NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

THE IMPORTANCE OF PARTNERING

yale program for recovery and community health

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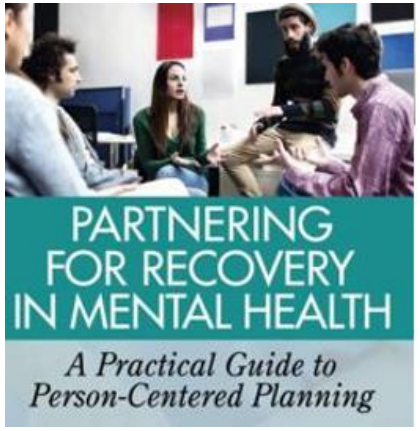
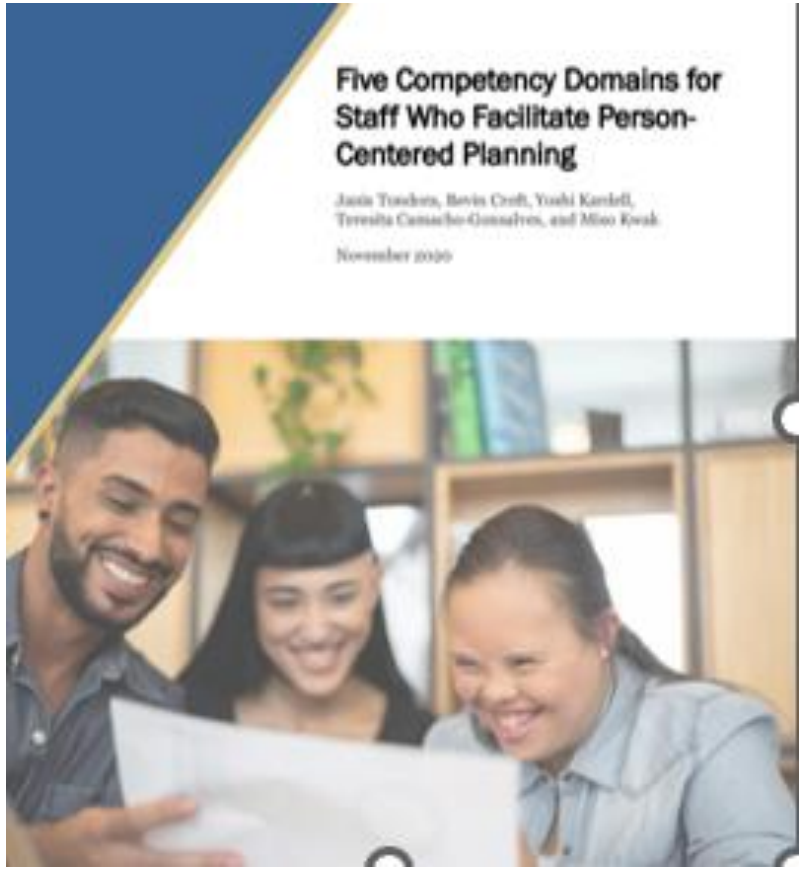
July, 2024

NC DMHDDSUS

PCP Initiative

What does a good PCP meeting look like and how does it inform a good Person-Centered Plan?





Introductions

A little bit about me…

How many of you have taken the introductory PCP course, either via "live" webinar" or BHS Springboard?

Plan for The Morning

Welcome, Intros, & Housekeeping

- Impromptu Networking Warm-Up

Background of PCP Effort in North Carolina

- Refresher/Review of Introductory PCP Training
- 4Ps and Roma Sample

PCP Process/Meeting

- What Kind of Thinking Undermines “Good” PCP Process and a “Good” PCP meeting?
- Tips and Tools for a Better Process/Meeting
  - Current PCP Process: Self-Reflection
  - Embedded Videos – “Unrealistic” Goals for “Unrealistic” People
- What should it (and should it NOT) look like in action?
  - Julie video illustration – What goes well and whrere do they get off track?

Q&A, Closing Remarks, and Evaluation

- Bright Ideas/Next Steps

Impromptu Networking

- When you think about PCP, what is ONE thing you are most proud of (for yourself or your staff)?
- What is a challenge you (or your staff) struggle with? ESPECIALLY as it relates to engaging service users in PCP conversations/meetings?

A Note About Language & Preferred Terms:

MOST IMPORTANT RULE:

Honor individual/family/group preferences; When in doubt – ASK!

History of PCP in North Carolina

- Identified a need for consistent messaging around PCP
- Diverse team of DMHDDSUS stakeholders engaged in multi-year effort
- Resulting in a PCP Guidance Document
- Including a recommended PCP template which outlines required elements
- And required PCP training for ALL that…
- Aligns with other key quality initiatives, e.g., trauma-informed, culturally-responsive care
    - *rooted in the belief that all people have the right to live, love, work, learn play, and pursue their dreams in the community*

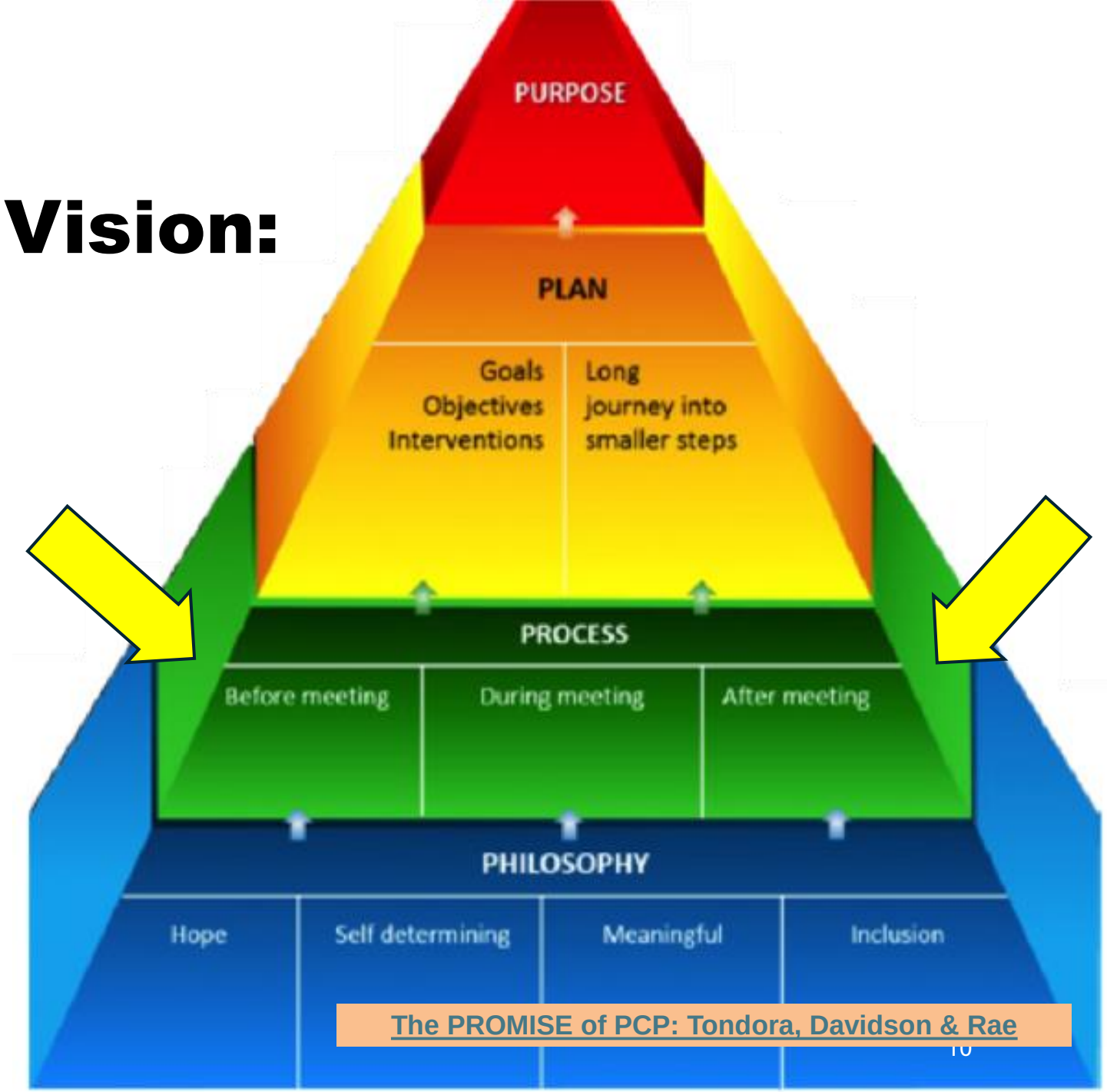
Phase 1 Activities & Achievements

- A virtual, 4-hour training was developed introducing the key principles and practices of PCP as outlined in the Guidance Document
- 2,416 participants over 7 training sessions
- Highly diverse audience in term of professional role and types of individuals/families served
- Hailing from all 100 regions of the state
- Very high degree of satisfaction and belief the training met intended learning objectives and would be applied in day-to-day work
  - *“It helped me to realign my clinical language in a more person-centered way, as well as re-establish how to maintain and protect PCP's that are individualized and empowering.”*

PCP Refresher

A Person-Centered Vision: 4 “Ps” to Consider

- **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



The PROMISE of PCP: Tondora, Davidson & Rae

PCP Process: Key Practices

- Person/family is a partner in all planning activities/meetings; advance notice (person-centeredness) – *NOTHING ABOUT US WITHOUT US*
- Person/family has reasonable control over logistics (e.g., time, invitees, etc.)
- Person/family offered a written copy/transparency
- Shift in structure/roles in planning meetings
- Education/preparation regarding the process and what to expect
- Appreciation for how cultural preferences impact ALL aspects of PCP

PCP Process: Key Practices

- Recognize the range of contributors to the planning process
    - Cultivate Circles of Support
    - Orient PCP Team members to helpful (and not helpful!) roles
- Capitalize on the talents of peers when available
- Understand/support rights such as self-determination
- Value community inclusion - “While,” not “after”
- Employs a strengths-based approach

PCP Documentation: Big Picture

Long-term GOAL
as defined by person;
what they are moving "toward"…not just eliminating

Strengths/Assets
to Draw Upon

Barriers/Assessed Needs
that Interfere

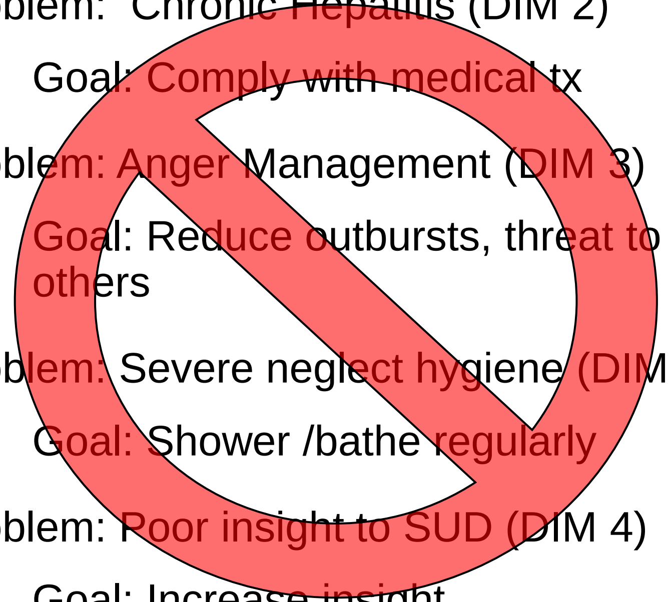
Short-Term Goal/Objective
S-M-A-R-T

Interventions/Methods/Action Steps
- Professional/"billable" services
- Clinical & rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters

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

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.

- Symptom ... ase, fatigue) impact work pe ... *much physical stuff*)
- Loss ... al conflict with co-worke ... *when I felt unsa* ...
- Self-ca ... present well in job intervie ... *for the interview.*)
- Substance ... absenteeism and job loss (*I called out ... and got let go.*)

Common Quality Errors and Tips

Long-term Goals:

- Focused on the reduction of symptoms or problems only
- “Re-phrased” in professional language
- “Well, that’s what she SAID she wanted... so I wrote it down.”

Strengths

- Identified in the assessment but ABSENT in the plan
- A “good patient”

Barriers

- Limited to diagnosis; fail to include descriptive content
- “Well, I didn’t put that it because they didn’t want to work on it…”
- Neglect of the PERSON’S perspective

Common Quality Errors and Tips

Objectives/Short-term Goals

- Participation in services is NOT the onjective/STG
- Go for sustainability, not "one-time occurrences" when writing your objectives.
- Be careful of the word "and" when writing the objectives.
  - e.g., *within 90 days a person will decrease self-injury and aggression or within 6 months, a person will quit smoking and lose 10 pounds*

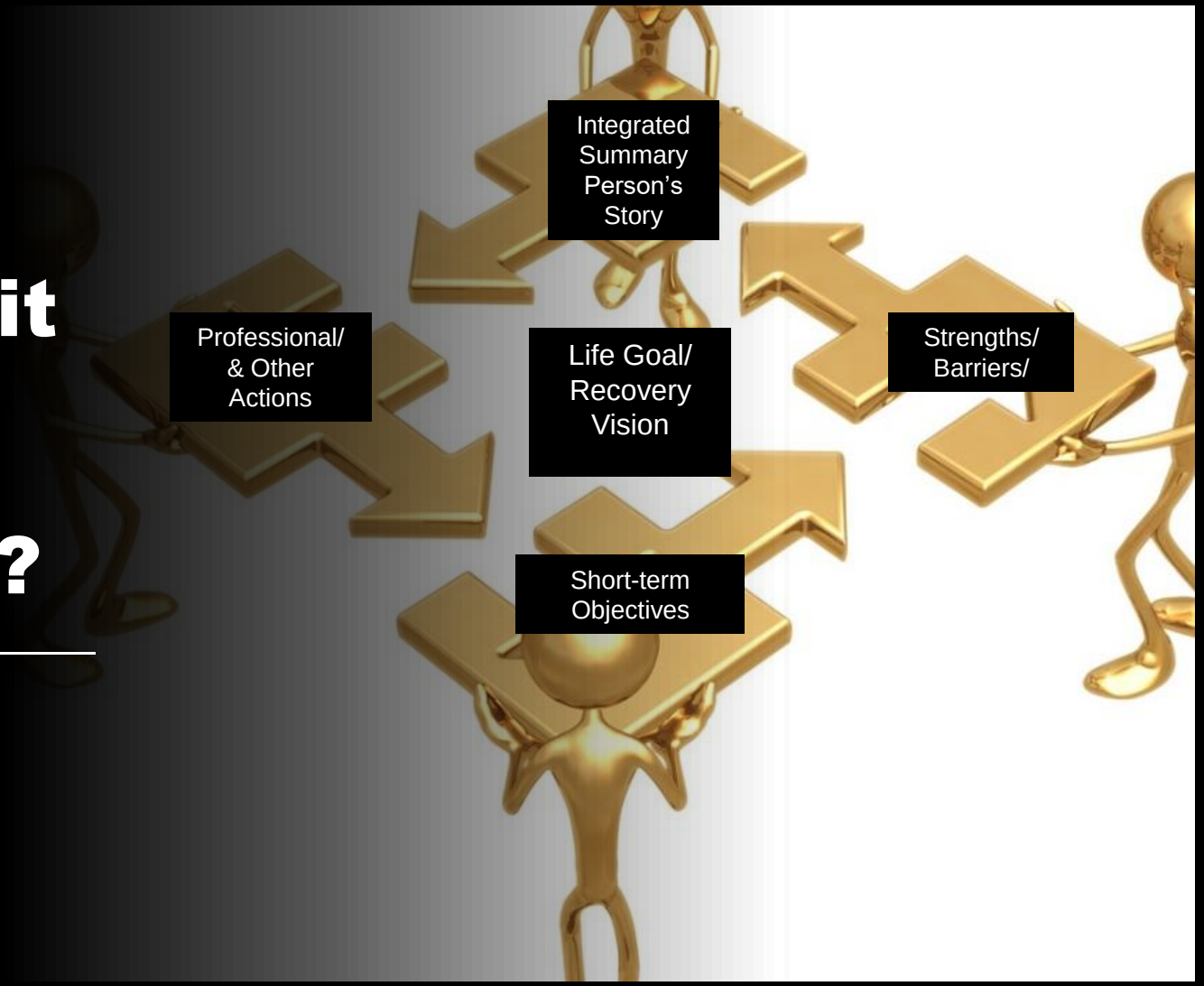
Interventions/Services:

- Fails to include key "Ws"
- Lack of individualization in the WHY (i.e., purpose and intent)

Review of Take-Home Points: PCRP Documentation

- Goals are longer-term meaningful statements (in person's own words) of desired life changes
- Plan should focus on identification, and active use of, strengths but…Barriers/functional needs continue to be an important part of the plan!
- Objectives must be meaningful to the person AND technically rigorous (S-M-A-R-T criteria); should NOT default to attending services
- Interventions/action steps are not limited ONLY to those services provided by paid professional staff, but also should include personal wellness and natural support actions
- Quality of discrete components of plan is important, BUT equally important is the how the components come together to tell a cohesive story, top to bottom and bottom to top

How does it all come together in the PCP?



Roma: Person-Centered Summary

Roma is a 29-year-old Puerto Rican woman, and a deeply loving mother. Through the years, she has had the support of a cousin to help provide for her minor age children as she struggled to manage a serious trauma history and subsequent medical and behavioral health issues (hepatitis C, major depression, PTSD, poly-substance use). She was recently referred to a Community Support Team (CST) by a representative from Child Protective Services 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 possible 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 follow-up 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 the program and has made it clear that her priority goal is to work toward re-gaining custody of her children. She is in the action stage of change and is motivated to work with her providers in order to develop the stability and skills needed to be the best mother she can be. This includes Roma's expressed desire to give up drinking and work toward abstinence. She may benefit from connection to trauma-informed care and specialty medical and substance use services as well as the development of parenting and communication skills, symptom management/coping skills, and independent living skills associated with household management (e.g., budgeting).

Roma: Person-Centered Summary

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 traumatic experiences 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 and poetry, which she uses as a coping skill.

Roma's PCP (p. 1)

Name: Roma Sanchez	DOB: 11/7/93	Medicaid ID:	Record #:
(Non - I/DD Plans ONLY) PCP Completed on: / /	(I/DD Plans ONLY) Plan Meeting Date: / /	Effective Date: / /	

Life Domains Assessed during Development of Person-Centered Plan:

Daily Life and Employment	Community Living
Safety and Security	Healthy Living
Social and Spirituality	Citizenship and Advocacy

What do you want to work on? What would you like to accomplish?
I want to be a better mother for my kids and work toward getting them back.
What strengths do you currently have?
Roma: I love my kids more than anything and always try to make sure they are OK. My cousin has been a huge help and she's always willing to give me a chance. I know I need help and I want to learn how to deal with things better. When I can't handle stuff, I try to relax by painting or reading. People always said I was "artsy," and that helps some. I feel safe with my CST team and that doesn't happen a lot. *Added by staff: Roma has been doing well helping out in the office at the shelter. She is a survivor and never gives up.*
What are the obstacles to meeting your goals?
Sometimes everything just builds up and I can't see a way out. I can't think straight or sleep at night and then I can't take care of my kids or my place. The worst thing is when I lose control at home and go off on my kids, especially my daughter. Sometimes I drink to escape it all, but that just makes things worse. I feel like a failure as a mother and CPS is going to take them away permanently if I don't get it together. Some days, I think they might be better off but I don't want to leave them the way my mom left me.

Roma's PCP (p. 2)

Long-Term Goal:

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

Short-Term SMART Goal
Roma: *I need to learn how to deal with my daughter. It kills me that she is afraid of me.* **SMART Goal #1:** *Roma will have a minimum of 3 successful supervised visits (without outbursts) with her daughter within 30 days as evidenced by Roma's self-report and cousin's report.*
Interventions – Provider(s): 1. *Sally Rodriquez, Team Lead/Clinician, will provide trauma-informed individual therapy 2x/monthly for 3 months for 30 minutes to assist Roma in identifying and managing mental health and trauma symptoms which impact her reactions with her daughter.* 2. *Sally Rodriguez, Team Lead/ Clinician, will refer Roma for Medication Management within 2 weeks and provide ongoing service coordination (1x/monthly for 3 months) with psychiatrist to ensure appropriate evaluation and treatment of Roma's ongoing distress from symptoms.* 3. *Michael Miller, Paraprofessional, will provide Coping Skills training 2x/monthly for 3 months to teach Roma conflict resolution and positive coping strategies to manage stressful situations which arise with daughter.* 4. *Audrey Jenkins, Peer Specialist, will meet with Roma 2x over the next month to help her identify and access parenting-support groups/organizations in the local community so she can develop a supportive peer network with which to share her parenting concerns.*
Interventions – Individual and/or Natural Support Actions: 1. *Roma will look into arts-related events/activities in the local community that she and her daughter might do together on their visits.* 2. *Roma's cousin will work with Roma and shelter staff in order to schedule visits. 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.*

Short-Term SMART Goal
Roma: *I want to give it up for good. I don't want CPS to take my kids.* **SMART Goal #2:** **Roma will maintain abstinence for the next 3 months as evidenced by bi-weekly urine screens which are included in her CPS family safety plan.* *(*Note that Roma has expressed a personal desire to give up drinking entirely so this short-term goal is consistent with that preference. In addition, she felt that it would be helpful to include required CPS urine screens in her plan as it "keeps me accountable." Other individuals may not feel ready to commit fully to abstinence. In this case, they may work toward a more modest short-term goal of reducing drinking, or simply not drinking during visits with children, etc. Each are examples of how to tailor the plan and short-term goal to be maximally responsive to the person's current preference and stage of readiness for change.)*
Interventions – Provider(s): 1) *Jennifer Adams, Substance Use Professional, will meet with Roma 2x/monthly for 3 months to help Roma develop and implement positive coping skills to deal with cravings and manage stressors/symptoms without substance use.*

Roma's PCP (p. 3)

Name:	DOB:	Medicaid ID:	Record #:

2) *Michael Miller, Paraprofessional, will meet with Roma 1x in the next 2 weeks to help her arrange transportation to appointments at the CPS office, including her regular drug screening.*

3) *Michael Miller, Paraprofessional, will connect Roma to a female hepatologist within 2 weeks. Hepatologist can provide evaluation and treatment as necessary while also educating Roma about the risks of continued drinking on her liver functioning.*

4) *Audrey Jenkins, Peer Specialist, will accompany Roma to scheduled appointments with hepatologist to support her follow-through as she is uncomfortable attending alone due to her past sexual abuse.*

Interventions – Individual and/or Natural Support Actions:

1) *Roma wants to get to a minimum of 3 local AA/NA groups over the next two weeks to explore if a 12-step program can be helpful in learning positive ways to manage stressors.*

2) *Roma's cousin has offered to provide transportation for 12-step meetings if Roma decides to use this as a resource in her recovery.*

Short-Term SMART Goal

Roma: *I can't take it anymore. I'm always exhausted. I can't function without sleeping.*
SMART Goal #3: *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 – Provider (s):

1) *Sally Rodriguez, Team lead/Clinician, will provide trauma-informed individual therapy 2x/monthly for 30 minutes for 3 months to assist Roma in identifying and managing mental health and trauma symptoms which lead to nightmares and sleep disturbance.*

2) *Michael Miller, Paraprofessional, will connect Roma to Sleep Hygiene group run by agency nurse within 2 weeks to help Roma improve sleep habits/patterns.*

Interventions – Individual and/or Natural Support Actions:

1) *Roma wants to try writing in a journal and reading poetry each evening before bed to relax and promote better sleep.*

2) *Roma's cousin offered to take her shopping and buy a writing journal and book of poetry readings within 2 weeks.*

This kind of PCP is a significant shift from “traditional” treatment plan design…

What perpetuates this kind of traditional 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

Objectives:

1. Roma will be med-compliant for the next 90 days.
2. Roma will have increased insight into her symptoms and behavior

Interventions:

1. Case Manager will communicate with shelter staff to verify Roma’s compliance with medication.
2. Therapist provide twice monthly depression treatment to address Roma’s irritability and aggression.
3. Psychiatrist will provide medication evaluation and management and monitor response.

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 CPS; 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 CPS monitor

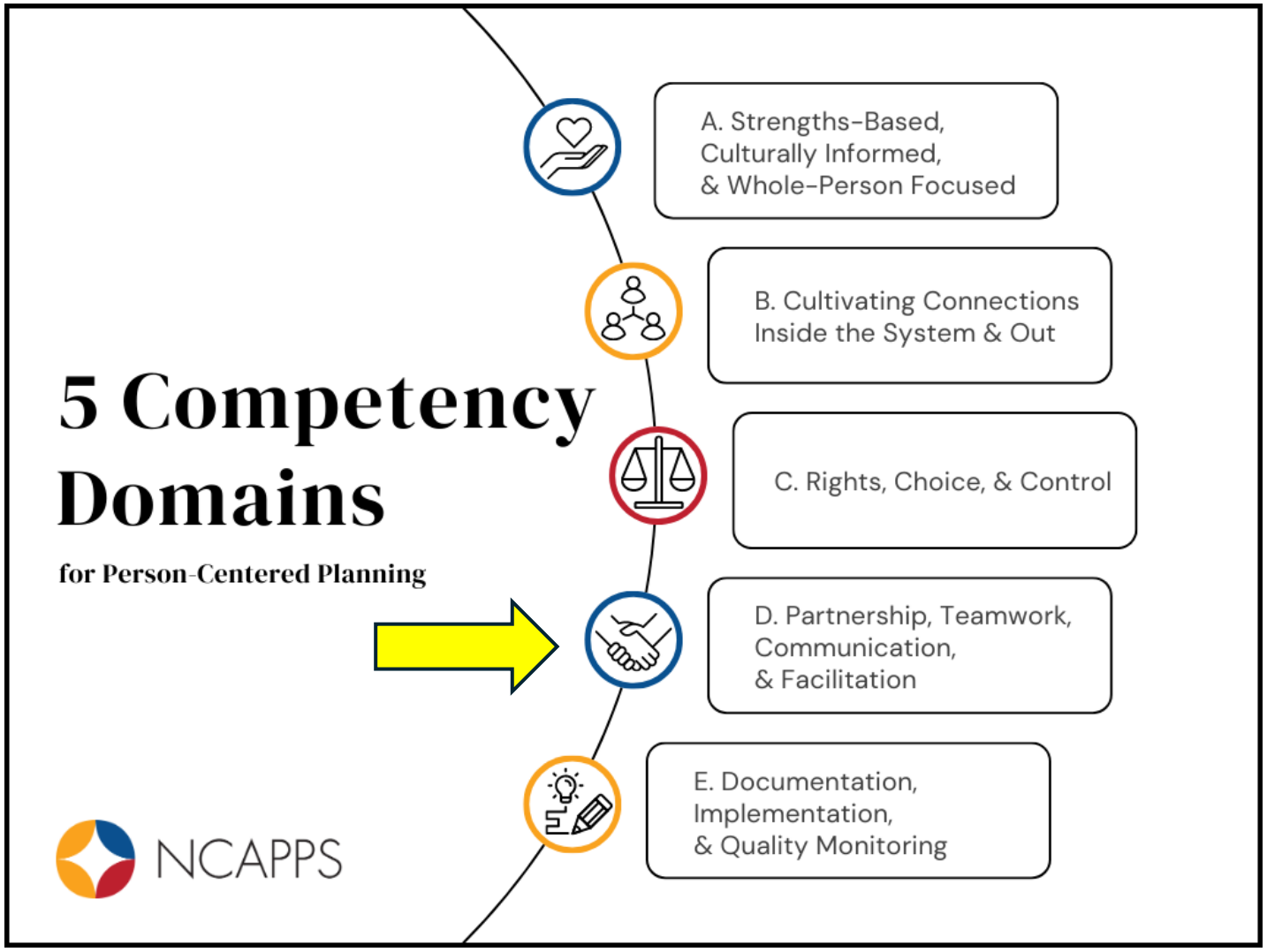
Interventions:

1. Case Manager will monitor Roma’s attendance 12 step meetings and secure urine screens for her CPS monitor
2. Substance Abuse Counselor will provide weekly relapse prevention meetings and report absences to CPS
3. Psychiatrist will prescribe Antabuse to deter Roma’s drinking and remind her of dangers of continued drinking due to her liver damage.

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

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

Toward a More Person-Centered Vision



Five Competency Domains for Staff Who Facilitate Person-Centered Planning, NCAPPS, 2022

Strengths-Based, Culturally Informed, Whole Person-Focused

- Assumes people grow, change, and realize personally valued goals; focuses on the universally valued goal of living a good life; all activities are “whole-person” oriented
  - comprehensive strengths-based profile; cultural humility; focus on goals most “IMPORTANT TO” the person/family

Cultivating Connections Inside the System and Out

- Supports linkages with paid and unpaid supports; Maximizes connections to activities and relationships in inclusive settings (and in accordance with the preferences of the person).
    - builds circles of support; avoids clinical/professional gate-keeping and the “trap of the one-stop-shop”

Rights, Choice, and Control

- Assumes people are competent and have the right to control decisions that impact their lives; Supports people in discovering (or reclaiming) their voice; Educates people about the range of legal protections that promote both fundamental safety and community inclusion
    - maximizes the use of self-determination tools, including advance crisis planning (e.g., WRAP, PADs)
- Educates people about the range of legal protections that promote both fundamental safety (i.e., the right to be free from abuse and neglect) and community inclusion (i.e., the right to be free from discrimination)

Documentation, Implementation, and Quality Monitoring

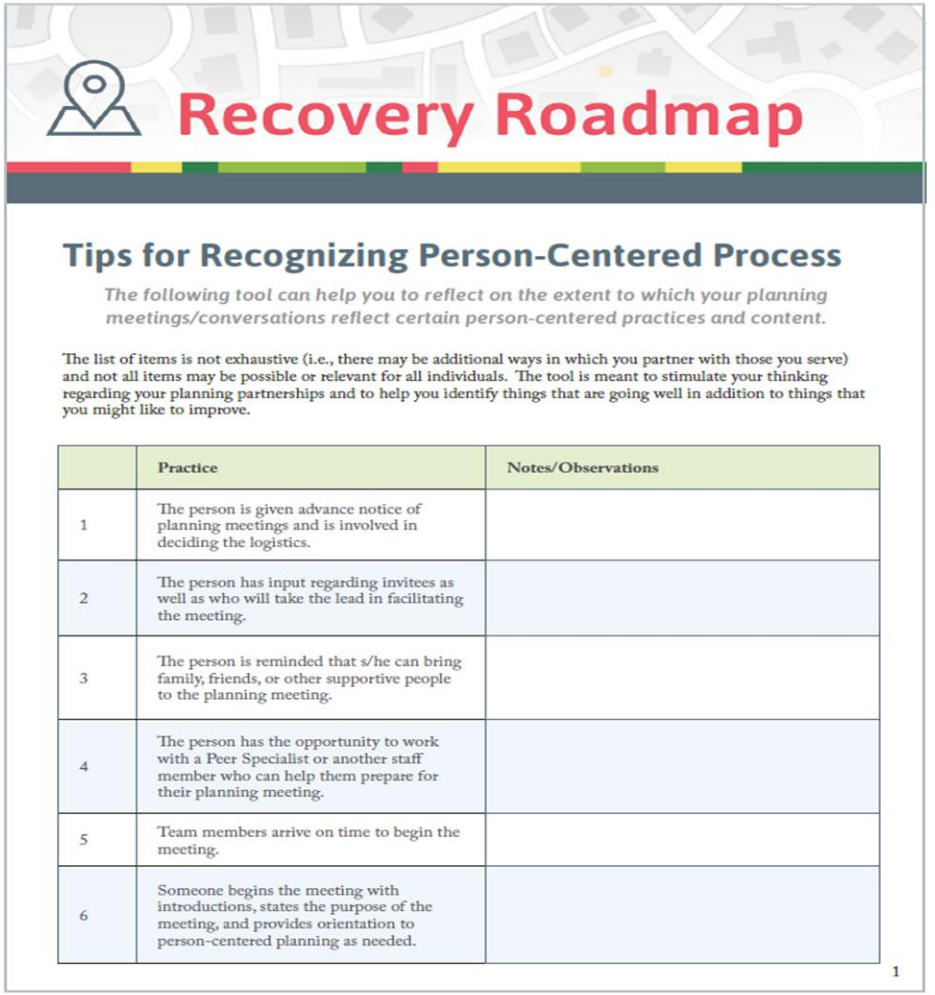
- Plan reflects the person's priorities and preferences; Plan is written in accordance with established expectations around person-centered plan documentation; Plan is a "living document;" Follow-up and monitoring are critical
    - Plan uses preferred name and identity preferences; goals are about the person's vision of a "good life;" strengths are identified and used; person-first language is consistently used

Partnership, Teamwork, Facilitation, and Coordination

- Respects the preferences of the person/family in “meeting” logistics and facilitation; Supports expansion of the “team” as desired (or not) by the person; Makes space for ALL voices; Elevates the person’s priorities and preferences
    - person’s preferences shape meeting logistics, agenda, and facilitation design; NO “talking about;” the person

Exercise:
What does your CURRENT PCP Process Look like?

- Take a few minutes and review *Tips for Recognizing Person-Centered Process*
- *Items often refer to the "team" or team meeting* ***but just as readily apply to 1:1 planning activities***
- *Identify at least ONE PCP practice you already feel really good about, a personal strength in your collaborative planning. Practice what we preach and start with our strengths ☺*
- *How about ONE thing you'd like to work on?*



Recovery Roadmap

Tips for Recognizing Person-Centered Process

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

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

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

1

Tips and Tools for PCP Conversations & Meetings

Make Use of The PCP Guidance: Person-Centered Interview Questions & Life Domains

Life Domains:

- Helps ensure that the action plan will be informed by a holistic understanding of the individual – not just a narrow assessment of their problems or health concerns

- Important to inquire about both current status as well as potential desired changes

PC Interview:

- Provides tips to directly solicit the person's perspective
- Keeps the conversation (and resulting action plan) process squarely focused on their preferences & values

Life Domains Assessed during Development of Person-Centered Plan:

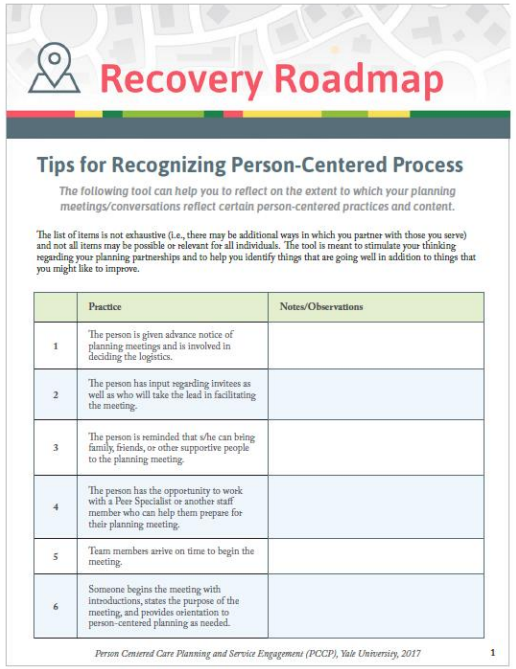
Daily Life and Employment What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.	**Community Living** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
Safety and Security Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.	**Healthy Living** Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition
Social and Spirituality Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.	**Citizenship and Advocacy** Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

What do you want to work on? What would you like to accomplish?
Using the assessment of the Life Domains, use this information to determine what is most important to the individual right now? What is their vision of a good life?
What strengths do you currently have?
These are the individualized, personal attributes, gifts, and skills a person possesses. Avoid what makes a "good client". Good examples: good sense of humor, artistic, knowledgeable about gardening, good soccer player, stylish. Avoid: shows up for appointments, takes medications as prescribed, smiles a lot, follows directions.
What are the obstacles to meeting your goals?
Help the individual identify the things that are getting in the way of meeting their goals and the resources they need to meet their goals.

Get Back to Basics: 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., "sacred space"
- 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 and Prepare the Person



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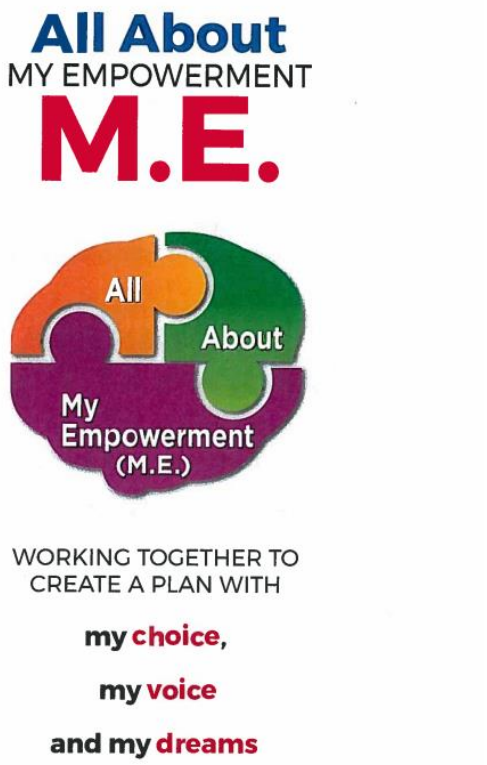
Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017 1



All About
MY EMPOWERMENT
M.E.

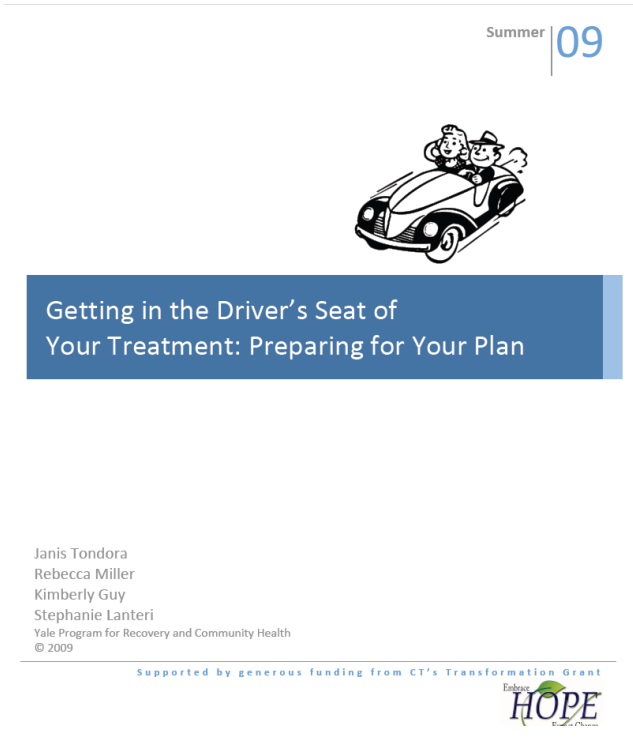
All About My Empowerment (M.E.)

WORKING TOGETHER TO CREATE A PLAN WITH

my choice,

my voice

and my dreams



Summer | 09

Getting in the Driver's Seat of
Your Treatment: Preparing for Your Plan

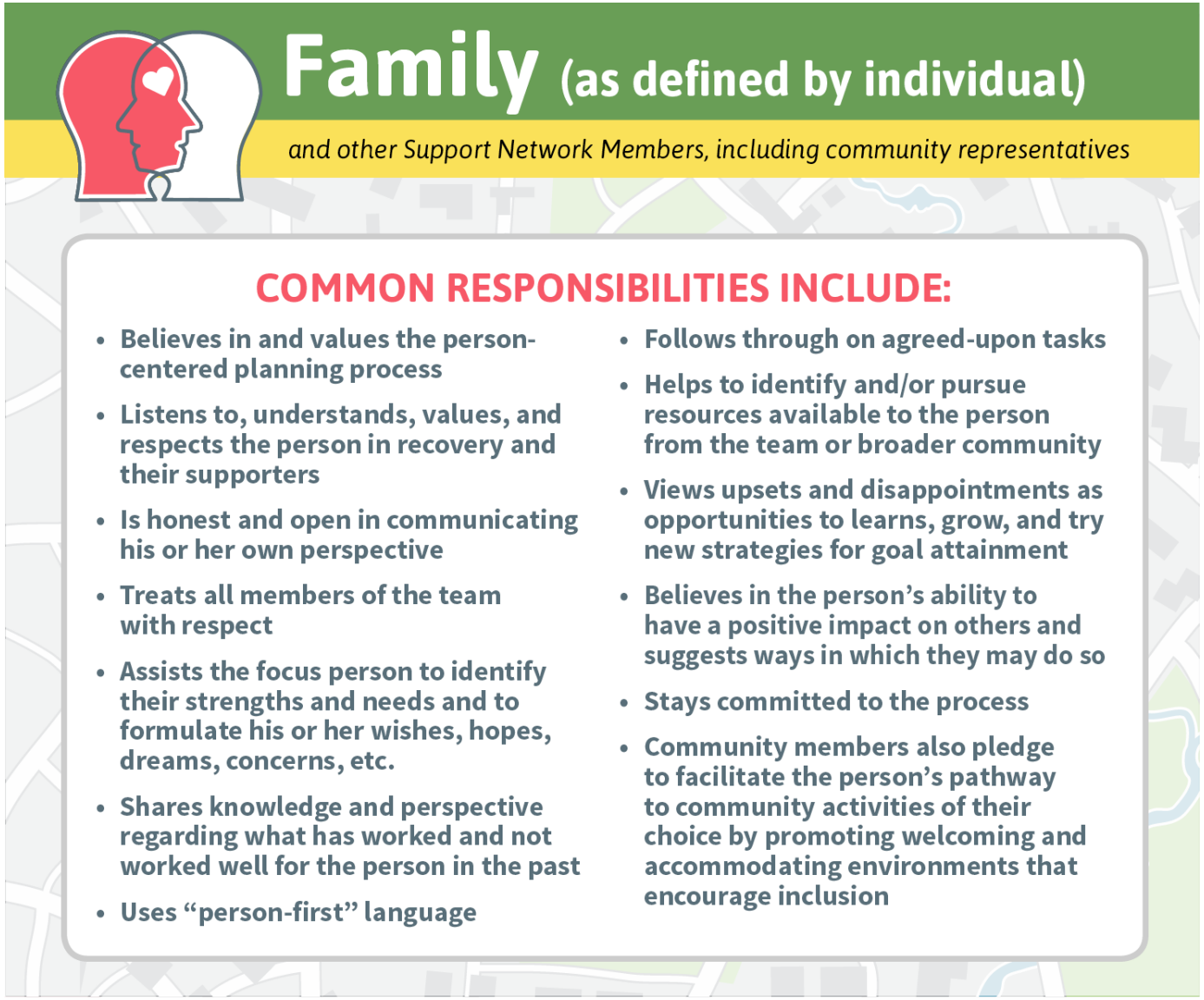
Janis Tondora
Rebecca Miller
Kimberly Guy
Stephanie Lanteri
Yale Program for Recovery and Community Health

Supported by generous funding from CT's Transformation Grant

Embrace HOPE

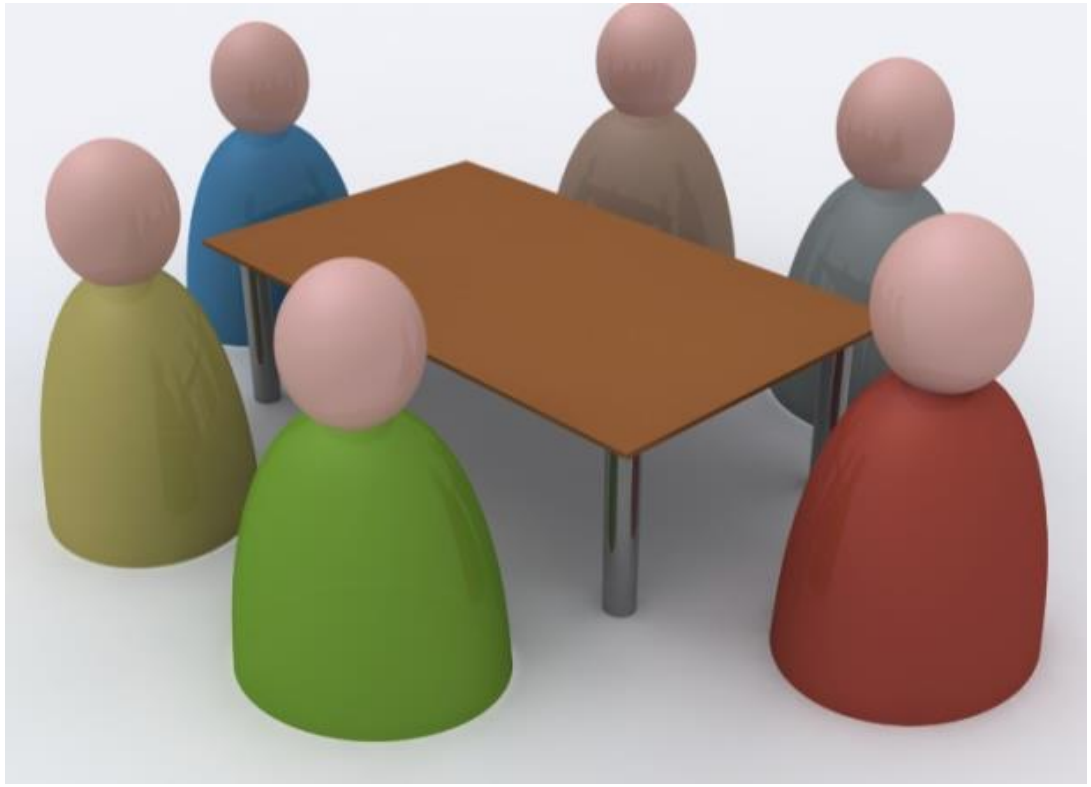
[All About Me: Hawaii State Council on Developmental Disabilities]
[Getting in the Driver's Seat: Yale Program for Recovery and Community Health]

And Family or Natural Supporters As Well!



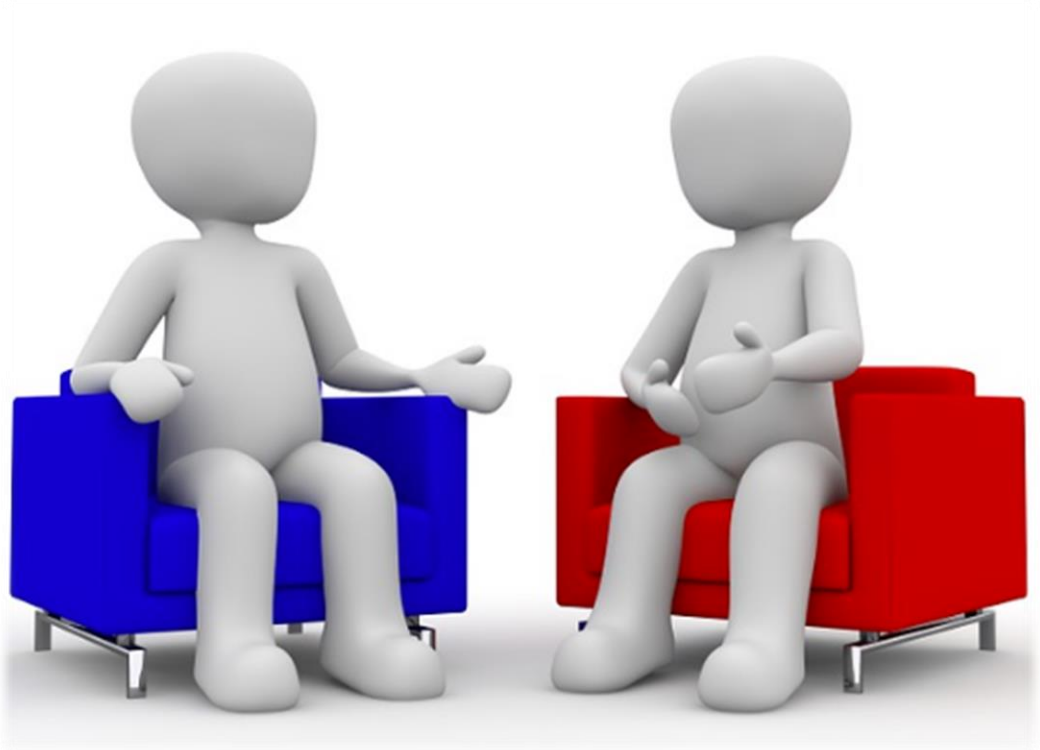
Does the Person Know What to Expect? And Can We Deliver on These things?

- You should get advance notice of the meeting
- When the meeting happens, who is involved and where the meeting takes place may vary
- You should have input into these decisions, e.g., you may choose to have a 1:1 meeting with your primary provider or you may prefer to gather a team of supporters, including a friend or a family member
- Team members arrive on time and give the process their full attention
- If needed, have your service provider start with introductions and a welcome



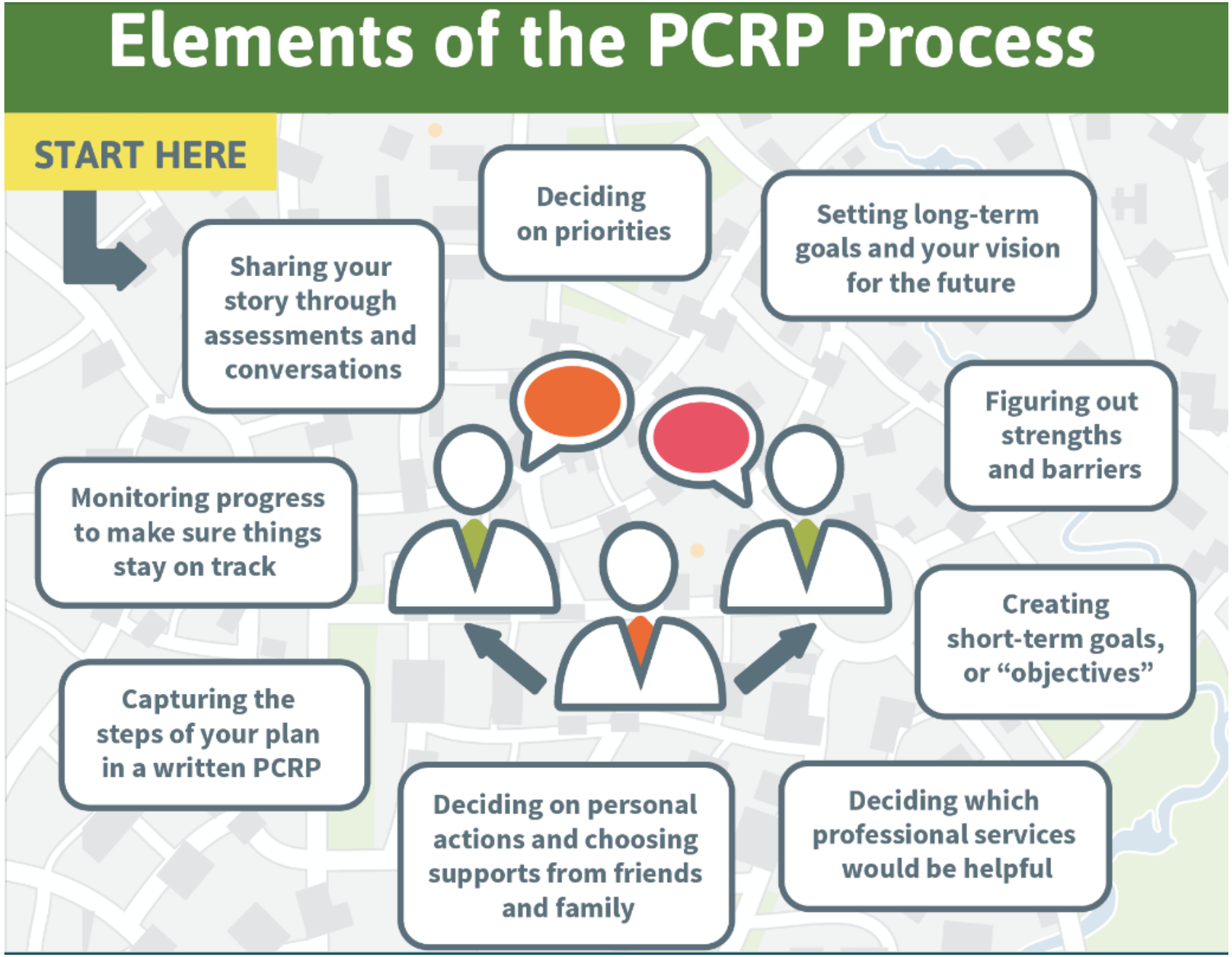
Does the Person Know What to Expect? And Can We Deliver on These things?

- Review the basic “ground rules” for how the team hopes to work together, e.g., as a sign of respect, people should talk
- Discuss a broad range of life areas that are important to you
- Ask someone to summarize key decisions and next steps
- Be sure to get a copy of the plan or ask when you might be able to get a copy if it is not completed in the actual meeting



Tips for Communicating with Your PCP Provider/Team

Elements of the PCRP Process



Support the Person to Take an Active Role in the PCP Meeting

Remind them:

- think about your priorities and goals ahead of time as well as who you might like to invite to participate.
    - Role of a Peer Support Specialist here?
- ask for the types of support that would be most helpful to you.
- SPEAK UP and share your ideas and needs with your team! You are encouraged to ask questions.
- Think about your own responsibilities in working towards your goals.
- Be cognizant of cultural preferences re: roles and decision-making

Recognize Culturally-Specific Preferences in PCP

- Working with anyone is inevitably a cross-cultural enterprise.
- Practice cultural humility
- Implications for PCRP in terms of the relationship, goal setting, and planning and treatment preferences.

- PCRP is fundamentally about freedom (freedom to pursue a good life in one's chosen community, free from discrimination and oppression). How can planning take into consideration the fact that not all people are equally free?

Julie Illustration

Strengths

- 54-year-old white woman from Boston, MA
- Loving mother and grandmother
- Kids are actively involved yet limiting contact
- Used to rely heavily on her sister who recently passed away
- Intelligent, well educated, and strong work history
- Many interests including knitting, walking, and reading (used to be in a book club), lover of animals
- Actively connected to an outpatient CSP program

Struggles

- Grieving loss of sister
- Using alcohol regularly. Symptoms of PTSD and bipolar disorder have led to multiple trips to the ER
- Julie has had trouble taking care of herself and her apartment
- Family has stopped visiting due to her issues with drinking, irritability, erratic behavior; Apartment is unsafe

Situation

- Julie feels sad about her strained relationships with family
- They no longer allow visits due to Julie's drinking, and they feel that she is not taking care of herself or her mental health .
- Julie has been living in her own apartment for 18 months and is overwhelmed by symptoms of mental illness and addiction.
- Loss of her sister has left her vulnerable, lonely, and disconnected from the people who are most important to her
- Family is still involved and want to help Julie better manage

The Importance of Advance “Pre-Planning”

Julie Gets Ready for Her PCRP Meeting With the Help of Her Peer Support Specialist

This video shows Grace and Julie meeting in Julie's home to discuss her upcoming PCRP meeting. Grace begins by reviewing the purpose of her visit and invites Julie to share what is most important to her going into the meeting. Julie begins to talk about how things have changed since her sister Beverly passed away.

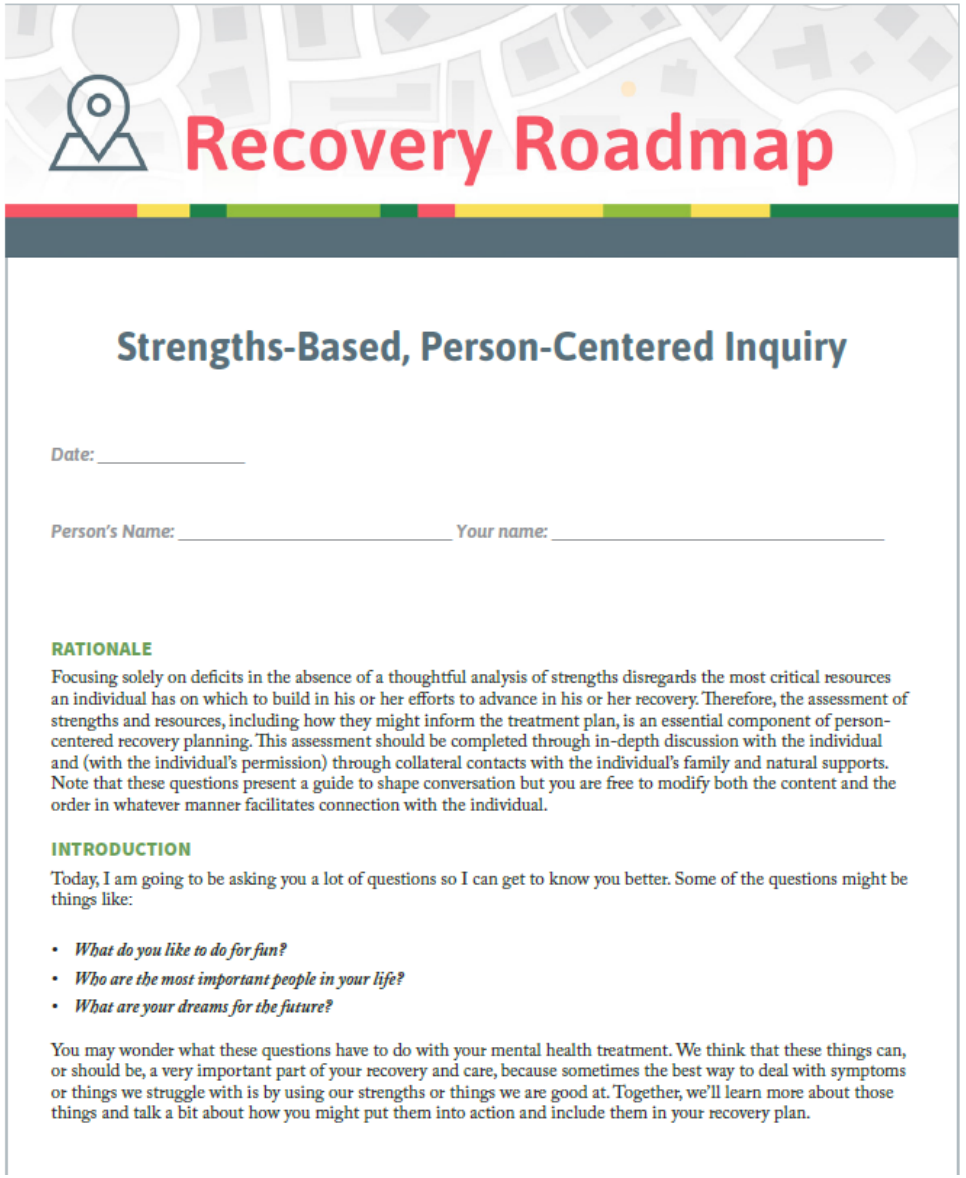
Note: Remember that you can pause and replay the video if you need more time to think these through.

- Julie begins to prepare for her PCP meeting by meeting with Grace, her PSS
- While watching the video, listen for moments where Julie begins to discover some things about her strengths, her barriers, her Circle of Support, and some of the goals she might like to work on

Use Strengths to Engage, Build Hope Around the Recovery Vision

- Root the conversation in STRENGTHS
- Remember: focusing on strengths promotes engagement, communicates a message of hope, AND shows respect for what gives people meaning in their day-to-day lives

Sample Strengths-Based Interview



Recovery Roadmap

Strengths-Based, Person-Centered Inquiry

Date: _____

Person's Name: _____ *Your name:* _____

RATIONALE

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to advance in his or her recovery. Therefore, the assessment of strengths and resources, including how they might inform the treatment plan, is an essential component of person-centered recovery planning. This assessment should be completed through in-depth discussion with the individual and (with the individual's permission) through collateral contacts with the individual's family and natural supports. Note that these questions present a guide to shape conversation but you are free to modify both the content and the order in whatever manner facilitates connection with the individual.

INTRODUCTION

Today, I am going to be asking you a lot of questions so I can get to know you better. Some of the questions might be things like:

- *What do you like to do for fun?*
- *Who are the most important people in your life?*
- *What are your dreams for the future?*

You may wonder what these questions have to do with your mental health treatment. We think that these things can, or should be, a very important part of your recovery and care, because sometimes the best way to deal with symptoms or things we struggle with is by using our strengths or things we are good at. Together, we'll learn more about those things and talk a bit about how you might put them into action and include them in your recovery plan.

Sample Strengths Questions

Hopes & Dreams: If you had a magic wand and could do or be anything, what would you wish for? If you could design the "perfect day" what would it look like?

Personal Strengths: What are you most proud of in your life? What was the best compliment you ever received? What do people like best about you?

Interests and Activities: What kinds of hobbies do you have – now or in the past?

- ***Relationships***: Who do you count on when things get tough and who counts on YOU?
- ***Open Ended Statements:***
  - My best qualities as a person are…
  - Something I would not change about myself is…
  - My sense of humor is…
  - The times I am most at peace are when…
  - People like that I am…
  - I feel really good about myself when…
  - The best compliment I ever received was when...
  - When I was little, I wanted to be a ?? When grew up?

Discovering Our Strengths

Working in pairs:

- Take turns interviewing each other for 5 minutes using these sample strengths-based questions
- Feel free ask follow-up questions to learn more about your partner's strengths.

Report Out:

- What did it feel like to be asked these kinds of questions?
- What was challenging about answering them?
- How might you ask these questions in a better way? What else might you ask?
- What did you learn from this exercise?

But what if a person isn't engaged or can't identify a goal or strengths?

- Not all people can easily articulate personal goals/desired results; The language of goals and goal-setting can be intimidating!
- Different ways of asking the question – what was YOUR favorite?
- Goals often unfold through reflective listening; it takes time and a trusting relationship
- It's OK to make a suggestion to get the ball rolling!
- 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?
- Who ELSE is in the person's life who might have ideas for you? Circles of Support!

If things were going well, how would life look for you?

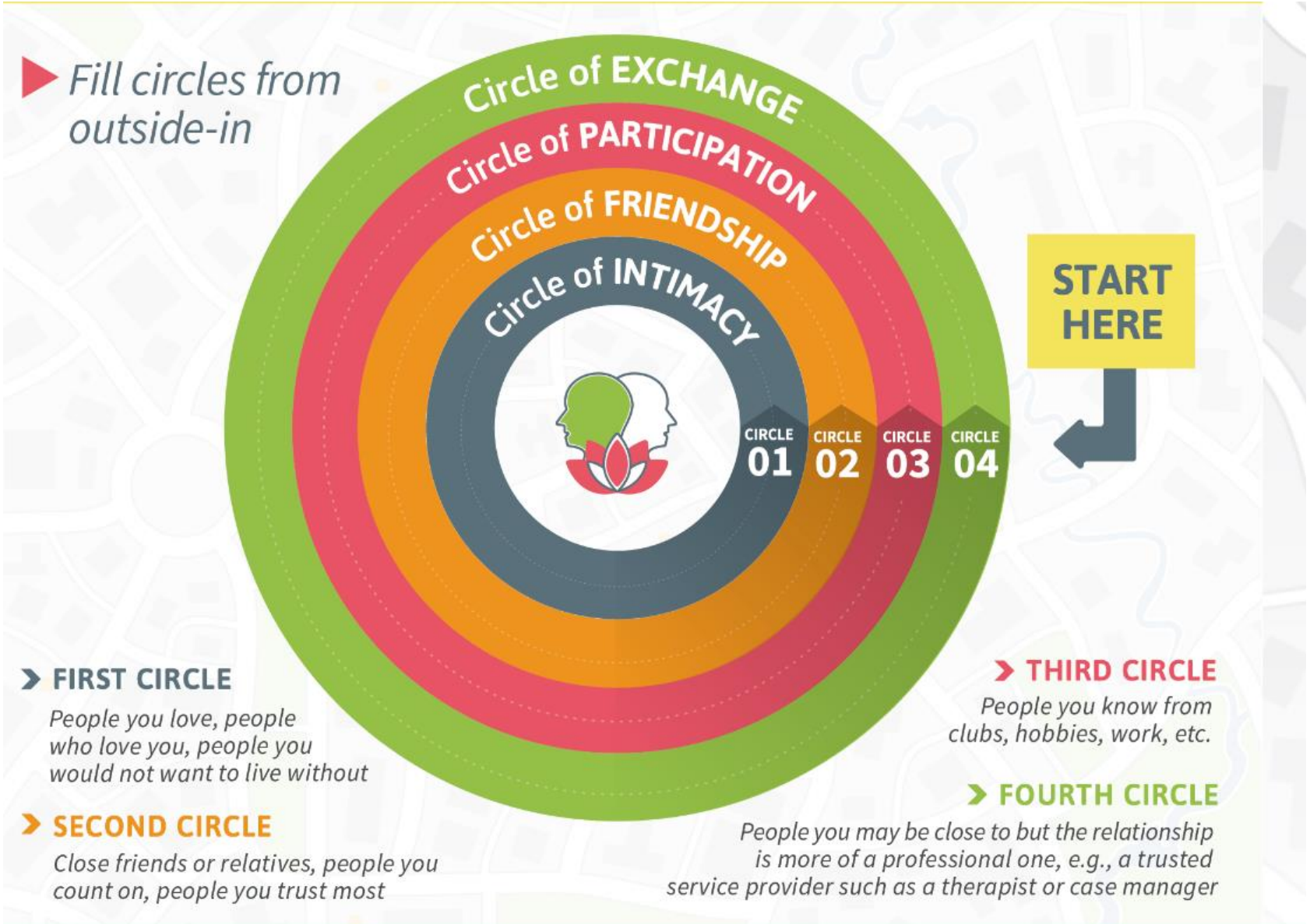
Conversations About Goals

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

Cultivate a Circle of Support

- Personal/natural connections are often our key to feeling safe and at ease
- Circles of support help decrease isolation and loneliness
- Balancing the PCCP Team with professional/natural supporters can be helpful
- Circles can become a group of people who agree to meet on a regular basis to you plan to reach your goals
- If a natural supporter is invited to be involved, be clear with each person about what you hope they will do, and will NOT do

Circles of Support

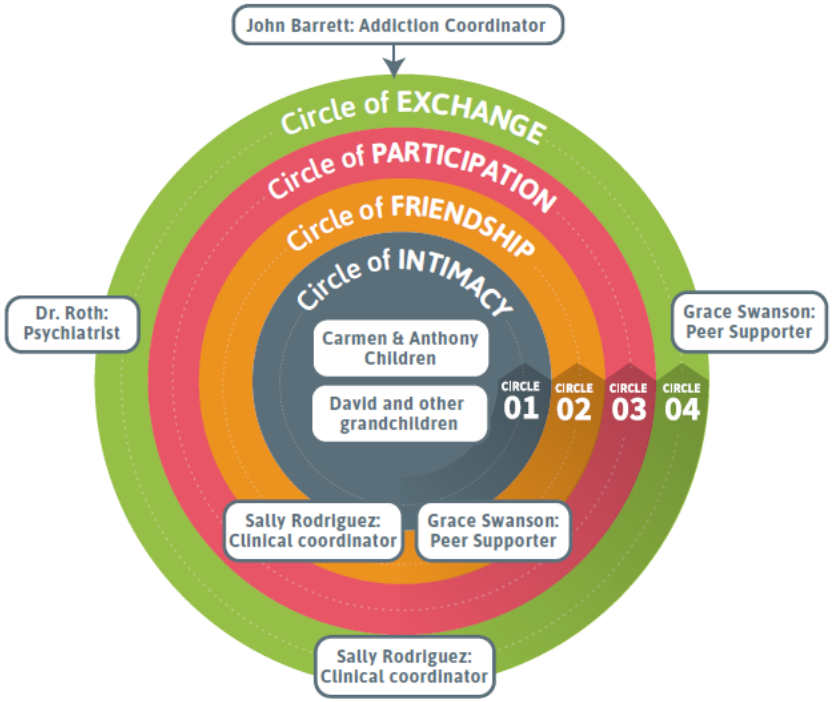


Julie's Circle of Support

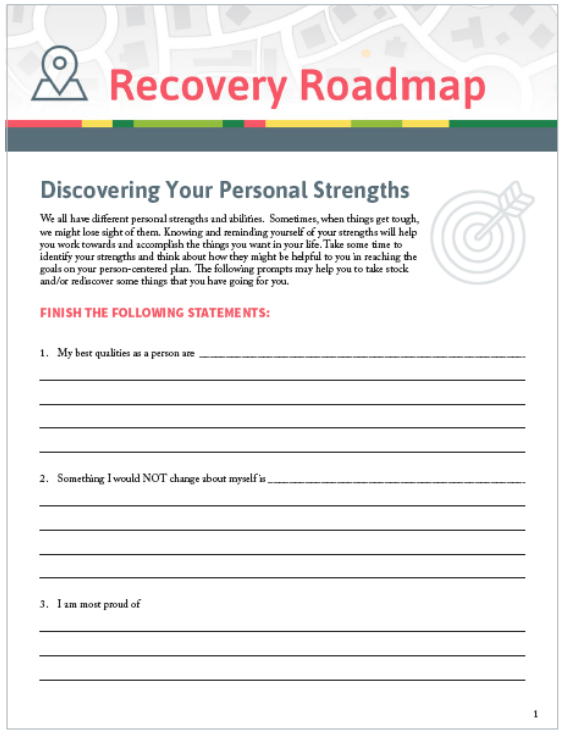
JULIE'S SAMPLE CIRCLE OF SUPPORT

- **Circle 1/Intimacy:** People Julie loves who she would not want to live without
- **Circle 2/Friendship:** Friends, relatives or other people you can count on; people you trust most
- **Circle 3/Participation:** People Julie might know from hobbies, clubs, or her neighborhood
- **Circle 4/Exchange:** People Julie is be close to but who she is in a professional relationship with

Start at the outside and work your way in. People can also be in more than one circle at a time. For example, Julie has included Grace and Sally in Circle 4 as they are her professional service providers; however, she trusts them and is very close to them so Julie has also noted them in Circle 2.



Sample Tools For Building Strengths and Identifying Goals



Recovery Roadmap

Discovering Your Personal Strengths

We all have different personal strengths and abilities. Sometimes, when things get tough, we might lose sight of them. Knowing and reminding yourself of your strengths will help you work towards and accomplish the things you want in your life. Take some time to identify your strengths and think about how they might be helpful to you in reaching the goals on your person-centered plan. The following prompts may help you to take stock and/or rediscover some things that you have going for you.

FINISH THE FOLLOWING STATEMENTS:

1. My best qualities as a person are _____

2. Something I would NOT change about myself is _____

3. I am most proud of

1

Setting Goals: The following ideas might help you

State each goal as a positive statement

Express your goals positively—"Have enough energy to take care of my daughter" can be more motivating than a goal of "Be less depressed."

Dream big and break it down

It is important for all of us to allow ourselves to dream. Dreams give us hope, and hope fuels our recovery. But dreams don't happen overnight. It takes hard work, time, planning, and achieving short-term objectives to make it to the end result. Break big goals into smaller ones, and dive in one step at a time.

Stay positive with yourself

Sometimes as we are working toward a goal, unexpected things may happen. We might lose sight of our goal and get off track. We might find that this goal is not what we really wanted after all. We are allowed to make mistakes and change our minds about goals. Running into problems may not always feel good, but it allows you to learn more about what is important to you. Ask yourself: What about that goal wasn't working? What changes can I make? What supports do I need if/when I try again? What is my plan?

Be true to yourself

A goal is based on your hopes and dreams, and not those of others (like parents, society, or even your providers). Sometimes people can have strong opinions and push their ideas of what they think your goals should be onto you. It's ok to listen, but be sure that your goals reflect what you want to achieve.

Set priorities

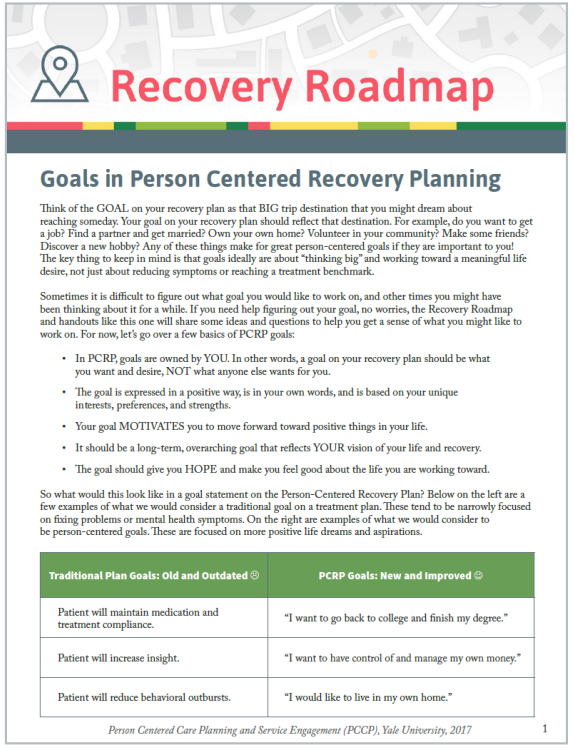
When you have several goals, decide which are the most important ones and which can wait. This helps you focus on the most important things in your life. Don't try to tackle too much at one time!

Believe in yourself

Believing in yourself and having the hope that you will achieve the goals you set is half of the battle. You are the expert in your life and your recovery.

Write goals down

This can make them more real and can give them more weight and meaning. Organize your thoughts ahead of time and be firm with your team about what is most important to you.



Recovery Roadmap

Goals in Person Centered Recovery Planning

Think of the GOAL on your recovery plan as that BIG trip destination that you might dream about reaching someday. Your goal on your recovery plan should reflect that destination. For example, do you want to get a job? Find a partner and get married? Own your own home? Volunteer in your community? Make some friends? Discover a new hobby? Any of these things make for great person-centered goals if they are important to you! The key thing to keep in mind is that goals ideally are about "thinking big" and working toward a meaningful life desire, not just about reducing symptoms or reaching a treatment benchmark.

Sometimes it is difficult to figure out what goal you would like to work on, and other times you might have been thinking about it for a while. If you need help figuring out your goal, no worries, the Recovery Roadmap and handouts like this one will share some ideas and questions to help you get a sense of what you might like to work on. For now, let's go over a few basics of PCRP goals:

- In PCRP, goals are owned by YOU. In other words, a goal on your recovery plan should be what you want and desire, NOT what anyone else wants for you.
- The goal is expressed in a positive way, is in your own words, and is based on your unique interests, preferences, and strengths.
- Your goal MOTIVATES you to move forward toward positive things in your life.
- It should be a long-term, overarching goal that reflects YOUR vision of your life and recovery.
- The goal should give you HOPE and make you feel good about the life you are working toward.

So what would this look like in a goal statement on the Person-Centered Recovery Plan? Below on the left are a few examples of what we would consider a traditional goal on a treatment plan. These tend to be narrowly focused on fixing problems or mental health symptoms. On the right are examples of what we would consider to be person-centered goals. These are focused on more positive life dreams and aspirations.

Traditional Plan Goals: Old and Outdated ☹	PCRP Goals: New and Improved ☺
Patient will maintain medication and treatment compliance.	"I want to go back to college and finish my degree."
Patient will increase insight.	"I want to have control of and manage my own money."
Patient will reduce behavioral outbursts.	"I would like to live in my own home."

Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017 1

Start with What People ALREADY Know Works for Them

There are <u>many</u> PCP models and tools to support a PC vision!

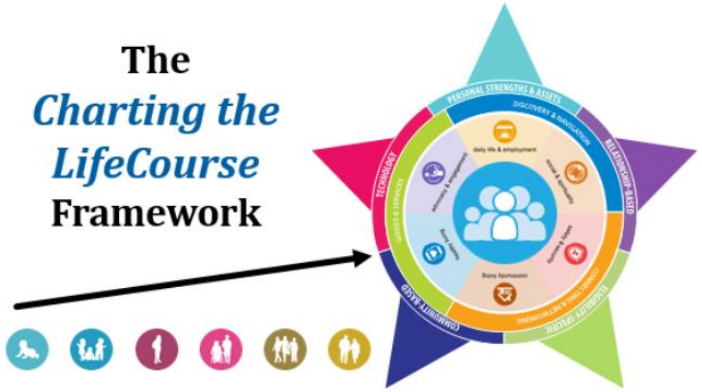
Use the ones that work best for YOU and the person/ family you are supporting ☺

[See Appendix B of the NCAPPS Core Competencies in PCP Resource]

the tools listed here.

Domain	Tools*
A: Strengths-Based, Culturally Informed, Whole Person–Focused	• Life Trajectory[4] • Life Domain Vision Tool[1] • Family Vision Planning[1] • Good Day/Bad Day[2] • Relationship mapping[2] • Gifts and Capacities[3] • Important to/Important for[2,3] • One-Page Profile[2,3] • Community Mapping[3] • Presence to Contribution[3] • Circle of Health Personal Health Inventory[4,5] • Recovery Roadmap: Strengths-based Person-Centered Inquiry[4] • Wellness Recovery Action Planning (WRAP)[5] • Wheel of Life/Plan-Do-Review[6] • Personal Medicine Model/Tools[9] • Tools for Transformation Series: Person First Assessment and Person Directed Planning[13]
B: Cultivating Connections Inside the System and Out	• Integrated Support Star[1] • Reciprocal Roles[1] • Presence to Contribution[3] • Community Mapping[3] • Community Inclusion tools[10] • Jump-Starting Community Inclusion: A Toolkit for Promoting Participation in Community Life[11]
C: Rights, Choice, and Control	• Integrated Support Star for Supported Decision Making[1] • Decision making profile[3] • Decision making agreement[3]

Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan



Beware the OPPOSITE problem… The person HAS goals but we fear they are “Unrealistic”

Vintage Pat Deegan on “Unrealistic Goals”

Julie’s Team PCP Meeting: What is on/off track?

- Julie's recovery team has gathered at the mental health center for Julie's PCP meeting. Sally, Julie's clinical coordinator, has welcomed everyone and all team members introduced themselves. Prior to the meeting, Julie told Sally that she would be most comfortable if Sally took the lead in guiding the conversation throughout.

- As you watch the video, be on the lookout for…
  - some person-centered things the team does really well together
  - and some moments where they maybe (Ok, definitely ☺) get “off track”

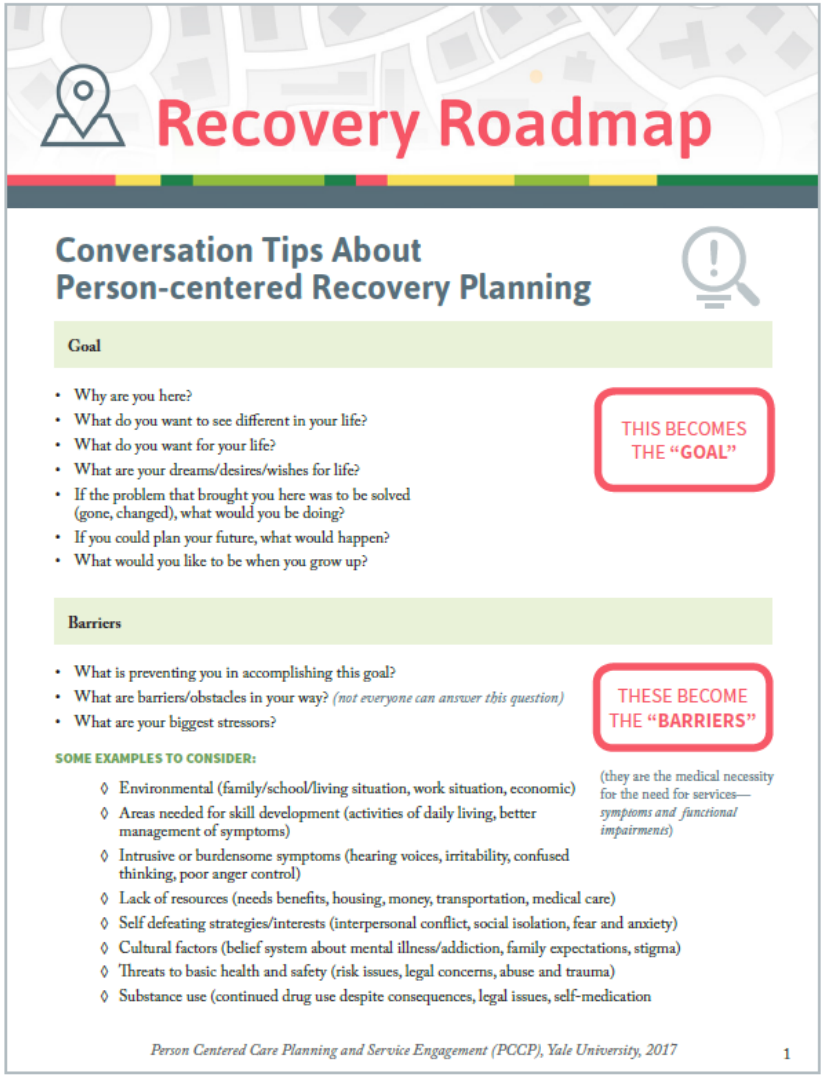
Gathering Input to DIRECTLY Inform the Plan

Life Domains Assessed during Development of Person-Centered Plan:

Daily Life and Employment What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.	**Community Living** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
Safety and Security Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.	**Healthy Living** Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition
Social and Spirituality Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.	**Citizenship and Advocacy** Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

What do you want to work on? What would you like to accomplish?
Using the assessment of the Life Domains, use this information to determine what is most important to the individual right now? What is their vision of a good life?
What strengths do you currently have?
These are the individualized, personal attributes, gifts, and skills a person possesses. Avoid what makes a "good client". Good examples: good sense of humor, artistic, knowledgeable about gardening, good soccer player, stylish. Avoid: shows up for appointments, takes medications as prescribed, smiles a lot, follows directions.
What are the obstacles to meeting your goals?
Help the individual identify the things that are getting in the way of meeting their goals and the resources they need to meet their goals.

-8-



Recovery Roadmap

Conversation Tips About Person-centered Recovery Planning

Goal

- Why are you here?
- What do you want to see different in your life?
- What do you want for your life?
- What are your dreams/desires/wishes for life?
- If the problem that brought you here was to be solved (gone, changed), what would you be doing?
- If you could plan your future, what would happen?
- What would you like to be when you grow up?

THIS BECOMES THE "GOAL"

Barriers

- What is preventing you in accomplishing this goal?
- What are barriers/obstacles in your way? *(not everyone can answer this question)*
- What are your biggest stressors?

THESE BECOME THE "BARRIERS"

SOME EXAMPLES TO CONSIDER:

- ◊ Environmental (family/school/living situation, work situation, economic)
- ◊ Areas needed for skill development (activities of daily living, better management of symptoms)
- ◊ Intrusive or burdensome symptoms (hearing voices, irritability, confused thinking, poor anger control)
- ◊ Lack of resources (needs benefits, housing, money, transportation, medical care)
- ◊ Self defeating strategies/interests (interpersonal conflict, social isolation, fear and anxiety)
- ◊ Cultural factors (belief system about mental illness/addiction, family expectations, stigma)
- ◊ Threats to basic health and safety (risk issues, legal concerns, abuse and trauma)
- ◊ Substance use (continued drug use despite consequences, legal issues, self-medication

(they are the medical necessity for the need for services—*symptoms and functional impairments*)

Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017

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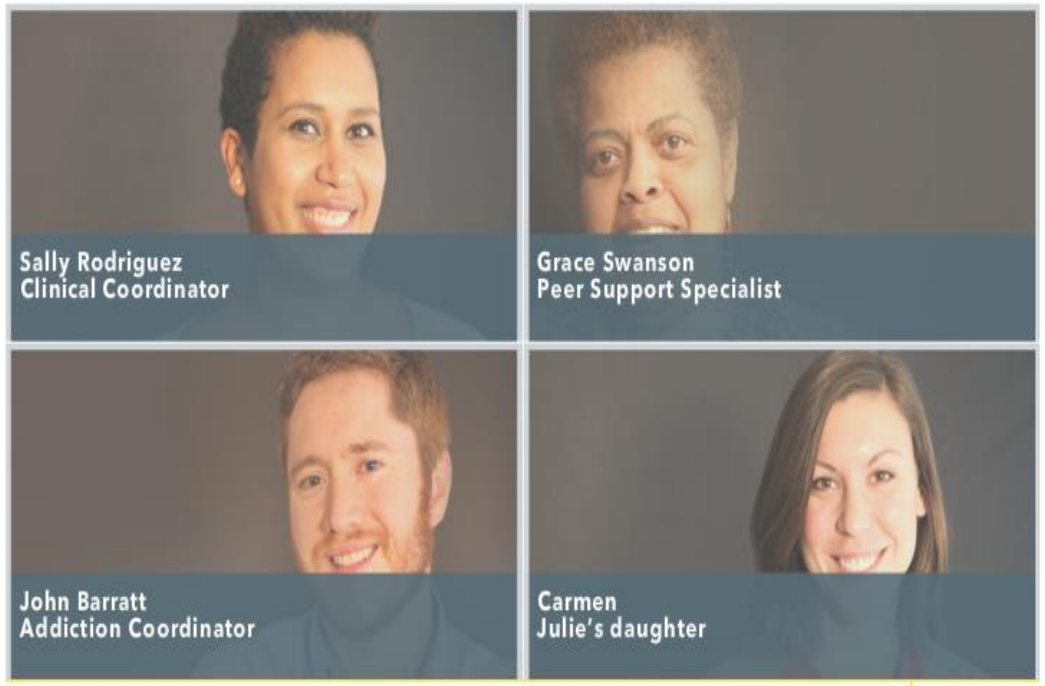
Julie’s PCP Meeting

- Remember, Julie has already spent some time in advance of her meeting identifying her strengths and goals with the help of Grace, her Peer Specialist.
- She has also identified the people she would like to be part of her recovery team, and they have agreed to participate.



Julie’s PCP Meeting

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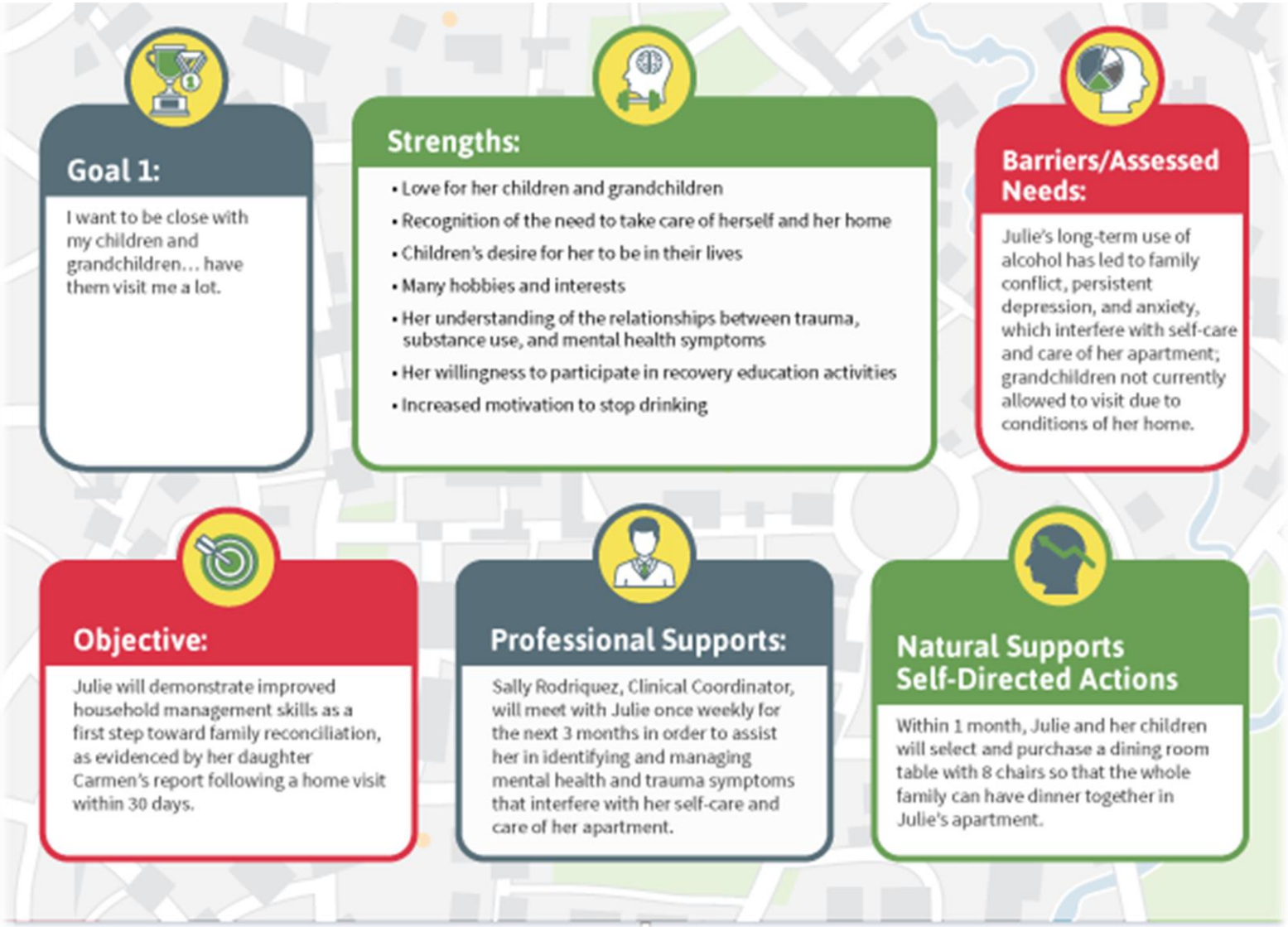
Julie's PCP Meeting: What Do You Think Went WELL?

- Sally explained the ground rules for the meeting and discussed its purpose and agenda.
- Sally turned the floor over to Julie at the start of the meeting so that Julie could share the ideas she had about her plan.
- Sally redirected John when he interrupted and when he talked "about" instead of "to" Julie.
- Grace noticed Julie's discomfort about the medication discussion and encouraged her to speak up. Is this something you would feel comfortable doing as a PSS?
- Julie realized the link between getting her apartment under control and her relationship with her family when Carmen noted that her children were unsafe there.
- Carmen introduced the idea of Julie spending time with her grandson in a different environment that builds on one of their shared strengths and interests, i.e., their love of animals.

Julie's PCP Meeting: And where did things get "off track?"

- John talked "about" Julie, instead of "to" her.
- John interrupted to conversation to push the medication agenda. and agenda. John stated that he and Dr. Roth developed a plan for Julie's medication (without involving her).
- John explained the need for Antabuse in a way that was judgmental: "You've been down this road before and nothing seems to have worked."
- John missed an opportunity to use his clinical skills and knowledge in a person-centered way. Instead of disregarding Julie's concerns, he could have educated her about the potential risks and benefits of Antabuse, and supported her in weighing those and arriving at her own informed decision.

And how does this PCP meeting inform the plan?



PCP RESOURCES

ENGAGING PEOPLE WHO RECEIVE SERVICES

A Best Practice Guide

August 2020

LINK

FIVE COMPETENCY DOMAINS FOR STAFF WHO FACILITATE PERSON CENTERED PLANNING

November 2020

LINK

NORTH CAROLINA DHHS PERSON-CENTERED PLANNING GUIDANCE DOCUMENT

LINK

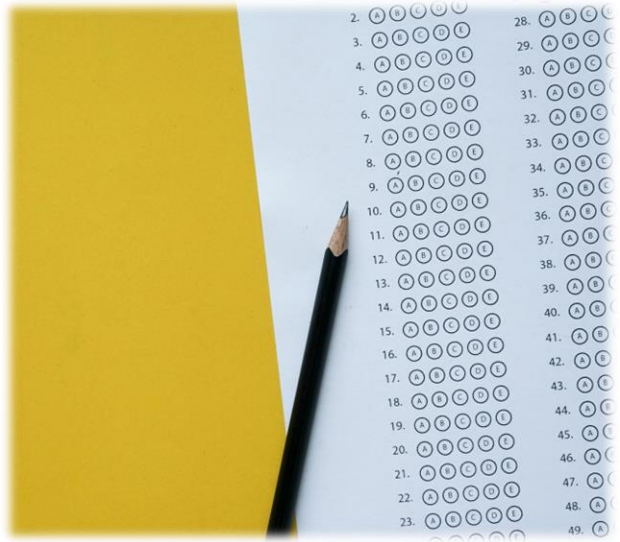
SAMHSA Issue Brief for SMHAs on Person-Centered Planning

LINK

You are also welcome to email janis.tondora@yale.edu to request these resources

Training Evaluation & Certificates

- In order to receive credit for this training, a brief training evaluation is required.
- Your feedback also helps US to continuously improve our training and outreach.
- A link to the evaluation is available through this QR code. The same link has also been sent to the e-mail you used to register, along with a copy of today's slides - Check your inbox ☺
- Expect your Certificate by email within approximately 2-4 weeks of completing your evaluation.
- Please check junk/spam mail prior to reaching out.



Bright Ideas & Next Steps…

What are some of your ideas of what you might do to further implement PCP moving forward?

- What is one specific action (under YOUR control) that you might try? A new habit/practice you might implement?
- What is one specific action your AGENCY could take to better align with and promote PCP?
- It is YOUR choice – try whatever feels right for YOU!

Closing Q & A… Your Thoughts and Ideas

For more information:

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