

Creating a Plan that Honors the Person AND Satisfies the CSP/RP Chart

Janis Tondora, Psy.D.
Yale Program for Recovery
& Community Health
&
Julienne Giard, MSW
Department of Mental
Health & Addiction Services





Agenda

9:00 to 9:30	Introductions/Overview/Warm-up
9:30 to 10:00	Recovery & CSP/RP: Why NOW & why it matters...
10:00 to 10:30	Implications of Recovery for Service Planning
10:30 to 10:45	Break
10:45 to 12:00	Group discussion/ Nuts and Bolts of Documentation
12:00 to 1:00	Lunch
1:00 to 2:00	In small groups, prepare integrated summary and plan excerpt for Mr. Blake
2:00 to 3:15	In large group, present formulations and plans
3:15 – 4:00	Next Steps & Wrap-up

A decorative vertical bar on the left side of the slide, featuring a gradient from blue at the bottom to orange at the top. It includes a white arrow pointing up at the top, a grey arrow pointing left at the top, and a red arrow pointing right at the top.

Function of the Recovery Planning Process

- 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...
- A high quality CSP/RP recovery plan is one tool the system can use to help people in this process!

Learning Objectives

- ...identify concrete, practical strategies that exemplify the implementation of best-practice Recovery Planning
- ...increase understanding and practice a logic model for building comprehensive Recovery Plans
- ...understand strategies to maintain the rigor of technical documentation in order to meet standards associated with the CSP/RP rehabilitation model
- ...learn strategies for respecting strengths-based, person-centered principles while also satisfying expectations associated with accreditation, and fiscal regulations, e.g., those associated with medical necessity criteria or MRO documentation standards.



Recovery & Role of the Service Plan

- ***A Consumer and Family Driven System... Recommendation 2.1***
 - The plan of care will be at the core of the consumer-centered, recovery oriented system
 - Providers should develop customized plans in full partnership with consumers

The PLAN is a window of opportunity to promote **CONCRETE** recovery-practice change!



Improving the Quality of Health Care for Mental and Substance-Use Conditions



QUALITY CHASM SERIES

IOM

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care

A Roadmap for Hospitals



JCAHO



Keystones for Collaboration and Leadership: Issues and Recommendations for the Transformation of Community Psychiatry

The American Association of Community Psychiatrists
 Pennsylvania Psychiatric Leadership Council
 Allegheny County Office of Behavioral Health
 Coalition of Psychiatrists for Recovery

Edited By
 Wesley E. Sowers, MD.

AACP

A Consistent Message...



In the Driver's Seat

Bazelon

Health Care
 Health Law &
 Policy Integration



DMHAS CSP/RP Model

- Opportunity to enhance & re-align MH Case Management services to CSP/RP;
- CSP/RP services focus on building & maintaining a therapeutic relationship with the individual while delivering rehabilitative, *skill building* interventions
- “Individual Services are delivered in accordance with a co-authored person centered recovery plan created in collaboration with the person served, people they request to be involved in their recovery plan, and the CSP/RP team...”
- **A natural extension of DMHAS’ commitment to recovery-oriented care.**

State Perspective

- Commissioner's Policy Statement #33, March 27, 2007
 - ...The Plan of care shall be developed in collaboration with the person.
 - ...Focusing solely on deficits in the absence of a thoughtful analysis of strengths leads to disregarding the most critical resources an individual has on which to build on his or her efforts to... advance in his or her unique recovery journey.
 - ...The primary focus of recovery planning is on what services the person desires and needs in order to establish and maintain a healthy and safe life in the community...

Role of the Consumer in Recovery Planning



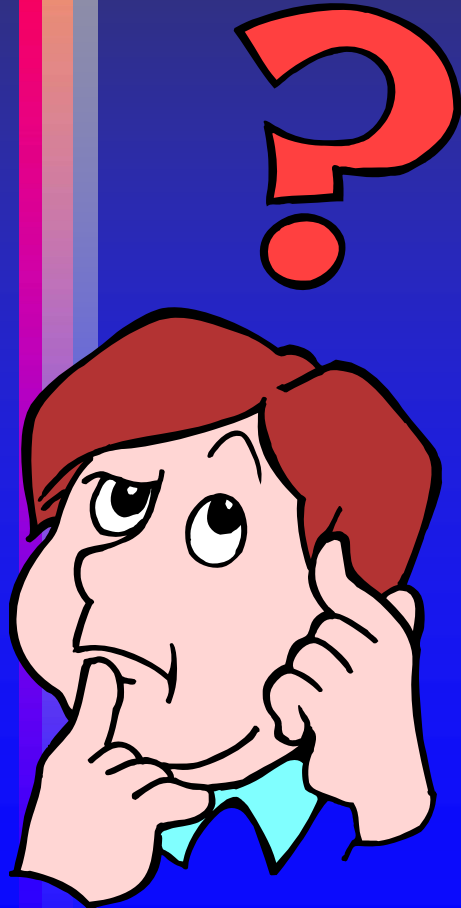
Even though state and local agencies often include consumers and other advocates in care planning, they often allow them to have only a marginal role and fail to provide important information that could enable them to participate fully and effectively.

Bazelon Center, 2008

In Other Words...

- *“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



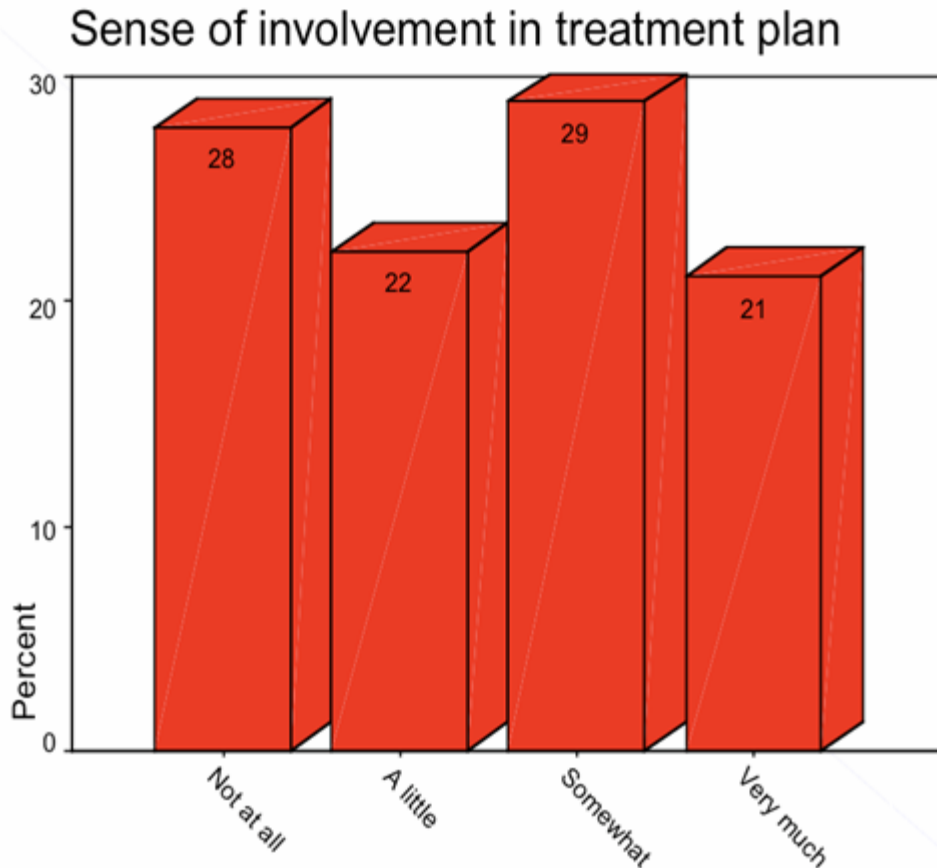
A photograph of a store's exterior. The building has a white facade with a red roof. A large yellow sign with black text reads "STORE CLOSING". To the right, a white sign with black text reads "NOW HIRING". The entrance is a glass door set within a white frame. In the foreground, there are several shopping carts and a few cars parked in the parking lot. The sky is overcast.

STORE CLOSING

NOW HIRING

Research Data Supports the Need to Enhance Collaboration

- 24% of sample (N=137) report NEVER having a treatment plan
- Of those who had experienced a treatment plan, half felt involved only “a little” or “not at all”.



- 21% of participants report being “very much” involved... BUT...
- 12% of people invited someone to their last treatment planning meeting
- Over half were not offered a copy of their plan



... & data shows collaborative recovery planning impacts outcomes!

- WNYCCP (July, 2008) has achieved the following outcomes:
 - 68% increase in competitive employment
 - 43% decrease in ER visits
 - 44% decrease in inpatient days
 - 56% decrease in self-harm
 - 51% decrease in harm to others
 - 11% decrease in arrests
- **Cost-effective**
 - The rate of increase between 2003 and 2007 for total Medicaid costs for WNYCCP participants LESS than for comparison group

Current Thinking



- Recovery Planning can be the bridge between the system as it exists now and where we need to go in the future
- ▶ Recovery plans are a key lever of personal and systems transformation at all levels:
 - ▶ Individual and family
 - ▶ Provider
 - ▶ Administrator
 - ▶ Policy and oversight



The Comprehensive Recovery Plan

Incorporates Evidence-Based Practices

Maximizes Self-Determination & Choice

Encourages Peer-Based Services

Informed by Stages of Change & MI Methods

Promotes Cultural Responsiveness

Respects Both Professional & Personal Wellness Strategies

Focuses on Natural Supporters/Community Settings

Consistent w/ Standards of Fiscal & Regulatory Bodies, e.g., CMS, JCAHO



Quality in Recovery Planning

Adhere to person-centered principles in the process

- Person is a partner in all planning activities/meetings
 - Maximize use of **shared decision-making** tools/theory
- Person has reasonable control over logistics including invitees and location; advance notice
- Transparency... person offered a copy



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
© 2009

Supported by generous funding from CT's Transformation Grant



Importance of
education &
skill-building
among
individuals to
prepare them
for their
recovery plan



Language Considerations

Written and spoken language honors strengths-based foundation

- Using person-first terms
- Avoiding overly negative connotations
- Being careful not to communicate hierarchy/social control
- Most important – deferring to the person
“when in doubt...” –
consumer/patient/person w/



The Power of Language in Recovery Planning:

The Glass Half Empty,

The Glass Half Full:

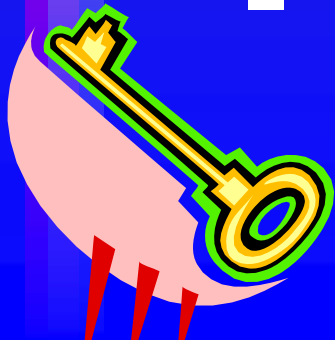
Exercise and Group Discussion

➤ 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 psychiatrist to find a med regimen that is highly effective for her and she has been an active participant in activities at the clinic and the social club. Sandra and her supporters all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. However, people have become concerned lately as she has been missed at several activities, including a bloodwork appointment at 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.

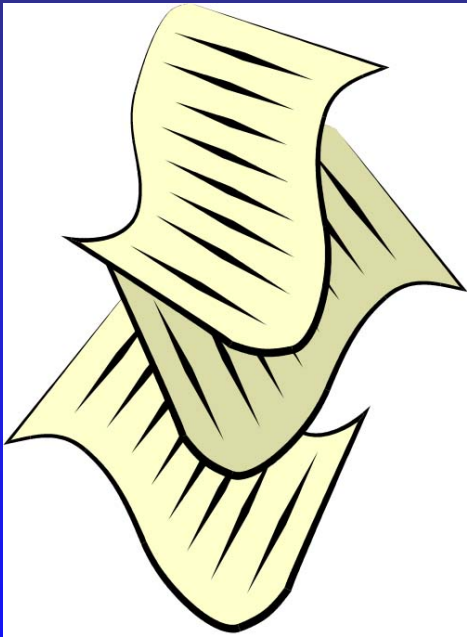
Quality in Recovery Planning

- Recognize the range of contributors to the planning process, especially “natural supports”**
- Value community inclusion
- Non-linear: Rehab and pursuit of valued roles/activities WHILE also working on symptoms (not after stabilization)
 - Trap of the one-stop-shop: Natural settings to the maximum extent possible
- Recovery-oriented risk management



What next?

Reflecting a quality
process in the
DOCUMENTATION
of the Recovery
Plan...



But, I feel like I keep trying to force a square peg into a round hole. And it just don't fit!



GOOD NEWS FOR CSP/RP:

By and large, your documentation structures are conducive to recovery-oriented planning!

One Plan...Many Pressures

- Many administrators and practitioners report feeling stuck between a rock and a hard place... as they struggle to reconcile (seemingly) competing tensions

**Regulations
Required Paperwork
Medical Necessity
Compliance**



**Collaborative
Person-Centered
Strengths-based
Transparent**



A more hopeful proposition...

- We can balance person-centered approaches with medical necessity 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!

Putting the Pieces Together in the Recovery Plan

GOAL

as Defined by Person

Strengths to Draw Upon

Barriers /Assessed Needs
Which Interfere

Short-Term Objective

- Behavioral
- Achievable
- Measurable

Interventions/Methods/Action Steps

- Professional/"Billable" Services
 - Clinical & Rehabilitation
- Action Steps by Person in Recovery
- Roles/Actions by Natural Supporters

The Plan...Must it be a heavy burden?



"Apparently, Smith's desk just couldn't withstand the weight of the paperwork we piled on his desk."



Example – GREG

- *I am so lonely. I just want a girlfriend. I used to go to the downtown jazz fests and meet lots of people. But I have been so exhausted lately, I can barely stay awake to go. The meds make me feel like a zombie. Even if I could, I am terrified. Its been 5 years since I had a girlfriend, I wouldn't know where to start...I can't take the bus anymore to get anywhere and I am afraid to go anywhere alone.*
- **Goal: I want a girlfriend.**



Example, cont.

- **Objective:**
 - Greg will better manage his social anxiety as evidenced by his ability to participate in a minimum of 1 social activity per week for the next 90 days
- **Strengths:**
 - Motivated to reduce social isolation; supportive brother; has identified community interests he enjoyed in past; well-liked by peers
- **Barriers:**
 - Intrusive thoughts increase anxiety in social situations; need for skill development to use public transportation and increase community mobility; negative sx and med side effects result in severe fatigue



Example, cont.

- **Interventions:**
- Jane Roe, Clinical Coordinator, to provide CBT 2X/mos. for next 3 mos. to increase Greg's ability to cope with anxiety symptoms in social situations.
- Dr. X to meet with Greg 2X/mos. for next 3 months to review his log and adjust meds prn to reduce fatigue
- Wanda Vasquez, CSP Specialist, will provide Community Exploration Group 1X weekly for 3 mos. to help Greg learn skills for identifying low-cost community activities
- John Smith, RP Peer Specialist, will help Greg with travel training 1X/wk. for 4 weeks to help him become independent with city bus.
- *Greg's brother, Jim, will accompany Greg to weekly social outings over the next 3 months.
- Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

Logic Model in Building PCPs





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



Assessment

- Initiates helping relationships
- Ongoing process
- Focus on functional abilities and impairments as opposed to symptoms per se
- Comprehensive domain-based data gathering
 - Identifies strengths
 - Abilities and accomplishments
 - Interests and aspirations
 - Recovery resources and assets
 - Unique individual attributes
- Considers ***stage / phase of change*** process



Strengths-Based Assessment Process

- Takes time and a trusting relationship
- Must be a reciprocal dialogue – not an interrogation
- Explore strengths beyond the individual
- Expand what we value as a “strength”
- Explore what has worked for them (or peers) in the past, e.g., WRAP
- Be creative in HOW we ask questions

Stages of Recovery and Treatment

Ohio	Village	Prochaska & DiClemente	Stage of Treatment	Treatment Focus
Dependent unaware	High risk/ Unidentified or Unengaged	Pre- contemplation	Engagement	<ul style="list-style-type: none"> ▪ outreach ▪ practical help ▪ crisis ▪ intervention ▪ relationship ▪ building
Dependent aware	Poorly coping/Engaged/ not self-directed	Contemplation /preparation	Persuasion	<ul style="list-style-type: none"> ▪ psycho-education ▪ set goals ▪ build awareness
Independent aware	Coping/Self responsible	Action	Active Treatment	<ul style="list-style-type: none"> ▪ counseling ▪ skills training ▪ self-help groups
Inter- dependent aware	Graduated or Discharged	Maintenance	Relapse Prevention	<ul style="list-style-type: none"> ▪ prevention plan ▪ skills training ▪ expand recovery



Importance of Understanding

- Data collected in assessment is by itself *not sufficient* for service planning
 - The “integrated summary” (often referred to as the “formulation” in clinical settings) is essential
 - Moves from **what to why**
 - Sets the stage for **prioritizing** needs and goals
 - The role of culture and ethnicity is critical to true appreciation of the person served
 - Recorded in a chart narrative
 - Shared with person served
- ▶ **Is the BRIDGE between the data and the plan!**



CARF's Interpretive Summary

- Central theme of the person
- Interrelationships between sets of findings
- Needs, strengths, limitations
- Clinical judgments regarding the course of treatment
- Recommended treatments
- Level of care, length, intensity of treatment



An example...

- Assessment data may have multiple references to a person not using medication effectively and the consequences of this behavior. In the Integrated Summary, we often note that a “long history of medication non-compliance in the community has led to repeated hospitalizations.”
- This is NOT Case Formulation but rather, a re-stating of the data/facts. The task in Case 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.



WHY Does the Person Not Use Meds?

- **Person is concerned re: side-effects:** exploration of meds with different side-effect profiles; consultation with nutritionist to get support to off-set weight-gain; family-based interventions to help couples deal with sexual side-effects
- **Person does not believe they have an illness/believex meds are poison:** trust-building; motivational approaches; psycho-education; peer specialist engagement interventions; empathic understanding
- **Person has religious objections to taking medications; has cultural preference to use alternative healing strategies:** collaboration with faith-based or cultural healers; integration of alternative strategies along-side traditional treatments/meds in plan
- **Person experiences stigma re: use of psych meds; family/others have advised them not to take it:** family-based interventions; NAMI involvement; peer support; exposure to positive recovery role models
- **Person becomes disorganized/can't track complex med schedule:** cognitive remediation; occupational therapy consult to develop compensatory strategies to promote organization



Prioritization As An Important Step in the Logic of Building Recovery Plans

- Individuals often have multiple needs and goals. Addressing too many things at one time can make the plan feel fragmented and efforts can be diluted across too many areas.
- It is the job of the Team to work collaboratively with the individual to do some PRIORITIZATION.
- During this process, we must balance what is “important TO” the person with what we feel might be “important FOR” them.

Important To vs. Important For: For more information,
See the Work of Michael Smull, The Learning Community for Person Centered Practices

Balancing Priorities in the Plan


Important *TO* the Person *Personal Perspective*

- Meaningful relationships
- A home/place of my own
- Valued roles/purpose
- Independence/Self-determination
 - Cultural/personal preferences may impact
- Faith/spirituality
- A job/career



Important *FOR* the Person *Professional Perspective*

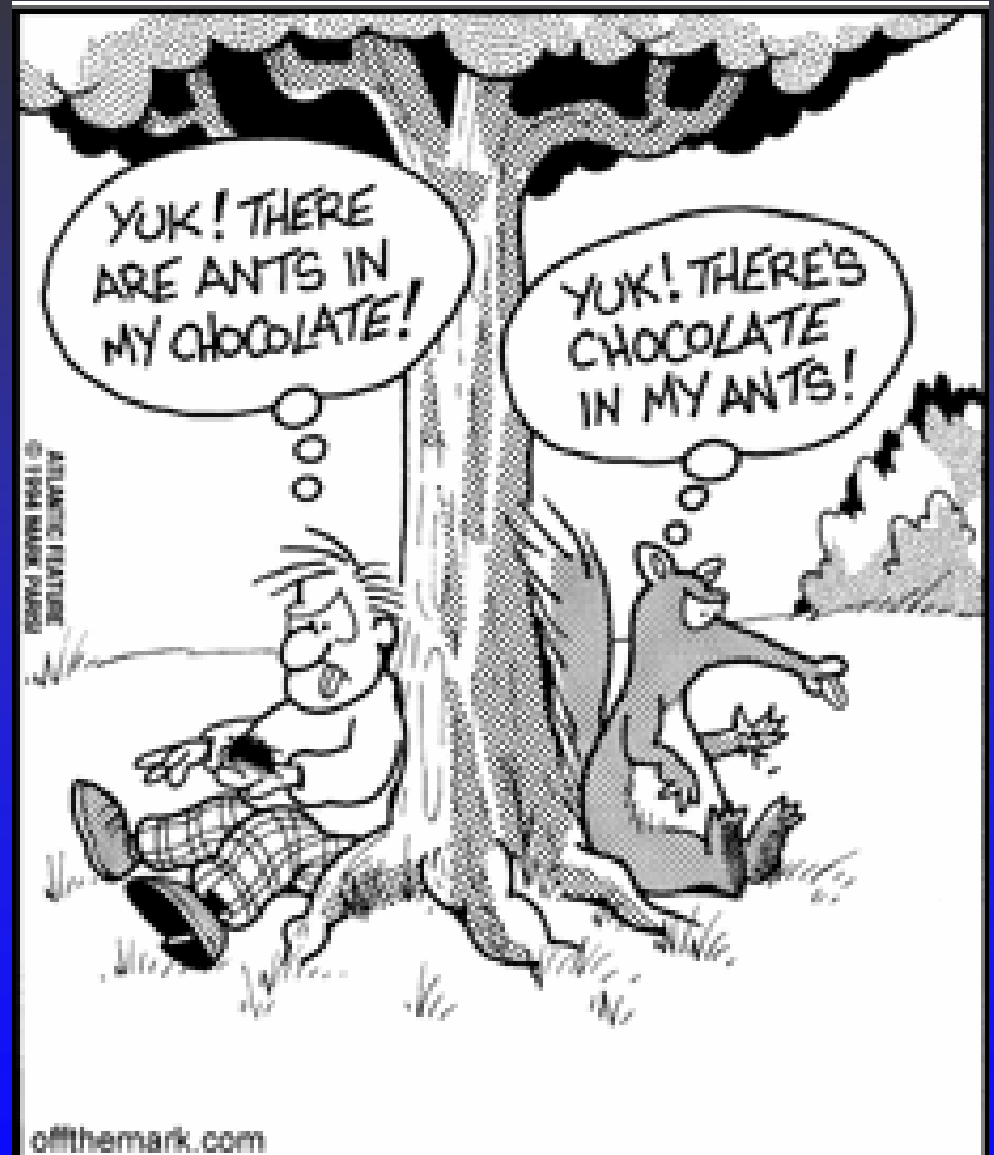
- Basic health and safety
 - Reduction of clinical sx
- Maslow's basic needs
- Harm reduction
- Management of risk issues
- Legal obligations and mandates
- Community Safety

A decorative graphic on the left side of the slide. It features a vertical bar with a color gradient from blue at the top to red at the bottom. At the top, there are three arrows: a grey one pointing left, a red one pointing right, and a larger orange one pointing up.

In collaborative treatment planning dialogues, the task is to strive for the integration/alignment of what is important TO/FOR the person

But there are times when you may see things differently...

The plan must make room for both perspectives, even if you have to “agree to disagree”



Finding the Recovery Zone



Let person do what he/she wants regardless of our concerns. This is not being person-centered; this is

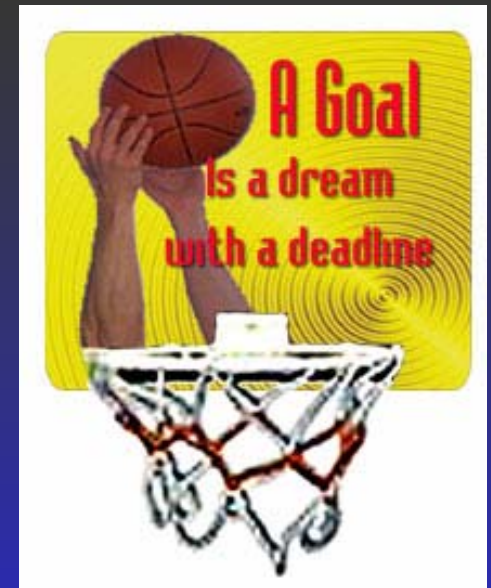
Neglect

Get the person to do what WE want regardless of their viewpoint. This is not acting in their best interest; this is

Coercion

Goals

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



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...

A vertical bar on the left side of the slide, featuring a color gradient from blue at the bottom to orange at the top. It includes a grey arrow pointing up, a grey arrow pointing left, and a red arrow pointing right.

And not just...

- **Goal**
 - *Maintain psychiatric stability*
 - **Objectives**
 1. *Take meds as prescribed*
 2. *Attend psychiatric appointments*
- 
- A large red prohibition sign (a circle with a diagonal slash) is overlaid on the list, indicating that the listed items are not the sole focus of the goal.

Barriers/Assessed Needs

- **What's getting in the way?**
 - need for skills development
 - Intrusive symptoms
 - lack of resources
 - need for assistance / supports
 - 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**
- **Note: the Functional Assessment is used to capture more detail re: BASELINE functioning and provide clear behavioral description of what person is/is not currently able to do**



Barriers/ Assessed Needs



- Barriers/ Assessed Needs not addressed in a vacuum but insofar as they interfere with GOALS!
- This distinction is critical if you are to avoid “deficit-driven” plans

Objectives

- Expected near-term changes to meet long-term goals; big chunk/little chunk
- Essential features
 - behavioral
 - achievable
 - measurable
 - time framed
 - understandable for the person served



• ***Services are not an objective!!***



Services are NOT an Objective!

- Gary will consistently attend all group programming over next 3 months.
- Gary will demonstrate increased engagement in care as evidenced by his attendance at IMR group 75% of groups over the next 3 months. (Assumes pre-contemplative!)
- AFTER he is engaged – do not default to this place! What do you want him to get/ how do you want him to change as a result of coming to IMR??



Objectives should be SMART

- Here's a way to evaluate your objectives.
Are they SMART?
 - Simple or Straightforward
 - Measurable
 - Attainable
 - Realistic
 - Time-framed

A decorative vertical bar on the left side of the slide. It features a gradient from blue at the bottom to orange at the top. At the top, there is a grey arrow pointing left, a red arrow pointing right, and a yellow arrow pointing up.

Measurability of Objectives

■ TEST:

- At the end of 3 month / 6 months, etc., can you definitely say yes / no that the objective was accomplished.
- WITHOUT differences of opinion around the table!



Objectives - Wording

- *“Within X days...The individual / family will ...”*
- *As a result of services and supports, Mr./Ms. X will....., as evidenced by.....”*
- changes in behavior / function / status
 - described in action words
- *Be careful of using the word “and”*



Objectives - Wording

AVOID these non-behavioral terms that often mean different things to different people:

interact

participate

socialize

cooperate

coherent

rescue

appropriate

actively

willingly

calm

relevant

agitated

normal

increase

decrease

improve



Objectives focus on SKILL-BUILDING

- Observable: can either see it or be articulated
- Must be practiced to be mastered and maintained – implications wording!
- Generalizable: Can be used in a variety of situations and/or locations
- Individualized, restorative interventions to develop coping/social/community living skills



Objectives

- Outcome-oriented objectives are more meaningful to the person served but also want to “program for success”
- Rule of thumb:
 - Start where person is at no matter how small a step it might be BUT
 - Be as ambitious as possible (i.e., don't default in objectives to phone calls, applications, interviews, etc.) and...

***RECOVERY MAY BE A JOURNEY;
BUT IF YOU NEVER GET ANYWHERE,
IT CAN EASILY BECOME A TREADMILL.***

*Joe Marrone, Institute for
Community Inclusion*





Stagger/Raise Bar Over Time!

- *Assume Audrey wants to go back to work but currently, severe depression & sleep disturbance is making it difficult for her to get out of bed*
- Over the next 90 days, Audrey will be able to get out of bed by 9am at least 4 days out of 5 M-F.
- Update: Within 3 months, Audrey will have completed a draft of her resume
- Update: Within 6 months, Audrey will be working 5 hours per week in community!



Objectives

- *Client will decrease social isolation.*

- Measurable/Concrete:

- Within 30 days, Sam will identify 3 ways in which he can begin to make acquaintances @ time of session w/ worker.
- Sam will participate in a minimum of 1 social activity outside of his apartment each wk. for next 90 days.



Objectives

- *Client will reduce assaultive behavior.*

- Measurable/Concrete:

- Within 90 days, Amy will identify 3 triggers to behavioral outbursts with children.

- (LEARNING objective)

- Within 90 days, Amy will have a minimum of one successful visit with her children AEB by report of Amy's DCF Case Worker

- (BEHAVIORAL OBJECTIVE)



Objectives

- *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)

Objectives

- *Client will be med-compliant for the next 3 mos.*
- ▶ What is the barrier??:
 - ▶ Beth will identify 3 benefits of taking medication over the next 3 months. (does she not believe she needs meds?)
 - ▶ Beth will create a written log/checklist of med times within 2 weeks. (or is she disorganized?)
 - ▶ Beth will exp an improvement in mood within 90 days AEB self-report on daily mood scale. (assumes she uses meds and raises bar to change in functioning)

Interventions

- *Actions* by staff, family, peers, natural supports
- Specific to an objective
- Respect consumer choice and preference
- Specific to the stage of change/recovery
- Support medical necessity by describing intended impact of professional services





Critical Elements

- Interventions must specify
 - Program staff responsible
 - Modality
 - *What type of group/skill-building service?*
 - *For what purpose/intent (brief phrase re: skills or behaviors being taught)*
 - Frequency (how often); intensity (for how many minutes); duration (over what period of time).

A decorative vertical bar on the left side of the slide. It features a gradient from blue at the bottom to orange at the top. At the top, there is a white arrow pointing up, a grey arrow pointing left, and a red arrow pointing right.

Again, the focus on skill-building

- Teaching Skills
 - Instructions; modeling; skill strengthening procedures
- Helping client rehearse/practice skill
 - Reinforce new skills; coaching and feedback;
- Helping clients link various skills together
- Helping client generalize skills to other settings
 - Adaptation & modification; building self-reinforcement; coaching & feedback; providing review materials/tools; in vivo practice; modifying the environment to reinforce/enlisting natural supports



Critical Elements

- Staff Responsible:
 - *CSP Community Integration Coordinator*
- Modality/Service:
 - *will provide Community Connections group (Rehab)*
- Frequency & Duration
 - *2X per month for 3 months*
- Purpose/Intent (Description of Methods)
 - *For the purpose of helping Greg to... identify local Adult Ed classes which fit his interests, to build skills and independence using public transportation, to complete financial aid and enrollment applications, to negotiate reasonable accommodations prn, etc.*



Critical Elements

- Wherever possible, include a task for the individual as well as family or other community or natural supporters
 - *Indicate the specific actions the person served will take to support achievement of the objective*
 - *Indicate the actions/support the parent/guardian/community/ others will provide*



Example

- Jane comes to your integrated clinic/CSP program asking for medications that help her with her 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:
 - Sam Smith, CSP 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.
 - Jane will attend AA meetings 3 x per week for 3 months in order to develop a sober support system



Example, cont.

- Objective 2
 - Within 60 days, Jane will demonstrate two stress reduction skills in session with CSP worker.
- Interventions
 - RP 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.



Writing a Recovery Plan Excerpt

- Write Mr. Blake's Integrated Summary and Plan:
 - Each team/group needs a spokes-person and a recorder
 - Write a brief (few paragraph) integrated summary
 - NOW, one group member can role play Mr. Blake
 - In your small group teams:
 - Write a plan excerpt on the transparency form provided, i.e., one goal, one objective, strengths/barriers, & a set of interventions)
 - Large group review and discussion

In Conclusion

- “Getting it” vs. “doing it” and “living it”
- Many MH systems change efforts get derailed by perpetual efforts to help people “get it”
- Sometimes you just have to dive in and do it/live it!!





Take Home Message

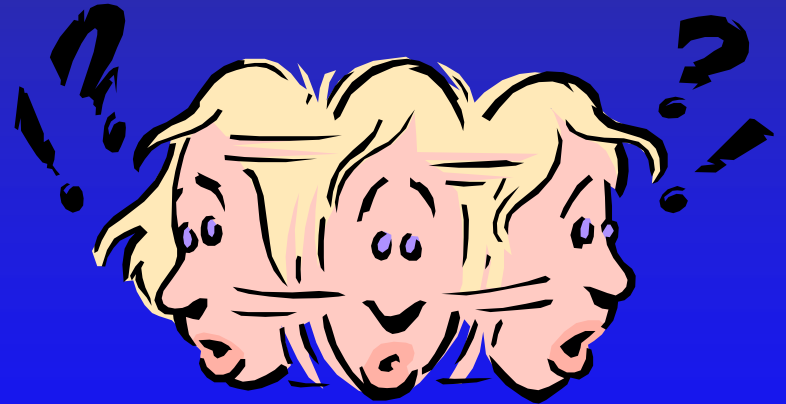
“We don’t think ourselves into a new way of acting, we act ourselves into a new way of thinking.”

Execution, The Discipline of Getting Things Done, by
Larry Bossidy and Ram Charan

Q&A



- ▶ What do you need to know more about?
- ▶ How is this impacting your work?



- ▶ What might be some of your next steps?
- ▶ What do you need support with...



For more information:

The DMHAS CSP/RP Website:

<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=457094>

Janis Tondora

203-605-8661

Janis.tondora@yale.edu

Julienne Giard

860-418-6946 or

julienne.giard@po.state.ct.us