Person-Centered Planning: A Whole-Person Approach to Move Beyond Homelessness

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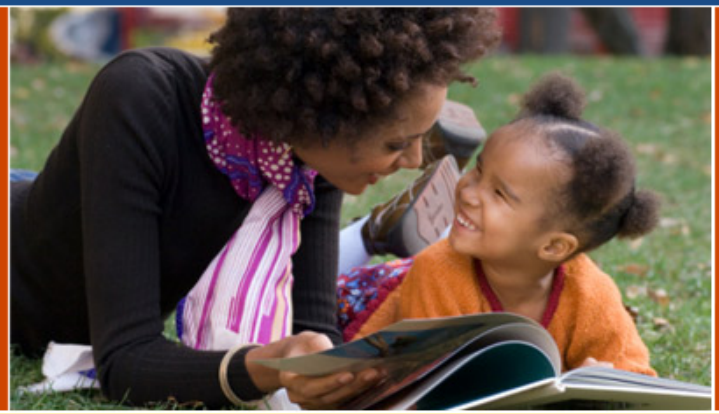
Annual Training Institute
Connecticut Coalition to End Homelessness
May 18, 2017

Introductions and Background

Yale School of Medicine | home | contact us | Enter keywords | Search

First you leap, then you grow wings.



yale program for recovery and community health

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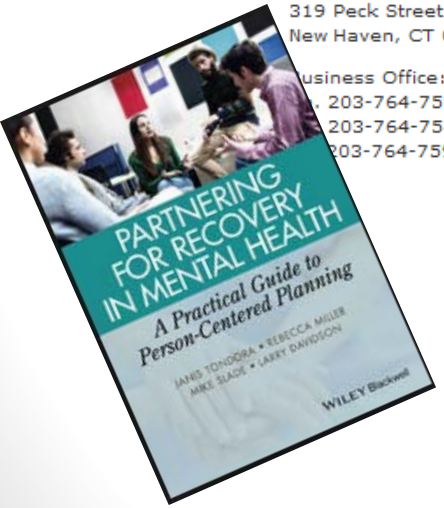

The Yale Program for Recovery and Community Health (PRCH)

The Yale Program for Recovery and Community Health, located at Erector Square in New Haven, CT, does collaborative research, evaluation, education, training, policy development, and consultation. We work to transform behavioral health programs, agencies, and systems to be culturally responsive and re-oriented to facilitating the recovery and social inclusion of the individuals, families, and communities they serve.

We seek to promote the recovery, self-determination, and inclusion of people experiencing psychiatric disability, addiction, and discrimination through focusing on their strengths and the valuable contributions they have to make to their communities.

Directions to our offices

VISIT US:
The Parachute Factory exhibit, *Out of House and Home,* through 2/2010.
Directions to our offices

JOIN:
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Parachute Factory lists
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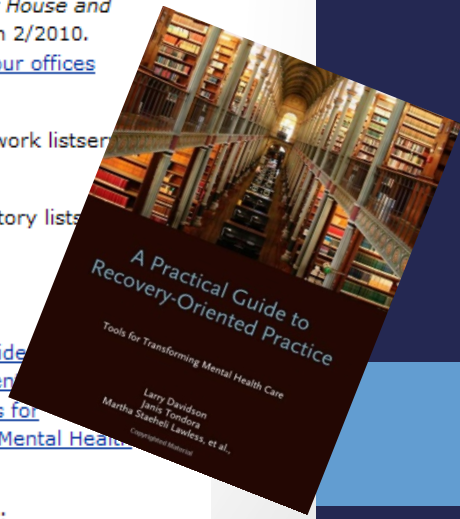
LEARN:
New Book:
A Practical Guide Recovery-Orien Practice: Tools for Transforming Mental Healt Care

New Resource:
Getting in the Driver's Seat of Your Treatment: A Toolkit for Person Centered Care (.pdf)



So what is this *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 (1 min)
  - Find a partner… swap answers. (2 min)
  - Then find another partner…Repeat. (2 min)
  - **Its OK to venture a wild guess ☺**

Person-Centered Care… 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
- PCP represents a unique opportunity to move from person-centered THEORY to person-centered PRACTICE

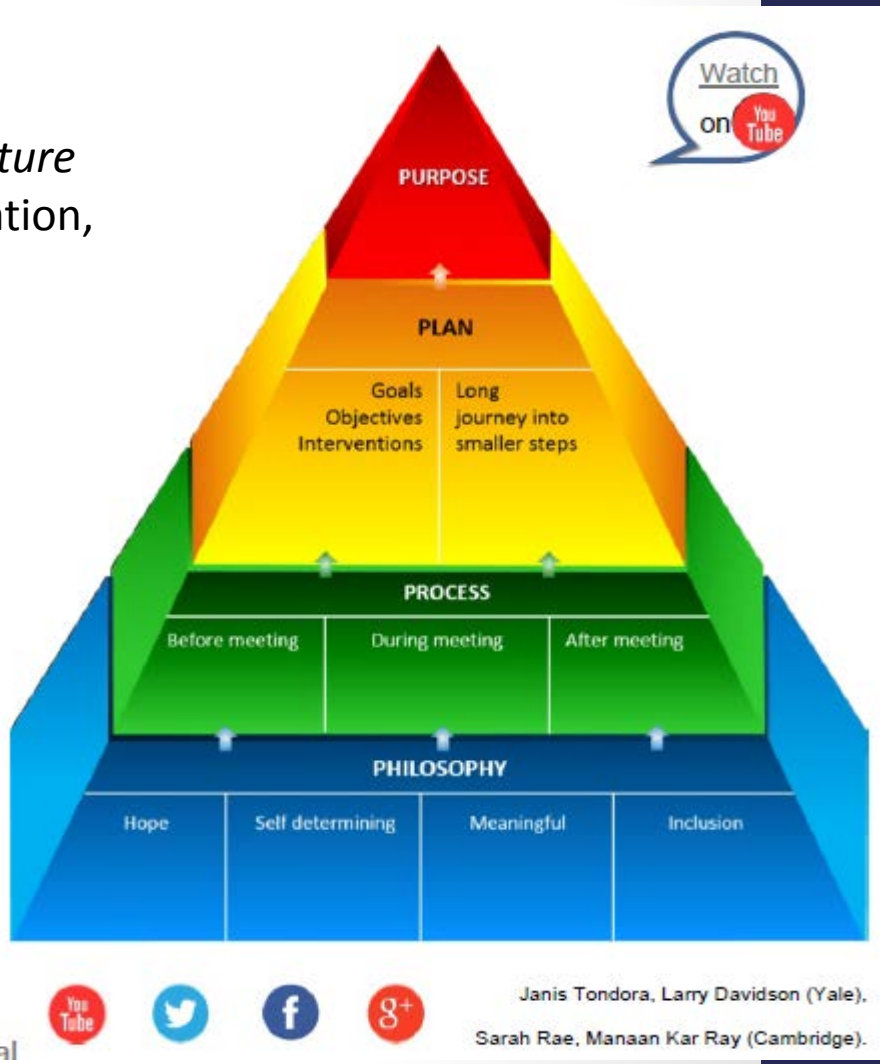
The Person-Centered Train: Who's on Board?

Forces Behind PCP

- Values-driven approach first and foremost! *Golden Rule*
- Endorsement by State of CT in Policy
- Federal/national endorsement (President's New Freedom Commission, SAMHSA, etc). (2001)
- Funders (e.g., CMS and other RFPs) and accrediting bodies
- 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.*
  - *You keep talking about getting me in the driver's seat when half the time I am not even in the damn car!*

What Exactly IS PCP? "The 4 Ps"

- 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



What does a person-centered system of care look like?

From:	To:
"Compliance" valued	"Choice" valued
Deficit Focused	Strength Focused
Being known by what's wrong	Being known as an individual
Professional "in charge"	Shared decision making
Learned Helplessness	Active Participation
"Silo of care" focused	Broad bio-psychosocial focused
Institutional resources	Community resources/integration
Planning is done for the person	Planning is collaborative, recurring, and involves an ongoing commitment to the person

What does this mean for you as Case Managers, Employment Navigators, Homeless Specialists, etc.?

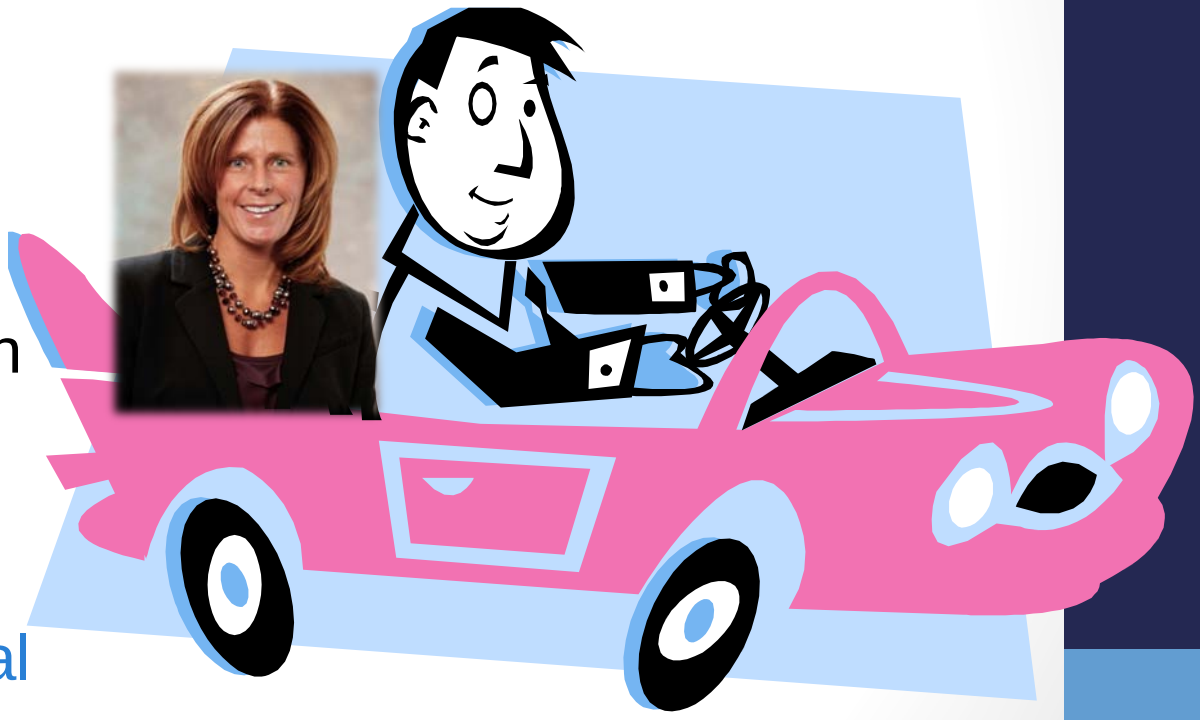
- You play a critical role in connecting people to necessary services and supports, but the connection is only the beginning.
  - Even follow-through/compliance with recommended services is NOT the end goal.
- The end goal is achieved when the network of services successfully helps the person achieve a higher quality of life with greater housing stability and economic self-sufficiency.
- Requires **thinking of the WHOLE PERSON** and using the service plan to address the range of barriers that underlie homelessness

On the flip side... Common Concerns in PCP:

1. If given choice, people will make BAD ones, they may end up homeless again
2. Clients aren't interested/motivated
3. It devalues our professional expertise
4. Lack of time/caseloads too high/ "initiative fatigue"
5. "My clients are too impaired/addicted/unmotivated"
6. Its important, but isn't this what the counselors do? Its not part of my role.
7. **Don't we already do PCP? Is it really any different?**

If the person is in the driver's seat of their care, where does that leave me?

- 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



Role of a PCP Provider/Counselor

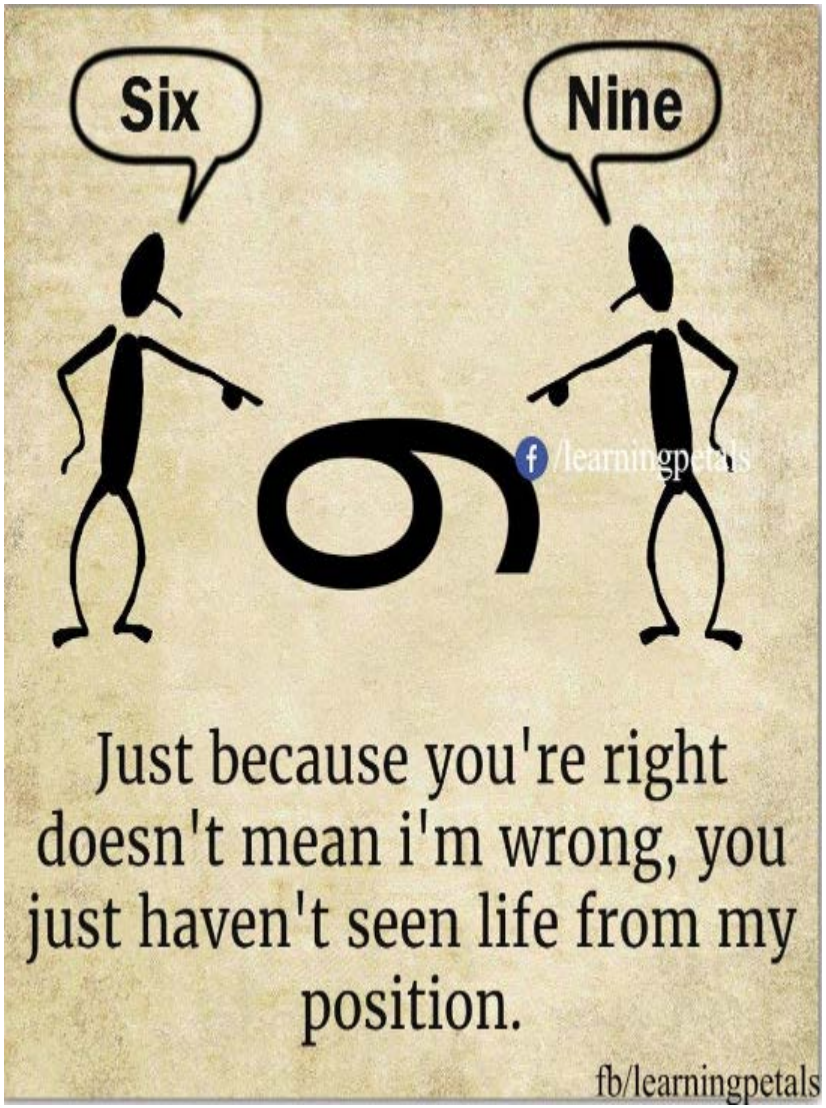
- **Partner** for planning & decision-making
- **Guide** for self-discovery
- **Facilitator** of planning meeting

- **Advocate** for person's preferences/needs
- **Educator** (orient to process & procedures)
- Not simply "the professional knows best!"

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 PCP practices!

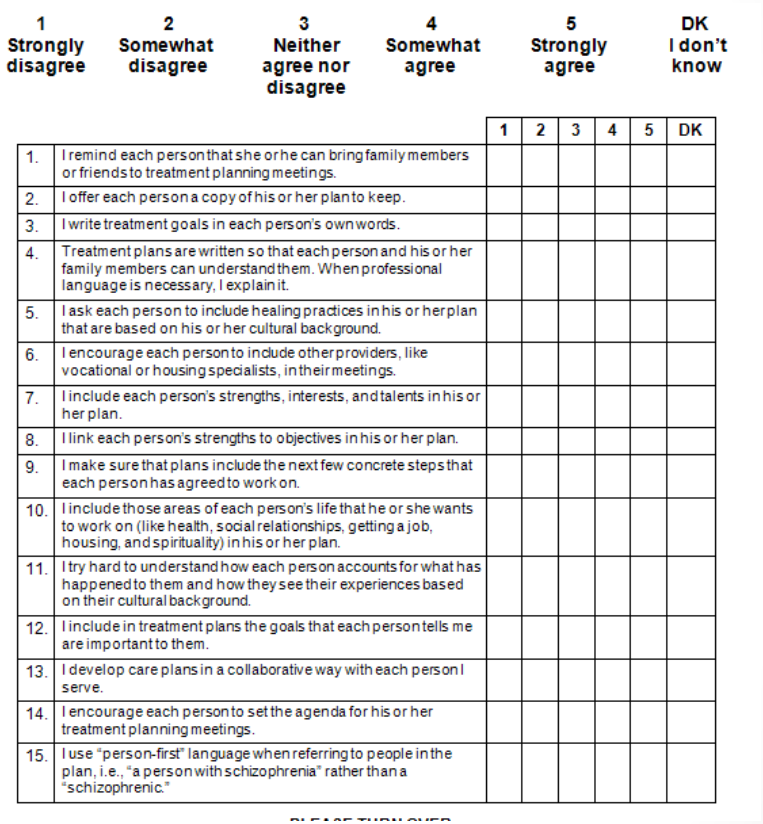


Partnering does not require that you always AGREE but it <u>does</u> require mutual respect and understanding

PCP:
Is it REALLY any different?

YES!

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



1 Strongly disagree	2 Somewhat disagree	3 Neither agree nor disagree	4 Somewhat agree	5 Strongly agree	DK I don't know

		1	2	3	4	5	DK
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.						
2.	I offer each person a copy of his or her plan to keep.						
3.	I write treatment goals in each person's own words.						
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.						
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.						
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.						
7.	I include each person's strengths, interests, and talents in his or her plan.						
8.	I link each person's strengths to objectives in his or her plan.						
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.						
10.	I include those areas of each person's life that he or she wants to work on (like health, social relationships, getting a job, housing, and spirituality) in his or her plan.						
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.						
12.	I include in treatment plans the goals that each person tells me are important to them.						
13.	I develop care plans in a collaborative way with each person I serve.						
14.	I encourage each person to set the agenda for his or her treatment planning meetings.						
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."						

PLEASE TURN OVER

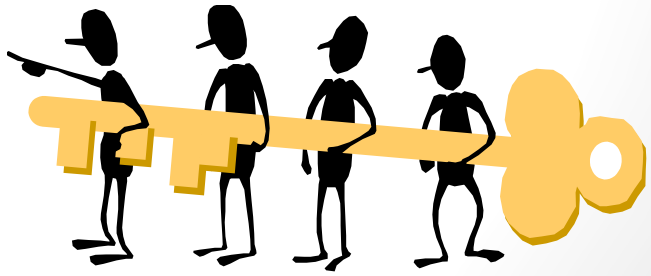
Person-Centered Care Questionnaire: Tondora & Miller 2009
http://www.ct.gov/dmhas/lib/dmhas/publications/PCPQprovider.pdf
http://www.ct.gov/dmhas/lib/dmhas/publications/PCPQperson.pdf

What Exactly is PCP?

- Person-centered planning
  - is a collaborative process resulting in a recovery oriented care plan
  - is directed by clients in partnership with care providers and natural supporters
    - is reflected in the co-created written Recovery/Service Plan which outlines the person's most valued goals and how all will work together to achieve them

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



Summer 09

http://www.yale.edu/prch/research/documents/toolkit.draft.7.24.09.pdf

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 Expect Change

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!!

Strengths as the Foundation of PCP

- "It's about what's STRONG, not just about what's WRONG! "
  - Gina, a former patient at co-occurring d/o program

Strengths-Based Communication

Consider the following statements from a psychosocial summary. Which is the best example of a strength-based perspective?

"Mary only has an 8th grade education."

"Roxanne was unable to graduate from high school due to addictions issues her senior year."

"Alexis was able to complete the 11th grade and start her senior year, even while living in a home where domestic violence was common."

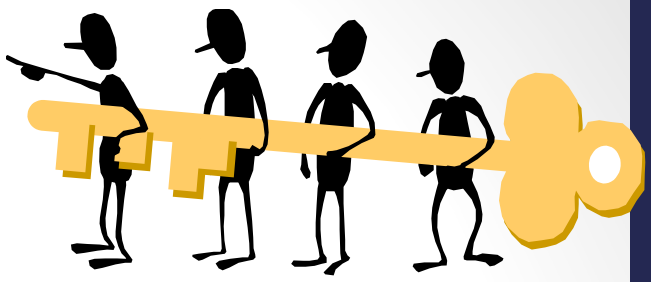
Language Counts: Glass Half Empty: Glass Half Full

Glass Half Empty, Glass Half Full:
Exercise and Group Chat

Exercise
Glass Half Empty... Glass Half Full

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
A schizophrenic, a borderline	A person diagnosed with...
Clinical Case Manager	Recovery coach/guide
Front-line staff/in the trenches	Direct support staff
Substance abuse/abuser	Person living with...SA interferes with...
Suffering from	Living with/recovering from
Treatment Team	Recovery team
High-functioning vs. Low Functioning	A person symptoms/addiction interferes with the following...
Unrealistic	Idealistic, high expectations
Resistant/non-compliant	Disagrees with, chooses alternatives
Weaknesses	Barriers to change; Support needs
Maintaining clinical stability/abstinence	Promoting life worth living
Puts self/recovery at risk	Takes risks to try new things/grow
Treatment works	Person uses tx as a tool in recovery

More Key Practices in the Process of PCP



- Recognize the range of contributors to the planning process (e.g., peers, natural supporters).
- Value community inclusion/life
  - "While," not "after"
- Demonstrate a commitment to both outcomes and process; high expectations.
- Understand/support rights such as self-determination

So you try your best to implement ALL of these "key practices," but how do we move from the PROCESS of PCP to the DOCUMENTATION of PCP?

A More Hopeful Proposition…

- We can balance person-centered approaches with regulations/charting requirements in creative ways to move forward in partnership with service users.
- We can create a plan that honors the person and satisfies the chart!
- So, how do all the pieces come together in the written person-centered service plan?

Putting the Pieces Together In a PCP Document

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

What we hope for THEM…

- ✓Compliance with services
- ✓Better judgment
- ✓Increased Insight…Accepts illness/limitations
- ✓Follows team's recommendations
- ✓Stays out of jail/hospital
- ✓Abstinent
- ✓Motivated
- ✓Increased functioning
- ✓Residential Stability
- ✓Healthy relationships/socialization
- ✓Use services regularly/engagement
- ✓Decreased symptoms/Clinical stability
- ✓Cognitive functioning
- ✓Realistic expectations
- ✓Attends the job program/clubhouse, etc.

What we value for US…

- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daughter
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓**A home to call my own**
- ✓**Love…intimacy…sex**
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning
- ✓A valued role

Beyond Us and Them

- People struggling with a range of complex life issues that are often associated with homelessness (e.g., addiction, mental health issues, lack of access to medical care, unaffordable housing, legal charges, etc.) want the exact same things in life as ALL people.

- People want to thrive, not just survive…

- PCC challenges us to move past the “us/them” dynamic and embrace the true pursuit of **RECOVERY** rather than mere compliance with social services or the maintenance of stability

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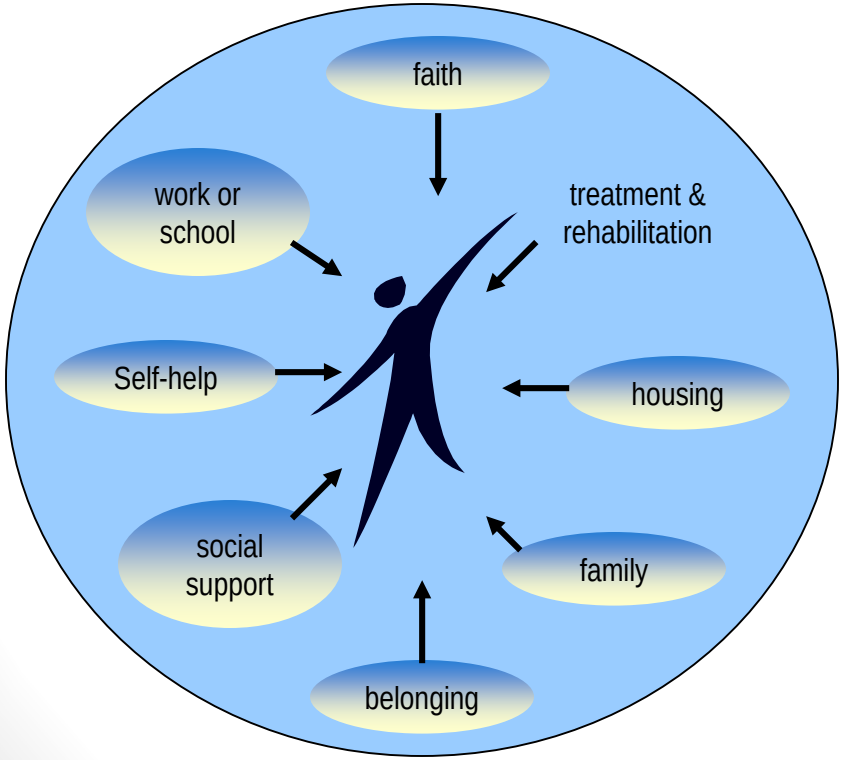
Developing Goals and a Vision

- Goals and objectives in the recovery plan are not limited to traditionally valued outcomes reducing problems, increasing adherence, service utilization, etc.



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

What Do People Want?

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

To be part of the life of the community…

ID & Use a 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 to church
  - Good physical health
  - Adaptive coping skills

- STRENGTHS SHOULD BE ACTIVELY USED IN THE PLAN!

Don’t Let Strengths Sit on a Shelf!

Barriers/Assessed Needs

What's getting in the way?

- need for skills development
- limited work hx and/or education
- lack of resources (e.g, child care)
- problems in behavior
- Past/current issues with criminal justice sy
- Cognitive issues
- Lack of credentials
- challenges in activities of daily living
- Victim of violence
- threats to basic health and safety
- Legal challenges
- Unaddressed medical issues
- challenges/needs as a result of a mental/ alcohol and/or drug disorder

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Barriers Should Be Descriptive

Weak Examples

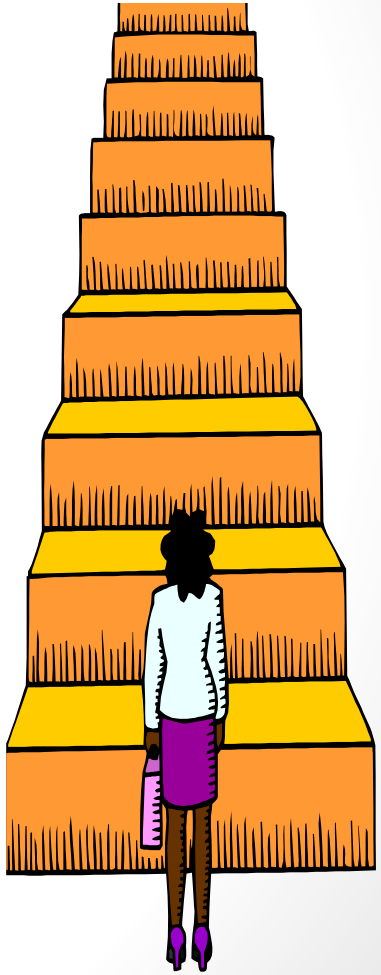
- Anger issues
- Depressive symptoms
- Addiction

Strong Examples

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

Short-term Objectives: What do they do?

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



Objectives Should be SMART

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

- **S**imple or Specific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**ime-framed

Interventions: Team Action Steps

- ***Actions*** by staff, client, or other natural supports
- Specific to an objective
- Respect recovery choice and preference
- Specific to the stage of change/recovery
- May be impacted by cultural factors

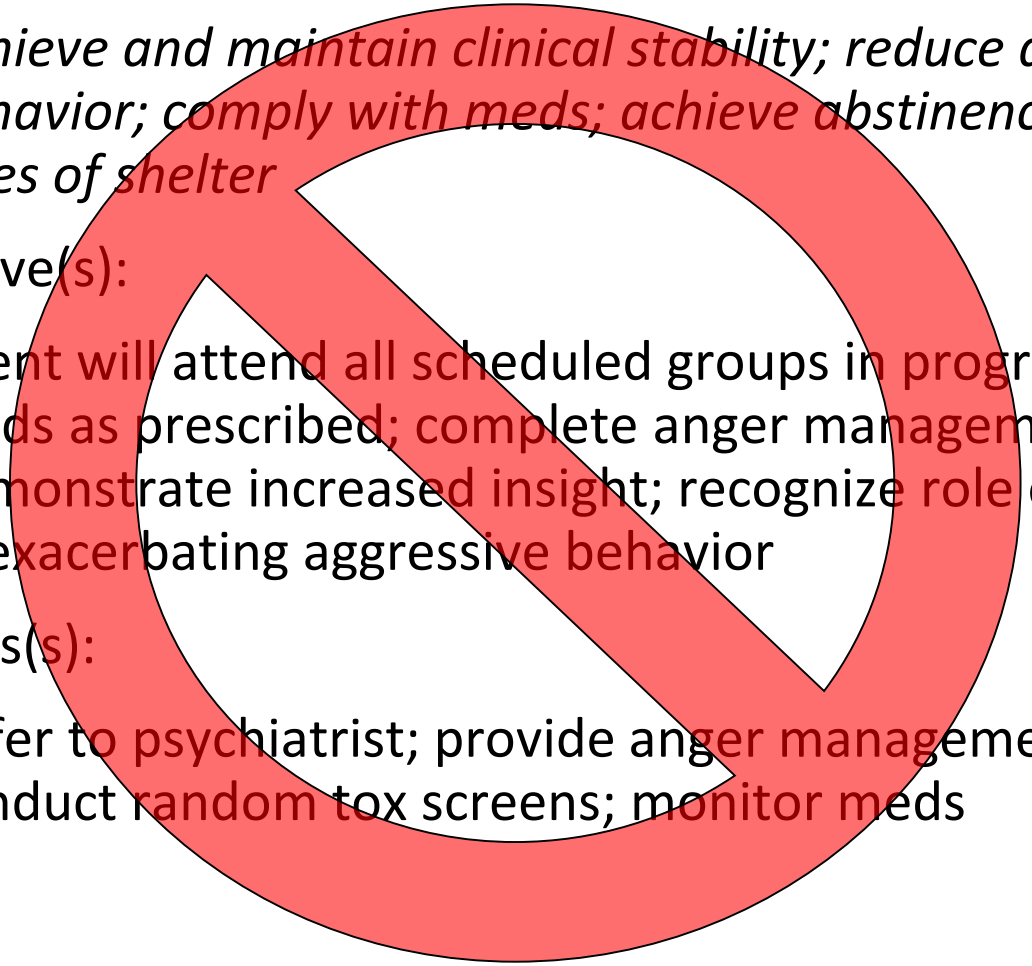
- Professional Services should describe:
  - WHO will provide the service, i.e., name and job title
  - WHAT: The TITLE of the service, e.g., Care Coordination with Medical Doctor
  - WHEN: The SCHEDULE of the service, i.e., frequency/duration
  - WHY: The individualized INTENT/PURPOSE of service
- Self-directed steps build a sense of agency in the individual; Natural support actions build a recovery network and decrease dependence on professional services

So what does a PCP look like? Meet Mr. Gonzalez

- *31-year-old married Puerto Rican man, father to 2 boys*
- *Living with bi-polar disorder and co-occurring ETOH addiction abuse*
- *Relies on ETOH as coping mechanism*
- *Recent violence in home while drinking - knocked his wife down in presence of boys - prompted domestic disturbance call & psych eval*
- *Mr. G's wife is supportive and involved, but she asked him to move out and told him he could not return home until he "gets control of himself"*
- *Mr. G is staying at your transitional shelter*
- *Mr. G tells his counselor 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 his AA sponsor with whom he has a close relationship.*

Snapshot: A Traditional Service Plan

- Goal(s):
  - *Achieve and maintain clinical stability; reduce assaultive behavior; comply with meds; achieve abstinence, follow all rules of shelter*
- Objective(s):
  - Client will attend all scheduled groups in program; take all meds as prescribed; complete anger management program; demonstrate increased insight; recognize role of substances in exacerbating aggressive behavior
- Services(s):
  - Refer to psychiatrist; provide anger management group, conduct random tox screens; monitor meds



Uh, excuse me…

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

- Take my meds
- Increase insight
- Attend anger management
- Comply with all rules and appointments

Recovery Goal:

I want to get my family back.
I don't want the boys to ever 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 AA sponsor and friends

Barriers Which Interfere:

Acute mental health symptoms 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 and MH counselor.

Services & Other Action Steps

- Within 2 weeks, M will refer to/coordinate care with local CMHC for ongoing psychiatric services and med evaluation.

-CM will refer to/coordinate with local CMHC family therapist re: Mrs. Gonzalez's expectations and feelings re: future reunification – 2x/mos contacts for 3 mos

-CM will offer Communication and Coping Skills training weekly to teach/coach skills that will foster successful visits with wife and children, 1x weekly for 3 mos

- CM will help Mr. G connect with a community-based Spiritual Director to promote use of faith/daily prayer as a positive coping strategy to manage stress

-Mr. G will meet with AA sponsor at least 1X weekly to receive peer support in developing healthy coping skills and maintaining his sobriety.

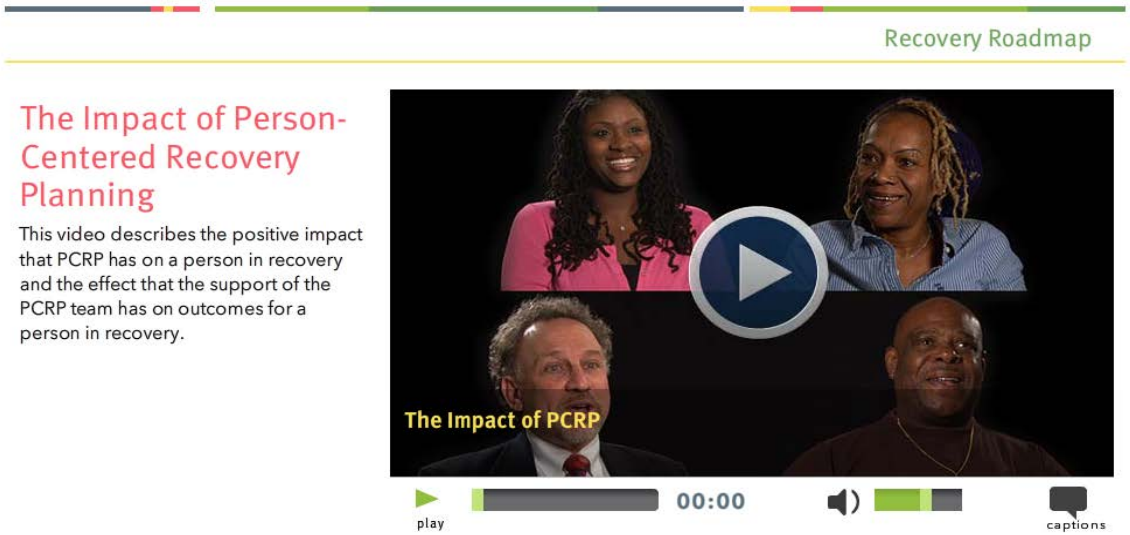
Interventions

- [Psychiatrist] to provide med management twice weekly to reduce irritability & improve sleep
- [Psychologist] to provide weekly family therapy sessions to address expectations and feelings regarding family reunification
- [Rehab Specialist] to provide weekly Communication & Coping Skills training to use for successful visits with wife and kids
- [Chaplain] to promote use of faith/daily prayer as a positive coping strategy to manage distress through monthly individual contact
- [Peer Specialist] will meet with Mr. Gonzalez at least weekly to complete WRAP to clarify personal goals for wellness

Self-Directed and Natural Support Actions

- Mr. Gonzalez will journal daily to reflect on the recent events, feelings and concerns to address in therapy & family sessions.
- Mrs. Gonzalez will speak to the kids about the events leading up to admission.

In Conclusion…



- You CAN create a person-centered plan which honors the person and satisfies your requirements!
- This is central in your partnership with individuals so you can help them move forward in their recovery!

Tools and Resources

- **CT Department of Mental Health and Addiction Services**
  - http://www.ct.gov/dmhas/cwp/view.asp?q=456036
- **New York Office of Mental Health, PCP Resource Page**
  - https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/
- **New York Care Coordination Program**
  - http://www.carecoordination.org/transformation-initiatives.aspx
- **ViaHope of Texas**
  - http://www.viahope.org/programs/person-centered-recovery-planning-imple

- **Getting in the Driver's Seat of Your Treatment and Your Life: Preparing for Your Plan (English & Spanish avail)**
  - http://www.ct.gov/dmhas/lib/dmhas/publications/PCPtoolkit.pdf
- **Person-Centered Care Questionnaire: Tondora & Miller 2009**
  - http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf
- **Adams & Grieder, 2014. *Treatment Planning for Person-Centered Care, Second Edition: Shared Decision Making for Whole Health (Practical Resources for the Mental Health Professional) 2nd Edition.***
  - http://www.amazon.com/Treatment-Planning-Person-Centered-Second-Edition/dp/0123944481
- **Tondora, J., Mathai, C., Grieder, D., & Davidson, L., 2014. When the rubber hits the road: From (2013). *Best Practices in Psychiatric Rehabilitation, 2nd Edition.* Psychiatric Rehabilitation Association.**
  - http://www.amazon.com/Practices-Psychiatric-Rehabilitation-Patricia-Nemec/dp/0615962653/ref=sr_1_sc_1?ie=UTF8&qid=1460118992&sr=8-1-spell&keywords=best+practice+in+psychiatric+rehabilittion
- **Tondora, Miller, Slade, & Davidson, 2014. *Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning***
  - http://www.amazon.com/Partnering-Recovery-Mental-Health-Person-Centered/dp/1118388577/ref=sr_1_1?ie=UTF8&qid=1459255392&sr=8-1&keywords=partnering+for+recovery+in+mental+health

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

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