible for what actions
  • Reflect a use of EBPs where available/desired
  • respect individual choice and preference
  • describe medical necessity by clearly describing how services are intended to overcome that individual’s barriers
  • are specific to an objective
• But they also incorporate actions by natural supporters and the person him/herself.

Critical Elements

• Professional services must specify…
  – WHO will provide the service, i.e., name and job title
  – WHAT: The TITLE of the service, e.g., Health & Wellness Group
  – WHEN: The SCHEDULE of the service, i.e., the time and day(s)
  – WHY: The individualized INTENT/PURPOSE of service
Examples of Interventions

- Psychiatrist will meet with Mary 1x per month for 30 minutes for the next 6 months to adjust medications. Purpose is to reduce symptoms, including Mary’s tendency to isolate and avoid social situations.

- PSC will meet with Mary at least 1x/week for the next 6 months. During these meetings, PSC will help Mary learn skills necessary to use ACCESS and to go into the community alone. Anxiety reduction techniques and social skills training will also be provided.

- Holly Baker, Addictions Counselor, will provide motivational enhancement interventions during weekly home visits over the next 90 days for the purpose of encouraging Oliver to refrain from using drugs or alcohol prior to visitation with children.

Actions by the Person & Natural Supporters

Note: It’s not necessary to describe personal action steps (also called “self-directed interventions” or “personal responsibilities”) and “Natural Support Actions” as fully as those to be performed by professional staff. However, you should provide enough detail/specificity so the responsibilities are clear to the person expected to carry out the action.

Avoid Vague/General Statements:

- Patient’s family will provide emotional support and encouragement…”

Be Specific:

- “Wanda’s mother has agreed to call on Sunday evenings so Wanda has an opportunity to speak with her mom and children.”
So, what do YOU think? Meet Greg

- Greg reports he is very lonely. 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 group home to do much of anything other than come to the Center. He wonders if this is due to his meds. Although he would like a girlfriend, Greg admits to being “terrified" to get out in community and meet women, and states that it has 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 often gets confused or fears others might try to hurt him.

Which of the below is the best goal statement for Greg’s PCRP?

1. I don’t want to feel like a “zombie,”
2. Greg will better manage distressing symptoms of paranoia.
3. I want a girlfriend.
4. Greg will voluntarily attend the Social Skills Group.
5. I just want to be happy.
How does it all come together in the PCRP?

Review and Discussion of Sample Plan

Greg’s PCRP

- **Goal:** I want a girlfriend… someone to share my life with.

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

- **Barriers/Assessed Needs/Problems:**
  - Intrusive thoughts/paranoia increase in social situations; possible negative symptoms of schizophrenia and/or med side effects result in severe fatigue/inability to initiate; easily confused/disorganized; need for skill development to: use public transportation/increase community mobility, develop symptoms management strategies, improve communication and social skills, attend to personal appearance

- **Objective:**
  - Greg will effectively use learned coping skills to manage distressing symptoms to participate in a minimum of 1 preferred social activity per week for the next 90 days
Interventions and Action Steps

- Dr. X to provide Med Management, 2X/mos for 30 min for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning.

- Allyson Jackson, Rehab Specialist, will provide in-vivo coping skills training 2X/mos. for 45 min for next 3 mos. to increase Greg’s ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)

- John Smith, Peer Coordinator, will provide travel training 1X/wk. for 60 min 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.)

- Greg’s brother, Jim, will accompany Greg to weekly social outings over the next 3 months.

- Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

Golden Thread of Medical Necessity

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

- Written to overcome MH Barriers which interfere with Goal: to address symptoms/functional impairments as a result of diagnosis
- Reflect a change in behavior/status/level of functioning to improve; beyond maintenance

- 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
Take Home Message

- We can balance person-centered approaches with medical necessity/regulations in creative ways to move forward in partnership with persons in recovery.
- We can create a plan that honors the person and satisfies the chart!
- In other words: PCRP is not soft!

References and Resources

- New York Office of Mental Health, PCRP Resource Page
  - https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/
- New York Care Coordination Program
- Getting in the Driver’s Seat of Your Treatment and Your Life: Preparing for Your Plan (English & Spanish avail)
References and Resources

• Person-Centered Care Questionnaire: Tondora & Miller 2009
  • https://www.spokanecounty.org/DocumentCenter/Home/View/3006

References and Resources

• Tondora et al., 2005, Implementation of Person-Centered Care and Planning: How Philosophy Can Inform Practice.
  • Copy available from: Wesley Evans at wesley.evans@myffamilies.com
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The Impact of PCRP

The Impact of Person-Centered Recovery Planning
This video describes the positive impact that PCRP has on a person in recovery and the effect that the support of the PCRP team has on outcomes for a person in recovery.

Closing Q & A...
Your Thoughts and ideas...

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