So what is *Person-Centered Planning*?

**Off the top of your head...**

- Imagine you are out to dinner last night with a group of friends.
- You tell them you have to head home because you have a work training tomorrow on person-centered planning.
- They respond: “*Sounds kind of interesting, so what is exactly IS person-centered planning?*”

- Please take a minute to write down 1-2 sentences that you might say to describe what it means to offer person-centered care:
  - Find a partner... swap answers.
  - Then find another partner...Repeat.
  - *It's OK to venture a wild guess 😊*
Learning Objectives

Participants will...

• be able to describe concrete, practical strategies that exemplify person-centeredness in collaborative recovery planning meetings.

• increase understanding and practice a logic model for the documentation of comprehensive Recovery Plans (e.g., goals, objectives, strengths and assessed needs, and interventions).

• be able to identify a minimum of 3 common Person Centered Recovery Planning implementation concerns and possible recovery-oriented responses.
And how we plan to achieve them...

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9:00 to 9:45</td>
<td>Introductions/Overview/ Warm-up Exercise</td>
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<tr>
<td>9:45 to 10:45</td>
<td>Recovery Context, Common Concerns, and PCCP process Language Exercise</td>
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<tr>
<td>10:45 to 11:00</td>
<td>Break</td>
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<tr>
<td>11:00 to 12:00</td>
<td>Logic Model/Nuts and Bolts of Documentation – Part I</td>
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<tr>
<td>12:00 to 1:00</td>
<td>Lunch</td>
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<tr>
<td>1:00 to 1:45</td>
<td>Roberto Small Group Exercise Part I: Interpretive Summary &amp; GOAL</td>
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<tr>
<td>1:45 to 2:30</td>
<td>Logic Model II: Recovery-Based Objectives/Interventions</td>
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<tr>
<td>2:30 to 3:45</td>
<td>Roberto Small Group Exercise Part II: +/-, 1 objective, set of interventions; “Self-Directed Break”</td>
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<tr>
<td>3:45 to 4:30</td>
<td>Present summary and plans in large group; Closing Q&amp;A</td>
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<tr>
<td>What we hope for THEM…</td>
<td>What we value for US…</td>
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<tr>
<td>------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>✓ Compliance with treatment</td>
<td>✓ Life worth living</td>
</tr>
<tr>
<td>✓ Decreased symptoms/Clinical stability</td>
<td>✓ A spiritual connection to God/others/self</td>
</tr>
<tr>
<td>✓ Better judgment</td>
<td>✓ A real job, financial independence</td>
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<tr>
<td>✓ Increased Insight…Accepts illness</td>
<td>✓ Being a good mom…dad…daughter</td>
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<tr>
<td>✓ Follows team’s recommendations</td>
<td>✓ Friends</td>
</tr>
<tr>
<td>✓ Decreased hospitalization</td>
<td>✓ Fun</td>
</tr>
<tr>
<td>✓ Abstinent</td>
<td>✓ Nature</td>
</tr>
<tr>
<td>✓ Motivated</td>
<td>✓ Music</td>
</tr>
<tr>
<td>✓ Increased functioning</td>
<td>✓ Pets</td>
</tr>
<tr>
<td>✓ Residential Stability</td>
<td>✓ A home to call my own</td>
</tr>
<tr>
<td>✓ Healthy relationships/socialization</td>
<td>✓ Love…intimacy…sex</td>
</tr>
<tr>
<td>✓ Use services regularly/engagement</td>
<td>✓ Having hope for the future</td>
</tr>
<tr>
<td>✓ Cognitive functioning</td>
<td>✓ Joy</td>
</tr>
<tr>
<td>✓ Realistic expectations</td>
<td>✓ Giving back…being needed</td>
</tr>
<tr>
<td>✓ Attends the job program/clubhouse, etc.</td>
<td>✓ Learning</td>
</tr>
</tbody>
</table>
Beyond US and THEM

- People with mental health and addictions issues generally want the exact same things in life as ALL people.

- People want to thrive, not just survive...

- Recovery-oriented care challenges us to move past the maintenance of clinical stability to the true pursuit of RECOVERY!
Recovery...a fuzzy concept

• Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what “It” is and what “It” might look in practice.

• Tondora et al., 2005, Implementation of Person-Centered Care and Planning: How Philosophy Can Inform Practice
A Simple Way to Think About It

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

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

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

- *https://youtu.be/IuNYB9Prnk0*
The Person-Centered Train: Who’s on Board?
Even though state and local agencies often include consumers and other advocates in care planning, they often allow them to have only a marginal role and fail to provide important information that could enable them to participate fully and effectively.

Bazelon Center, 2008
...there’s still a gap

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

Person in Recovery as Quoted in CT DMHAS Recovery Practice Guidelines, 2005
What exactly is PCRP?

- Person-centered planning
  - is a **collaborative process** resulting in a recovery oriented care plan
  - is directed by persons in recovery in **partnership with care providers** and natural supporters
  - is reflected in the **co-created written Recovery Plan** which outlines the person’s most valued recovery goals and how all will work together to achieve them
A few words about what PCRP is **NOT**...

- PCP is **NOT**
  - ...“anti-clinical/anti-tx”; invalidating of professional expertise
  - ...reserved for those who are “high functioning” or well on their way to recovery. It applies universally across all service populations but application of specific PCP practices may look different in different treatment settings, e.g., MH versus SA, inpatient versus outpatient, adult versus child, mandated versus voluntary, etc.
  - ...incompatible with the concept of medical necessity required in clinical documentation
  - ...business as usual
If the person is in the driver’s seat of their care, where does that leave us?

- PCP is based on a model of PARTNERSHIP...
- Respects the person’s right to be in the driver’s seat but also recognizes the value of professional co-pilot(s) and natural supporters
How can planning still be “person-centered” when there is disagreement between provider & client or limited participation by the person?

How will a plan look when collaboration is limited?

Keep this in mind as we go over specific PCRP practices!
Person-centered care does **NOT** require that the provider always agree with the person in recovery or that differences in viewpoint, opinion or recommendations should be avoided at all costs.
Aren’t we already doing it?

In some ways, YES, but, it is also different...

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

Person-Centered Care Questionnaire: Tondora & Miller 2009
Can we **balance** the spirit of person-centered care with the rigor required in clinical documentation?
A Preview: Meet Mr. Gonzalez

- 31-year-old married Puerto Rican man, father to 2 boys
- Living with bipolar disorder and co-occurring ETOH addiction abuse
- Relies on ETOH as coping mechanism
- Recent violence in home during manic episode - knocked his wife down in presence of boys - prompted domestic disturbance call, psych eval, and emergency admission
- Following hospitalization, wife remains supportive/open to reconciliation but Mr. G not allowed to return home until he “gets control of himself”
- Mr. G tells outpatient clinician at CMHC that his love for his family and his faith in God are the only things that keep him going
- He wants to be able to reunite with his family and be a good role model for his sons.
- He feels that the only person who understands him is the Center Peer Specialist with whom he has a close relationship.
Goal(s):

- Achieve and maintain clinical stability; reduce assaultive behavior; comply with medications; achieve abstinence

Objective(s):

- Patient will attend all scheduled groups in program; patient will meet with psychiatrist and take all meds as prescribed; patient will complete anger management program; patient will demonstrate increased insight re: clinical symptoms; patient 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; Psychologist will provide individual therapy
I’m here to return YOUR goals. You left them on MY recovery plan!

- Comply with meds
- Stop drinking
- Reduce aggressive behavior
- Increase insight
**Recovery Goal:**
*I want my family back.*
*I don’t ever want the boys to be afraid of me.*

**Strengths to Draw Upon:**
Devoted father; motivated for change; supportive wife; Catholic faith and prayer are source of strength/comfort; positive connection to Center Peer Specialist; intelligent

**Barriers Which Interfere:**
Acute symptoms of mania led to violence in the home; lack of coping strategies to manage distress from symptoms; abuse of alcohol escalates behavioral problems
Sample Short-Term Objective(s)

Within 30 days, Mr. Gonzalez will have a minimum of two successful visits* with wife and children as reported by Mrs. Gonzalez in family therapy sessions.

Services & Other Action Steps
- Center doc/APRN to provide med management to reduce irritability & acute manic sx 1x per month for 3 mos
- Psychologist to provide family therapy sessions to discuss Mrs. Gonzalez’s expectations and feelings re: future reunification every 2 weeks for 3 mos
- Addictions Specialist to provide Relapse Prevention training weekly to teach/coach skills that will increase understanding of role of drinking in family conflict and build skills to decrease use of alcohol
- Center chaplain/local minister to promote use of faith/daily prayer as a positive coping strategy to manage distress 1x p/w
- Peer Specialist to promote daily wellness through the use of creating a Wellness Recovery Action Plan and self-directed strategies 2x p/w
A Hopeful Proposition…

• We can **balance** person-centered approaches with medical necessity/regulations in creative ways to **move forward in partnership** with persons in recovery.

• We can create a plan that honors the person and satisfies the chart!

• In other words: **PCP is not soft!**
Person-centered does NOT = “soft”
Maintaining the Golden Thread of Medical Necessity

**Goal**
- Person directed/own words
- Big picture/life role
- Clinician can add clarifying statement as needed to show link between life goal and treatment goal

**Objective**
- Written to overcome documented MH Barriers which interfere with goal
- and to address symptoms/functional impairments as a result of diagnosis
- Reflect a change in behavior/status/level of functioning; 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
Sample Key Practices in the Process of PCP

• Person is a partner in all planning activities/meetings; advance notice
• Person has reasonable control over logistics (e.g., time, invitees, etc.)
• Person offered a written copy
• Education/preparation regarding the process and what to expect
• Meeting ground-rules may shift
• Strengths-based assessment and language as a key practice
• Recognize the range of contributors to the planning process (e.g., peers, natural supporters).
• Value community inclusion
  • “While,” not “after”
• Trap of the one-stop shop
• Understand/support rights such as self-determination (e.g., role of advance directives; WRAP, etc.)
This toolkit can be useful for anyone – regardless of whether they have a psychiatric condition or an addiction. Everyone needs help at times setting goals, and figuring out what they want. This toolkit has some specific parts that are helpful to people with a mental illness or addiction, but could be really used by anyone.

-Janis Tondora
-Rebecca Miller
-Kimberly Guy
-Stephanie Lanteri

Yale Program for Recovery and Community Health, © 2009

http://www.yale.edu/PRCH/documents/toolkit.draft.3.5.11.pdf
Practical Tips for 1:1 or Team Planning Meetings

- Spatial set up of the room speaks volumes

- Team members arrive on time; introductions

- A range of contributors are involved in the planning process (e.g., peers, natural supporters, other community providers).

- The person is given your/the team’s full attention, e.g., cell phones are turned off; there are no side-bar conversations; team member’s are not completing/reading other paperwork/texting/responding to e-mail, etc.

- The person is not “talked about” during the meeting as if they are not there.

- “What comes next” is explained to the person, including an opportunity for them to review the plan; provide input
PCP Shifts in PROCESS:

*I’m on the Team!!*
For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

In the last 18 months, Sandra has worked with her M.D. to find meds that are highly effective for her. She has been active in activities at the clinic and the social club. Sandra and her Team all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. People have become concerned as she has been missed at several activities, including a bloodwork appointment at today’s clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.
What next?

So you try your best to implement ALL of these “key practices,” but how do we move from the PROCESS of PCRP to the DOCUMENTATION of PCRP?
Building the Plan

Adams and Grieder, 2014, Treatment Planning for Person-Centered Care
Role of Assessment

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

• Should gather information across life domains to determine eligibility, extent of needs, and direction of

• What’s different about person-centered assessment? What requires special emphasis?
  • Role of culture in treatment and life goals
  • Strengths and interests
  • Stage of change
PCCP and Cultural Sensitivity

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

• Solutions to any problem are to be sought within individuals, their families (however they define them), and their cultures.

Multicultural Principles of Psychiatric Rehabilitation, (USPRA, 2008)
Individualism or Collectivism?

“I”
“WESTERN ETHNOS”

• Focus on the person’s agenda
• Relationship as equal
• Must not give advice
• Client is responsible for his or her own destiny

(“I”)
(Nangalia and Nangalia, 2010)

“We”
“EASTERN ETHNOS”

• Hierarchy governs personal relationships
• Family /communal obligations
• Respect for age
• Collectivism
• Trust
• Hospitality
## Stages of Recovery and Treatment

<table>
<thead>
<tr>
<th>Ohio</th>
<th>Village</th>
<th>Prochaska &amp; DiClemente</th>
<th>Stage of Treatment</th>
<th>Treatment Focus</th>
</tr>
</thead>
</table>
| Dependent/unaware         | High risk/Unidentified or Unengaged    | Pre-contemplation      | Engagement         | • outreach  
                          |                                         |                        | • practical help                | • crisis                         |
|                           |                                        |                        |                    | • intervention                     | • relationship                  |
|                           |                                        |                        |                    | • building                         |                                |
| Dependent/aware           | Poorly coping/Engaged/not self-directed| Contemplation/preparation | Persuasion         | • psycho-education                  | • set goals                    |
|                           |                                        |                        |                    | • build awareness                   |                                |
| Independent/aware         | Coping/Self responsible                | Action                 | Active Treatment   | • counseling                        | • skills training              |
|                           |                                        |                        |                    | • self-help groups                  |                                |
| Interdependent aware      | Graduated or Discharged                | Maintenance            | Relapse Prevention | • prevention plan                   | • skills training              |
|                           |                                        |                        |                    | • expand recovery                   |                                |
Strengths Perspective

“It’s about what’s STRONG, not about what’s WRONG! “

• Gina, a former patient at a state psychiatric hospital
Diversity of Strengths

- Identified by the person, the provider, and also natural supporters/collaterals where appropriate
  - Motivated to change
  - Has a support system – friends, family
  - Employed/does volunteer work
  - Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
  - Intelligent, artistic, musical, good at sports
  - Has knowledge of his/her disease
  - Sees value in taking medications
  - Spirituality/connected to church
  - Good physical health
  - Adaptive coping skills
  - Capable of independent living
O: Poor eye contact, unresponsive to social cues, preoccupation with parts of things.

A: R/O 299.80 Asperger’s

P: Encourage client to explore part-time employment opportunities such as lawnmower repair or animal grooming.
Don’t Let Strengths Sit on a Shelf!
Importance of Understanding

Integration/Formulation/understanding is essential

- DATA ALONE IS NOT ENOUGH; put pieces together
- Requires skill, experience and judgment
- Moves from “what” (data) to “what does this mean and how do we use it?”
- Sets the stage for prioritizing needs and goals
- The role of culture and ethnicity is critical to true appreciation of the person served
- Understanding is **shared** to promote healing and partnership
Integrated Summary Outline

• Identity
• Explanation of Illness/presenting issues
• Stage of Change
• BioPsychosocial Environment
• Strengths, Preferences and Priorities
• Summary of Priority Needs/Barriers to Goal Attainment
• Hypothesis
Hypothesis

• Conclusion to the narrative summary
• Helps **prioritize and sequence** services to fit the individual’s unique needs
• **Best guess** about what’s going on
• **Identifies important information that is not known**
  • Important for dual diagnosis or when multiple factors are present
  • Example: “It’s not clear whether irritability and aggression are caused by substance use, manic symptoms or a combination of both.”
An Example...

• Assessment data may have multiple references to a person not using medication effectively. The summary notes: “long history of medication non-compliance in the community has led to repeated hospitalizations”

• This is NOT a formulation but rather, a re-stating of the data/facts
  • The task in formulation is to try to understand **WHY** the person is not using meds effectively as a tool in his/her recovery
  • This formulation/understanding may take the plan in very different directions.
Developing Goals and a Vision

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

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

[Diagram showing various elements such as faith, self-help, social support, family, housing, work or school, treatment & rehabilitation, and belonging]
Goal Setting:
Keep in Mind the WHOLE PERSON

Video clip...The Gestalt Project

http://www.youtube.com/watch?v=QficvVNIxTI&feature=youtu.be
Questions for Consideration

- What stood out for you in the clip and why?
- How did you feel emotionally MID-WAY through the clip? How did you feel at the end?
- What did you learn? And how might this relate to person-centered recovery planning?
- What if YOU were defined largely by ONE part of yourself – a part you really struggle with...maybe an illness, maybe a difficult experience in your life. What if that was what others focused on most all the time? What would that be like?
- Are these the types of “stories” of the whole person that you tend to know about people you serve? How can we use a person-centered approach to know people in different kinds of ways?
Goals

- Long term, global, and broadly stated
- Life changes as a result of services
- Ideally expressed in person’s own words
- Written in positive terms
- Consistent with desire for self-determination
  - may be influenced by culture and tradition
- The goal becomes a shared vision of success & begins to envision an endpoint to services
What Do People Want?

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

To be part of the life of the community…
And NOT just traditional treatment plan goals...

- **Goal:**
  - Maintain psychiatric stability

- **Objectives**
  1. Compliance with meds
  2. Attend appointments with primary care provider
  3. Attend all psychiatric appointments as scheduled
Roberto Part I: Write Integrated Summary and Goal

- Let’s all look at the background assessment data for Roberto and work together in small groups/teams to assemble
  - an integrated summary OUTLINE and
  - ONE person-centered goal for/with him
- Record your team’s summary and plan on the templates provided
- Identify a spoke’s person (or people!) to share your work
- Check your work:
  - Is the summary complete, including a hypothesis? Is the goal in the person’s words?
Barriers/Assessed Needs

What’s getting in the way?

• need for skills development
• intrusive symptoms
• lack of resources
• need for assistance / support
• problems in behavior
• challenges in activities of daily living
• threats to basic health and safety
• challenges/needs as a result of a mental/alcohol and/or drug disorder
Short-term Objectives: What do they do?

- Take into account the culture of person served (what’s relevant)
- Divide larger goals into manageable steps of completion
- Become markers for assessing progress.
- 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?

• **S**imple or Specific
• **M**easurable
• **A**chievable
• **R**ealistic
• **T**ime-framed
Objectives should NOT Default to Service Participation

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

  "Wanda will voluntarily attend DBT group 2x weekly."

- Objectives are about what you hope will change for the person as a result of services. Ask yourself the question:

  As a result of attending DBT groups, how do you expect her behavior/quality of life/status to change in a measurable way?

  "Wanda will apply mindfulness techniques to reduce instances of self-injury to no more than one per week for 2 consecutive weeks."
BARRIER: pattern of job termination due to outbursts on job and inability to get along with co-workers

**LEARNING OBJECTIVE**

“Within 30 days, Amy will verbally identify issues that lead to job termination.

**BEHAVIORAL OBJECTIVE**

“Within 90 days, Amy will better manage conflict on the job as evidenced by an absence of conduct citations in the workplace.”
Objectives – Stage Responsive

- Client will decrease frequency & intensity of substance use.

- Measurable/Concrete:
  - 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)
Interventions: Action Steps

• *Actions* by staff, family, peers, other natural supports

• Specific to an objective

• Respect recovery choice and preference

• Specific to the stage of change/recovery

• Availability and accessibility of services may be impacted by cultural factors

• Describes medical necessity
Critical Elements

- Professional services must specify...
  - **WHO** will provide the service, i.e., name and job title
  - **WHAT**: The TITLE of the service, e.g., Health & Wellness Group
  - **WHEN**: The SCHEDULE of the service, i.e., the time and day(s)
  - **WHY**: The individualized INTENT/PURPOSE of service
Natural Support & Self-Directed Actions

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

Avoid Vague/General Statements:

Patient’s family will provide emotional support and encouragement...

Preferred: Be Specific:

“Wanda’s mother has agreed to call on Sunday evenings so Wanda has an opportunity to speak with her mom and children.”
### Natural Support & Self-Directed Actions

Self-directed interventions should not simply mirror other interventions on the plan. **Try to USE STRENGTHS HERE** and focus on the specific “value-added” tasks the person can pursue on their own.

<table>
<thead>
<tr>
<th>Avoid:</th>
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<tbody>
<tr>
<td>“attend DBT group”</td>
</tr>
<tr>
<td>“participate in discharge planning”</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Preferred:</th>
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<tbody>
<tr>
<td>“complete Diary Cards for at least of 15 minutes daily”</td>
</tr>
<tr>
<td>“call electric company within one week to determine status of bill and confirm utilities are still active at his apartment”</td>
</tr>
</tbody>
</table>
Example – Jane

• Jane comes to your program asking for referrals to income assistance programs and voc rehab. She lives with depression and anxiety. In the past, she has been overwhelmed by sadness and would drink to “numb-out”. Feeling much better, Jane wants to get back into the workforce. She occasionally experiences relapses, but finds that she gets back on her feet more quickly now.
  • **Goal:** I want to get back to work.
“I want to get back to work.”

• **Objective 1**
  - Jane will be clean and sober for three months as measured by self-report.
• **Interventions:**
  - Case Manager will refer Outpatient SA program within 30 days and coordinate care with twice monthly phone calls or e-mails thereafter.
  - Case Manager to complete My Ride application with client to ensure transportation is in place to attend SA treatment.
  - Sam Smith, Substance Abuse Coordinator, will provide dual recovery groups once per week for one year to Jane so she can learn the tools to stay clean.
  - Brenda Miller, Clinical Coordinator, will meet with Jane once per week for 3 months to provide individual counseling to increase her use of positive coping skills and decrease reliance on substances for stress management.
  - Jane will attend AA meetings 3 x per week for 3 months in order to develop a sober support system.
“I want to get back to work.”

- **Objective 2**
  - Jane will effectively demonstrate two stress reduction skills in the next 60 days.

- **Interventions**
  - Case Manager will facilitate connection to local peer program offering Mental Health peer support within 2 weeks.
  - Peer Coordinator will meet with Jane every other week in the community for 2 months to practice stress reduction skills.
  - Rehabilitation Coordinator will provide skills training on stress management one hour/once per week for 60 days.

- **Objective 3**
  - Jane will complete VR intake process within 4 weeks.

- **Interventions**
  - Case Manager will facilitate provide referral to local VR office within 2 weeks for the purpose of obtaining supported employment services. Following initial referral, CM will have once weekly phone contact with VR rep to monitor progress.
PCP Practice: Roberto’s Plan Part II

• Complete the template provided by developing
  • 1 goal: Strengths/barriers
  • 1 objective to help him move towards achieving his goal (overcoming one of his barriers); and a
  • Set of interventions/action steps (include professional, self-directed, and a natural support action)

• Check your work:
  • Is the goal in the person’s words?
  • Is the objective SMART? Does it go beyond service participation? Is it consistent with the person’s stage of change? Can it be linked back to a documented mental health/addictions barrier?

• Do your interventions:
  • Include all the W’s?
  • Are they consistent with the person’s stage of change?
  • Can they be linked back to the objective?
  • Did you include a self-directed and natural support action?
Change is coming (or here!)...
How can this initiative help your agency prepare and adapt?
Capturing New Ideas

Have an exciting idea for an action related to PCP?

Write on a notecard:
1. the idea
2. next action step (be specific)

BE BOLD!
In Conclusion...

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

- This is central in your partnership with individuals so you can help them move forward in their recovery!
For more information:

Janis Tondora:

janis.tondora@yale.edu