Person-Centered Recovery Planning: Partnering in Process and Documentation

Janis Tondora, PsyD
Yale Program for Recovery and Community Health
Introductions and Background
Learning Objectives

• Define Person-Centered Recovery Planning (PCRP) and its essential elements

• Increase familiarity with existing and emerging state and federal requirements regarding PCRP

• Articulate a minimum of three differences between traditional methods of treatment planning and best-practice Person-Centered Recovery Planning (PCRP)

• Learn strategies to maintain the rigor of documentation in order to meet fiscal and accreditation standards.
**POLL:**

**How about you?**

What hat(s) are you wearing in today’s conversation?

- Direct support practitioner
- Peer support specialist
- Supervisor/team leader
- Family member/natural support
- Guardian/conservator
- Leadership/administration
- LME/MCO representative, etc.
- *Service recipient/person with lived experience*
- Advocate
- Other (and let us know in CHAT)

*A note on use of terms: service user, participant, client, service recipient, person in recovery, survivor, patient, person with a disability, person with lived experience, consumer… **PERSON**
• Person-centered recovery planning (PCRP) is a collaborative process between the person and their behavioral health care providers and natural supporters that results in the development and implementation of an action plan to assist the person in achieving their unique, personal goals along the journey of recovery.
Forces Behind PCRP

- Values-driven approach first and foremost! 
  *Golden/Platinum Rule*

- Endorsement by state health and social service authorities

- Federal/national endorsement (Freedom Commission, SAMHSA, Certified Community Behavioral Health Clinics, Federally Qualified Health Centers, National Center on Advancing Person-Centered Practices and Services, etc.)

- Funders (E.g., Centers for Medicare & Medicaid Services), accrediting bodies, licensing

- Accumulating evidence/data showing improved outcomes

**Voice of service recipients:**
*When I have a voice in my own plan, I feel a responsibility to “work it” in my recovery.*
PCRP Implementation Concerns: Which of these is the most challenging?

- PCRP devalues the role of clinical expertise; what is the professional’s role if the person/family is in the driver’s seat?
- People receiving services are too impaired or uninterested to partner in the way PCRP requires.
- PCRP documentation puts us at risk for compliance issues, i.e., the plan might not meet medical necessity criteria.
- Sometimes Managed Care Organizations/Local Management Entities have certain expectations of things that must be included.
PCRP Implementation Concerns: Which of these is the most challenging?

• The forms/templates/Electronic Health Records don’t have the right fields for PCRP documentation.
• There is not enough time to do PCRP; caseloads are too high.
• If PCRP increases choice, how do we manage risk issues in the face of what some feel might be “bad/risky” choices?
• Don’t we already do PCRP? Is it really any different?
4 “Ps” of PCRP

- **Philosophy** – core values and beliefs
- **Process** – new ways of partnering and sharing decision making
- **Plan** – a concrete roadmap to guide the work
- **Purpose** – meaningful person-centered outcomes
A Few Words About What PCRP is NOT...

- PCRP is NOT
  - ...incompatible with the concept of medical necessity required in clinical documentation
  - ...reserved for those who are “high functioning.” It is a universal right for ALL, but the application of specific practices may look different in different settings
  - ...“anti-clinical/anti-treatment”; invalidating of professional expertise
  - ...in conflict with risk assessment and risk management
  - ...an “add-on” or special new program
    - but rather an integrating framework for quality care
BUT IS A PERSON-CENTERED, APPROACH AT THE LEVEL OF SERVICE DELIVERY AND PLANNING ENOUGH?

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

• …that align in support of recovery-oriented services AND…
• that promote staff wellness and growth through employee-centered organizational strategies
  - PARALLEL WORLDS ALIGN!!
  - It is a BOTH/AND, not an EITHER/OR approach to person-centered transformation
The Practice of PCRP Must be Embedded in a Person-Centered System of Care

• This means that everyone in an organization has an important contribution to make to person-centered care: clinicians AND… admin staff, security, plant operations, Board of Directors, IT, marketing, QM, and leaders
  - Articulating mission/vision
  - Engaging funders to promote consistency in expectations
  - Reflecting on policies and procedures
  - Building and disseminating PCRP tools and resources, including FAQ documents
The Practice of PCRP Must be Embedded in a Person-Centered System of Care

• This means that everyone in an organization has an important contribution to make to person-centered care: clinicians AND… admin staff, security, plant operations, Board of Directors, IT, marketing, QM, and leaders
  - Establishing QI mechanisms to continuously get feedback from both individuals served and those who serve them
  - Identifying and responding to PCRP barriers as you work toward implementation
  - Developing guidance documents and tools to support PC work, e.g., assessment and planning templates, electronic health record design
An Acknowledgement...

• Behavioral health work is often high-stress and can cause you to feel burnt out emotionally and physically
• We recognize that you all are doing the very best you can, often in the face of overwhelming circumstances
• Nothing about today’s conversation should be taken as an indictment of your good work, nor does it invalidate your expertise
• Opportunity to learn and take it to the next level!
But don’t we ALREADY do this?

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

Exercise/Reflection

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

**But don’t we ALREADY do this?**

**Exercise/Reflection**
Think About It…

Just imagine…

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

Family
Friends
Job
Think About It...

Just imagine...

- Beyond US and THEM
  - People with mental health and substance use concerns generally want the exact same things in life as ALL people.
  - People want to thrive, not just survive…
Mr. Gonzalez is a 31-year-old Puerto Rican cisgender man. He is married and has 2 young sons (ages 3 and 5). He lives with bipolar disorder, and he struggles with alcohol misuse, which he often relies on to manage distressing symptoms. During a recent period of acute mania, Mr. Gonzalez was having increasingly volatile arguments with his wife in the presence of his boys. On one occasion, he shoved her to the floor, which prompted her to call the police. When the police arrived, Mr. Gonzalez was uncooperative and agitated, and he was subsequently admitted inpatient for evaluation and treatment. His wife is open to reconciliation, and she is actively involved in his treatment at the hospital. Mr. Gonzalez states that his love for his family and faith in God (he is a devout Catholic) keep him going in difficult times.
**Goal(s):**
Achieve and maintain clinical stability; reduce assaultive behavior; comply with medications

**Objective(s):**
Pt will attend all scheduled groups on the unit and mall; Pt will take all meds as prescribed; Pt will complete anger management program; Pt will demonstrate increased insight re: clinical symptoms; Pt will recognize role of substances in exacerbating aggressive behavior

**Services(s):**
Psychiatrist will provide medication management; Social Worker will provide anger management groups; Nursing staff will monitor medication compliance
Traditional Plan

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

• Take my lithium
• Increase insight
• Reduce assaults
• Comply with group schedule
Five Competency Domains for PCRP

5 Competency Domains
for Person-Centered Planning

A. Strengths-Based, Culturally Informed, & Whole-Person Focused
B. Cultivating Connections Inside the System & Out
C. Rights, Choice, & Control
D. Partnership, Teamwork, Communication, & Facilitation
E. Documentation, Implementation, & Quality Monitoring

Five Competency Domains for Staff Who Facilitate Person-Centered Planning, NCAPPS, 2022
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
The Process of PCRP: Key Practices

- Recognize the range of contributors (including peers) to the planning process
- Understand/support rights such as self-determination
- Value community inclusion/life - “While,” not “after”
- Employs a strengths-based approach
- ALL of the above are impacted by cultural factors
“Person” versus “Family” Centered Care: Making Space for All Voices

• There are unique challenges and opportunities in youth and family services where you have TWO distinct customers

• Sometimes views on priority goals (and how to achieve them) align, sometimes NOT!

• How do we honor the youth as much as possible while also respecting the perspective and critical role of family/caregivers?
  • Core Competencies in: family engagement, group facilitation, dispute resolution, understanding of power dynamics

• Similar tensions exist in the adult world when individuals elect to involve family members and/or have them involved as legally-appointed guardians

National Quality Foundation Person-Centered Planning and Practice Final Report, 2020
### Recovery Roadmap

**Tips for Recognizing Person-Centered Process**

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

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

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

*Note: Items often refer to the “team” or team meeting but just as readily apply to 1:1 planning activities*
Video Reflection: “I’m on the team!”

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

• Henry David Thoreau
Sounds great… but how do you balance the spirit of person-centered care with the rigor required in plan documentation?
... without creating plans so detailed, no one uses them?!
PCRP Documentation: Big Picture

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

Strengths/Assets to Draw Upon

Barriers/Assessed Needs that Interfere

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

Interventions/Methods/Action Steps
• Professional/“billable” services
• Clinical & rehabilitation
• Action steps by person in recovery
• Roles/actions by natural supporters
**Problem-Centered**

One Goal for Every Problem as Identified in the Assessment

- Problem: Chronic Hepatitis (DIM 2)
  - Goal: Comply with medical tx
- Problem: Anger Management (DIM 3)
  - Goal: Reduce outbursts, threat to others
- Problem: Severe neglect hygiene (DIM 1,3)
  - Goal: Shower /bathe regularly
- Problem: Poor insight to SUD (DIM 4)
  - Goal: Increase insight

**Person and Goal-Centered**

Goal of the PERSON and How Barriers Interfere

*I want my job back so I can provide for my kids.*

- Symptoms (joint pain, liver disease, fatigue) impact work performance (*I can't do too much physical stuff*)
- Loss of control at work led to physical conflict with co-worker and termination (*I lashed out when I felt unsafe*).
- Self-care improvements needed to present well in job interviews. (*I need to look my best for the interview.*)
- Substance use led to frequent absenteeism and job loss (*I called out too much and got let go.*)
Problem-Centered
One Goal for Every Problem as Identified in the Assessment

- Problem: Chronic Hepatitis (DIM 2)
  - Goal: Comply with medical tx

- Problem: Anger Management (DIM 3)
  - Goal: Reduce outbursts, threat to others

- Problem: Severe neglect hygiene (DIM 1,3)
  - Goal: Shower /bathe regularly

- Problem: Poor insight to SUD (DIM 4)
  - Goal: Increase insight

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

I want my job back so I can provide for my kids.

- Symptoms (joint pain, liver disease, fatigue) impact work performance (I can't do too much physical stuff)

- Loss of self-control led to conflict with co-worker and termination (I lashed out when I felt unsafe)

- Self-care improvements needed to present well in job interviews (I need to look my best for the interview)

- Substance use led to frequent absenteeism and job loss (I called out too much and got let go)
Learning Through Roma’s Story

Roma: Assessment and Background Information

History, Demographics, and Presenting Issue

Roma is a 20-year-old, Puerto Rican female who has been treated on and off in the XYZ system of care for 15 years due to problems associated with her diagnosis of major depression, post-traumatic stress disorder, and polysubstance use. She was incarcerated for a year for drug-related offenses (possession of cocaine, theft, prostitution) and risk of injury to a minor (repeated DUI with children in her car; leaving children unattended during drug use). During this time, her children currently a 14-year-old daughter and a 9-year-old son were in the custody of their aunt who is a supportive influence in Roma’s life and recovery. Upon her release from prison 6 months ago, Roma began living with her cousin and kids. At some point, Roma started drinking and then stole money from her cousin to buy alcohol. During one incident, she couldn’t find the kids overnight in Roma’s care so she could attend an out-of-state funeral. When she returned, Roma was passed out on the couch and she didn’t know what the 9-year-old was. It turned out that the 9-year-old was playing basketball at a local community court, but Roma later admitted that she had left the kids unattended as she was drinking with neighbors. In addition, Roma’s cousin tells you that Roma had been having great difficulty getting along with the children, and that she relates to them more as a friend than as a maternal figure. In addition, there were frequent verbal ‘blow-ups’ with her teenage daughter, and on one occasion, Roma slapped her across the face when she was drunk. Roma’s cousin is very concerned about Roma’s continued alcohol use and her volatile relationship with her daughter, so she asked Roma to leave the apartment until she ‘cleaned up her act.’

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

Family Background/Early Childhood

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

Education/Employment

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

- 29-year-old Puerto Rican female and loving mom of 2 teens
- Survivor of childhood abuse and multiple Adverse Childhood Experiences (ACEs)
- Long history of polysubstance use, major depression, and Post-Traumatic Stress Disorder
- Intermittent homelessness and incarceration
- Medical issues (Hep C) but “refuses” to go to the doctor
- Many strengths, including her supportive cousin, creativity, work history
- Released from prison 6 months ago
- Began living with a cousin who had temporary custody of her children
- Asked to leave 1 month ago due to verbal and physical “blowouts” with daughter and concern re: substance use
- Clinician referred Roma to a local transitional shelter with behavioral health services
- Doing well volunteering in reception but admits to “slips” with drinking
- Roma is open to services and highly motivated to get her kids back
“Traditional” Roma Service Plan

**Roma Traditional Treatment Plan:**

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

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

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

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

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

**Goal:** Abstinence from all drugs including alcohol

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

**Interventions:**
1. Case Manager will monitor Roma’s attendance 12 step meetings and secure urine screens for her PO.
2. Substance Abuse Counselor will provide weekly relapse prevention meetings and report absences to PO.
3. Psychiatrist will prescribe Antabuse to deter Roma’s drinking and remind her of dangers of continued drinking due to her liver damage.
Person-Centered Plans are Grounded in 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!
Integrating Summary: Moving From the “WHAT” to the “WHY”

• Moving from the “what” (facts only) to the “why” (i.e., how you make sense of the data
  • “Hypothesis” or best-guess as to what is going on
  • Informed by both the person’s understanding as well as by your professional opinion
• Information in summary should have a direct impact on the plan
• Recorded in a chart narrative – in the “integrated summary”
• “shared” with person served
An Example: **WHY** do individuals choose not to use medication at times?
An Example: **WHY** do individuals choose not to use medication at times?

Person is concerned about side-effects
An Example: **WHY** do individuals choose not to use medication at times?

<table>
<thead>
<tr>
<th>Person is concerned about side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of medications with different side effect profiles, consultation with nutritionist to get support to off-set weight gain, family-based interventions to help couples deal with sexual side-effects</td>
</tr>
</tbody>
</table>
An Example: **WHY** do individuals choose not to use medication at times?

<table>
<thead>
<tr>
<th>Person is concerned about side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of medications with different side effect profiles, consultation with nutritionist to get support to off-set weight gain, family-based interventions to help couples deal with sexual side-effects</td>
</tr>
</tbody>
</table>

| Person has a culturally-informed preference to use alternative healing strategies |
An Example: **WHY** do individuals choose not to use medication at times?

<table>
<thead>
<tr>
<th>Person is concerned about side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of medications with different side effect profiles, consultation with nutritionist to get support to off-set weight gain, family-based interventions to help couples deal with sexual side-effects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person has a culturally-informed preference to use alternative healing strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with faith-based or cultural healers, integration of alternative strategies into recovery plan</td>
</tr>
</tbody>
</table>
An Example: **WHY** do individuals choose not to use medication at times?

<table>
<thead>
<tr>
<th>Person is concerned about side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of medications with different side effect profiles, consultation with nutritionist to get support to off-set weight gain, family-based interventions to help couples deal with sexual side-effects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person has a culturally-informed preference to use alternative healing strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with faith-based or cultural healers, integration of alternative strategies into recovery plan</td>
</tr>
</tbody>
</table>

| Person becomes disorganized and struggles with keeping track of complex medication schedule |
An Example: **WHY** do individuals choose not to use medication at times?

<table>
<thead>
<tr>
<th>Person is concerned about side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of medications with different side effect profiles, consultation with nutritionist to get support to offset weight gain, family-based interventions to help couples deal with sexual side-effects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person has a culturally-informed preference to use alternative healing strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with faith-based or cultural healers, integration of alternative strategies into recovery plan</td>
</tr>
</tbody>
</table>

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

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

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

- **GOAL**: as defined by person; what they are moving “toward”…not just eliminating

- **Strengths/Assets to Draw Upon**

- **Barriers/Assessed Needs that Interfere**

- **Short-Term Objective (S-M-A-R-T)**

- **Interventions/Methods/Action Steps**
  - Professional/“billable” services
  - Clinical & rehabilitation
  - Action steps by person in recovery
  - Roles/actions by natural supporters
Goals: What Do People Want?

Independence
I want to control my own money.

Work /education
I want to finish school

Spiritual connection
I want to get back to church.

Health/well-being
I want to lose weight.

To be part of the life of the community…

Housing
I want to move out of the group home.

Social activities
I want to join a bowling league.

Satisfying relationships
I want to see my grandkids.

Valued Roles
I want to volunteer at the Senior Center.
What Makes a Good Goal for a PCRP?

- Goals express the hopes and dreams of the person. The “IMPORTANT TO” people
- Written in the person’s own words
- Often (but not always) reflect a desire for self-determination
- Culturally appropriate to the person
- Not just about the management of health/disability-related problems, but about quality of life
• Goal:
  ➢ Maintain psychiatric stability
  ➢ Achieve abstinence

• Objectives
  1. Compliance with meds
  2. Attend appointments with primary care provider
  3. Attend all appointments as scheduled
## Traditional vs. Person-Centered Goals

<table>
<thead>
<tr>
<th>Patient will be med and treatment compliant</th>
<th>I want to go to college.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe will have decreased outbursts in class</td>
<td>I want to go on the class field trips.</td>
</tr>
<tr>
<td>Client will follow diabetes diet</td>
<td>I want to be able to live safely on my own.</td>
</tr>
<tr>
<td>Patient will have improved boundaries and healthy socialization.</td>
<td>I want to have friends and family in my life.</td>
</tr>
</tbody>
</table>
POLL:

Which is the best goal statement for Roma’s PCRP?

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

• Identifies aspects of the person’s life that they can draw from to move toward a specific goal

• Promotes engagement and communicates message of hope and confidence in the person’s abilities
Strengths

- Captures the person’s unique identity, resources, interests
  - best qualities/motivation
  - strategies already utilized to help, self-directed wellness
  - competencies/accomplishments
  - cultural traditions and connections
  - community and social relationships
  - environmental factors that will increase the likelihood of success
For the last 18 months, the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

In the last 18 months, Sandra has worked with her doctor to find meds that are highly effective for her and she has been active in activities at the clinic and the social club. Sandra 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 Clozaril clinic. The Mobile Outreach Team did a visit to see if there was any way the staff could assist her.
Capitalize on Strengths in the Plan

i.e., A person with a love for books might be engaged by asking him/her to help out in the agency library…

A person who loves music might benefit from access to CDs/headphones as a way to quiet voices…

A spiritual person contemplating suicide might want direction from a Spiritual Director…

An animal lover struggling with obesity due to medication side effects might walk a dog regularly.
• What is getting in the way of the person achieving their goal?
  - Why can’t they do it tomorrow?
  - What prevents them from doing it on their own?

• Remember:
  - Like ALL parts of the PLAN, the development of the barriers is a partnership. This means that you START with the person’s perspective on what is getting in the way and add your professional perspective
Descriptive Barriers Connect the Dots Back to the Goal

Weak Examples

• Anger issues
• Depressive symptoms
• Addiction

Strong Examples

• Outbursts and conflicts with neighbors
• Lacks the energy to take care of basic household tasks
• Substance use at apartment has led to police calls and risk of eviction
Transition to the Short-term Objective

• What can you tackle first?

• “Pick” a barrier(s) from the list and ask what will be the proof this thing is improving?
Short-term Goals/ 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 the plan working as intended??

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**
• **Relevant**
• **Time-framed**

Will you definitively be able to say, it was achieved, yes or no…?
Technical Formula for Crafting Objectives

Within ________ (amount of time), _________ (Name) will have improved (documented barrier) ____________, as evidenced by__________ (a meaningful change in functioning or behavior that is related to the life role goal.)

Examples:

• Within the next 30 days, John will have improved management of panic as evidenced by successfully riding the subway to work without exiting the train before his stop.

• Phillip will have increased social interaction as evidenced by meeting a friend for coffee at Dunkin’ Donuts at least one time per week within the next 30 days.
Objectives Are About Outcomes, NOT Service Participation

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

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 the DBT, how do you expect the person’s behavior/quality of life/status to change \textit{in a measurable way}?

• \textbf{NOT:} Wanda will voluntarily attend DBT group 2x weekly.

• \textbf{BUT:} Wanda will apply mindfulness techniques to reduce instances of self-injury to no more than one per week for 2 consecutive weeks.
Objectives Build Over Time

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

- “Within 90 days, Audrey will overcome isolation due to depression, as evidenced by getting out of bed by 10am at least 4 out of 5 days, M-F.”
Objectives Build Over Time

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

- “Within 90 days, Audrey will overcome isolation due to depression, as evidenced by getting out of bed by 10am at least 4 out of 5 days, M-F.”

- Update: “Within 3 months, Audrey will have completed a draft of her resume, as the result of less depression.”
BARRIER: Audrey is currently unable to work because severe depression and sleep disturbance is making it difficult for her to get out of bed.

- “Within 90 days, Audrey will overcome isolation due to depression, as evidenced by getting out of bed by 10am at least 4 out of 5 days, M-F.”

- Update: “Within 3 months, Audrey will have completed a draft of her resume, as the result of less depression.”

- Update: “Within 6 months, Audrey will have part-time employment, because of better managed depressive symptoms.”
Objectives – Stage Responsive

- Joe will identify a min. of 2 adverse effects that substance use has on his/her recovery within 30 days (pre-contemplative)

- Joe will be substance-free for 6 months as evidenced by self-report (action-oriented)
POLL:

Assume her goal is:

I want to be a better mother for my kids and work on getting them back.

Which of the below is the best objective for Roma’s PCRP?

- Case Manager will refer Roma to community parenting group within 1 week.
- Within 30 days, Roma will have 3 successful visits with her daughter (without outbursts) as evidenced by her self report and cousin’s report.
- Roma will demonstrate improved anger management.
- Roma will attend all appointments with her mental health providers.
- Roma will take all medications as prescribed to reduce her irritability.
Interventions/Services and Action Steps

The plan serves as a contract for who is responsible for what actions:

- Reflect a use of evidenced-based practices
- Respect individual choice and preference
- Describe medical necessity by clearly describing how services are intended to overcome that individual’s barriers
- Are individualized and specific to the person’s goal/objective
Critical Elements – The “Ws”

Professional services should specify…

• WHO will provide the service, i.e., name and job title

• WHAT: The TITLE of the service, e.g., Health & Wellness Group

• WHEN: The SCHEDULE of the service, i.e., the time and day(s)

• WHY: The individualized INTENT/PURPOSE of service
Examples of Interventions

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

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

Holly Baker, Addictions Counselor, will provide Motivational Enhancement interventions during weekly home visits over the next 90 days for the purpose of encouraging Oliver to decrease substance use.
Interventions: Self Directed and Natural Support Actions

- **Self-directed** actions are a reminder that the person, too, has a responsibility in contributing to the recovery plan.

- **Natural Support** actions reflect the growth of the informal recovery network that supports the person’s recovery over time.

**Personal, or self-directed, actions:**
- Frank will attend AA meetings a minimum of three times per week this month.
- Wayne will call the phone company within one week and get a copy of his bill so he can work toward paying it off.
- Elaine will read web-based recovery stories nightly to give her hope for the future.

**Natural Support Actions:**
- Within one week, Father Cronin, Hilda’s priest, will arrange rides to and from Sunday services.
- Within four weeks, Shirley’s sister will help Shirley get a disability pass for reduced fare on public transportation.
- During the first week of the semester, Dennis, Nathan’s classmate, will help Nathan sign up for math tutoring at the Greenway Community College Student Support Center.
Assume her short-term goal is:
Roma will have 3 successful visits with her daughter (without outbursts) as evidenced by her self-report.

POLL:

Which of the statements could be well-written interventions for Roma’s PCP?

*Pick up to 2.

Why are others NOT the “best?”

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

Rehab specialist will meet with Roma monthly for the next 3 months.

Sally Rodriguez, Clinician, will provide trauma-informed individual therapy 2x/monthly for 3 months for 30 minutes to address symptoms which impact Roma’s reactions with her daughter.

Within 2 weeks, Roma and her cousin will check into arts-related activities that Roma and her daughter can do together on visits.

Case Manager will communicate with shelter staff to make sure that Roma is complying with all medications and shelter rules.
Tips for Recognizing a Good Person-Centered Plan

The following are some practices and common tips to help you recognize if your person-centered plan is effective and person-centered.

1. The plan uses "I" language (e.g., "I need help..."), which promotes self-awareness and self-advocacy.
2. The plan is based on individual needs and preferences.
3. The plan is flexible and adaptable to changes in the individual's needs or circumstances.
4. The plan is shared among all involved parties (e.g., family, friends, service providers).
5. The plan includes measurable goals and outcomes.
6. The plan is reviewed and updated regularly.

Note: This is a general guideline and may vary depending on the individual's needs and circumstances. It is essential to consult with professionals and stakeholders to ensure the plan is effective and person-centered.
How does it all come together in the PCRP?
Roma New and Improved

Roma PCRP Example

Person Centered Goals

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

Strengths

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

Barriers/Assessed Needs

Frequent verbal and physical altercations with daughter; in need of skill development in areas of communication, parenting, and conflict resolution; mental health symptoms (irritability, severe depression, trauma exacerbates parenting difficulties); vivid nightmares; has not slept through night in months; tends to sort to drinking to sleep and relieve distress; chronic hepatitis C associated with past IV drug use; symptoms of depression and trauma have also led to difficulty with some independent living skills. e.g., Roma has neglected bills in the past and failure to pay rent has led to eviction proceedings and instability in housing for her and children.

Objective 1 (Targeting conflicts with daughter)

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

Interventions and Action Steps

1) Sally Rodriguez, Primary Clinician, will meet with Roma one-time weekly for the next 3 months in order to assist her in identifying and managing mental health and trauma symptoms which impact her parenting and trigger her angry reactions with her daughter.

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

3) Anthony Sells, M.D., to provide medication evaluation and monitoring two times per month for the next 3 months for purpose of addressing trauma symptoms which contribute to her reactivity with daughter.
Roma New and Improved

Roma PCR P Example

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

Client Self-Directed Wellness and/or Natural Support Actions

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

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

Objective 2: (Targeting sleep disturbance)

Within 90 days, Roma will report at least 2 nights per week of uninterrupted sleep (minimum of 7 hours) for 3 consecutive weeks where she does not wake up from nightmares.

Interventions:

1) Sally Rodriguez, Primary Clinician, will provide supportive counselling one-time weekly for the next 3 months in order to assist Roma in identifying and managing mental health and trauma symptoms which lead to nightmares and sleep disturbance.

2) Denea Shipp-Coutre, Rehabilitation Coordinator, will provide one-time weekly Sleep Hygiene group for the next 3 months in order to improve sleep habits/patterns.

3) Anthony Sells, M.D., to provide medication evaluation and monitoring two times per month for the next 3 months for purpose of optimizing medications to address Roma’s trauma-induced sleep disturbance.

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

4) Roma’s cousin will buy her a writing journal and book of poetry readings within 2 weeks in order to help Roma in practicing her preferred relaxation strategies daily before bed.

Objective 3: (Targeting alcohol use which complicates serious medical issues)

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

Interventions:

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

2) Audrey Jenkins, Peer Community Connector, will accompany Roma to scheduled appointment with hepatologist to support her follow-through as she is uncomfortable attending alone due to
Roma PCRP Example

her past sexual abuse. Hepatologist will provide evaluation/treatment and educate Roma about the dangers of continued drinking on her liver functioning to increase motivation for recovery.

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

3) Roma to attend a minimum of 3 local AA/NA groups within two weeks to explore if 12-step program can be helpful source of support in learning positive ways to manage stressors and sleep disturbance without substance use.

Objective 4 (Targeting ADLs of budgeting)

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

Interventions and Action Steps

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

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

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

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

4) Within 2 weeks, Roma’s cousin has agreed to help her outline and bring in records of her bills in order to assist Roma and Rehab Specialist in creating a budget to cover all expenses with available income.
PCRP Honors Both Professional Expertise and the Wisdom of Lived Experience

**Important TO the Person**

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

**Important FOR the Person**

- Basic health and safety
- Management of clinical symptoms
- Maslow’s basic needs
- Harm reduction
- Management of risk
- Legal obligations and mandates
Golden Thread of Medical Necessity

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

- **Objective**
  - Written to overcome MH and SA 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**

- **Services**
  - 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
A Parting Thought

You CAN create a recovery plan which honors the person and satisfies the chart!

This is central in your partnership with individuals so they can move forward in their recovery in the community of their choice!

*We just need to stop accepting what is and start creating what should be…*

Dale DiLeo
Closing Q&A... Your Thoughts and Ideas
References

