Person-Centered Care & Planning: Policy to Practice to Evaluation

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Who are we? - We're

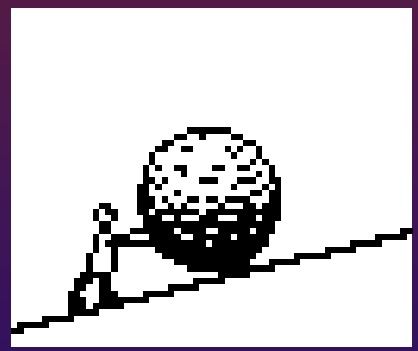
Department of Mental Health and Addiction Services
A Healthcare Services Agency

- CT Substance abuse and mental health authority
- 70,000 people in care annually
- 3,600 employees, two hospitals, 15 LMHAs
- $600 million/year operating expenses
- Contracts with 250 non-profit agencies
- Prevention (all ages)
- Treatment (age 18+)
- **RECOVERY IS OUR BUSINESS**

"addicts"

"a chronic, relapsing disease"

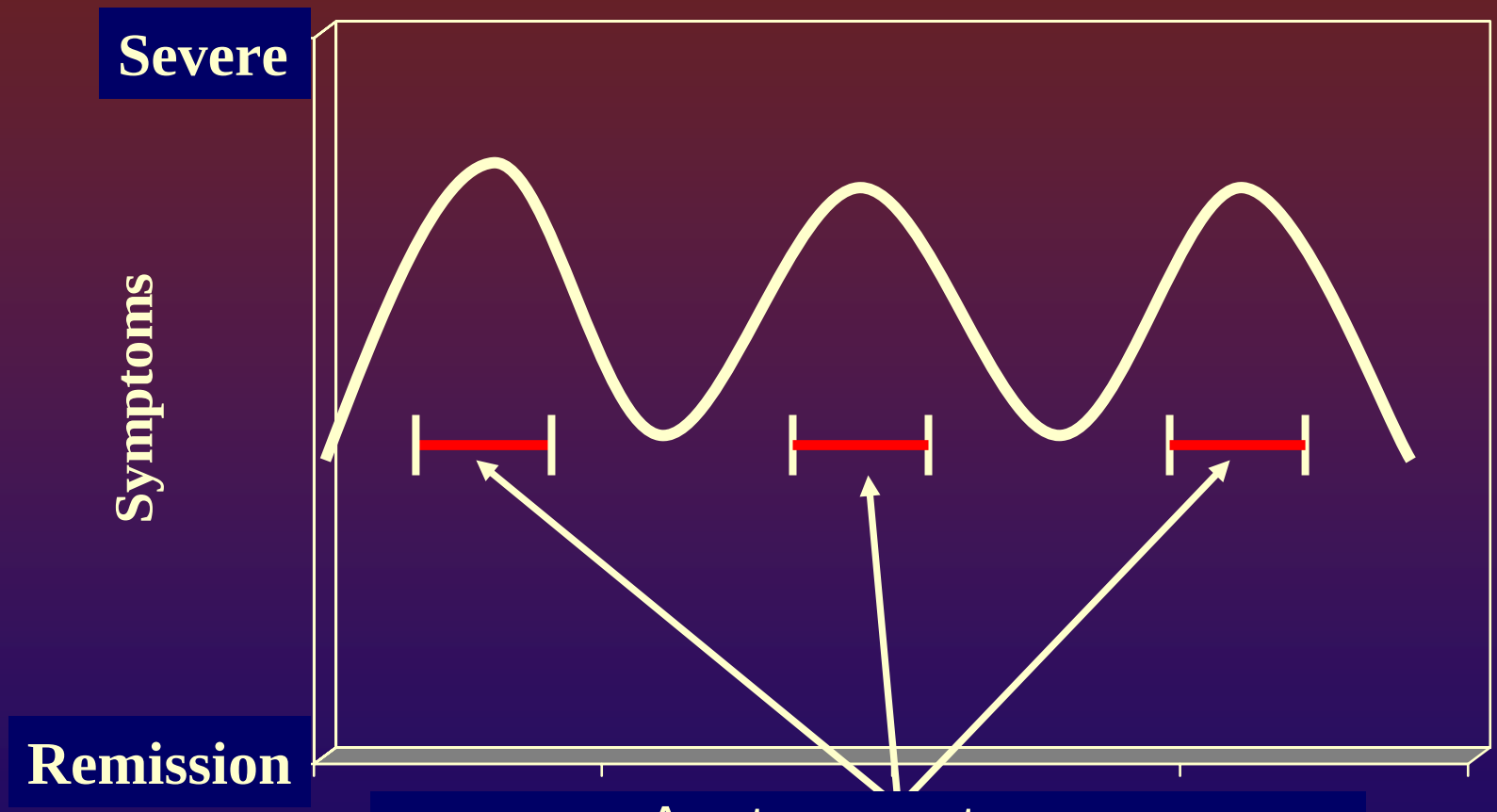
"severe persistent mental illness"



What message are we conveying?

Doesn't anybody ever get better?

Typical service response



Acute symptoms

Discontinuous treatment

Crisis management

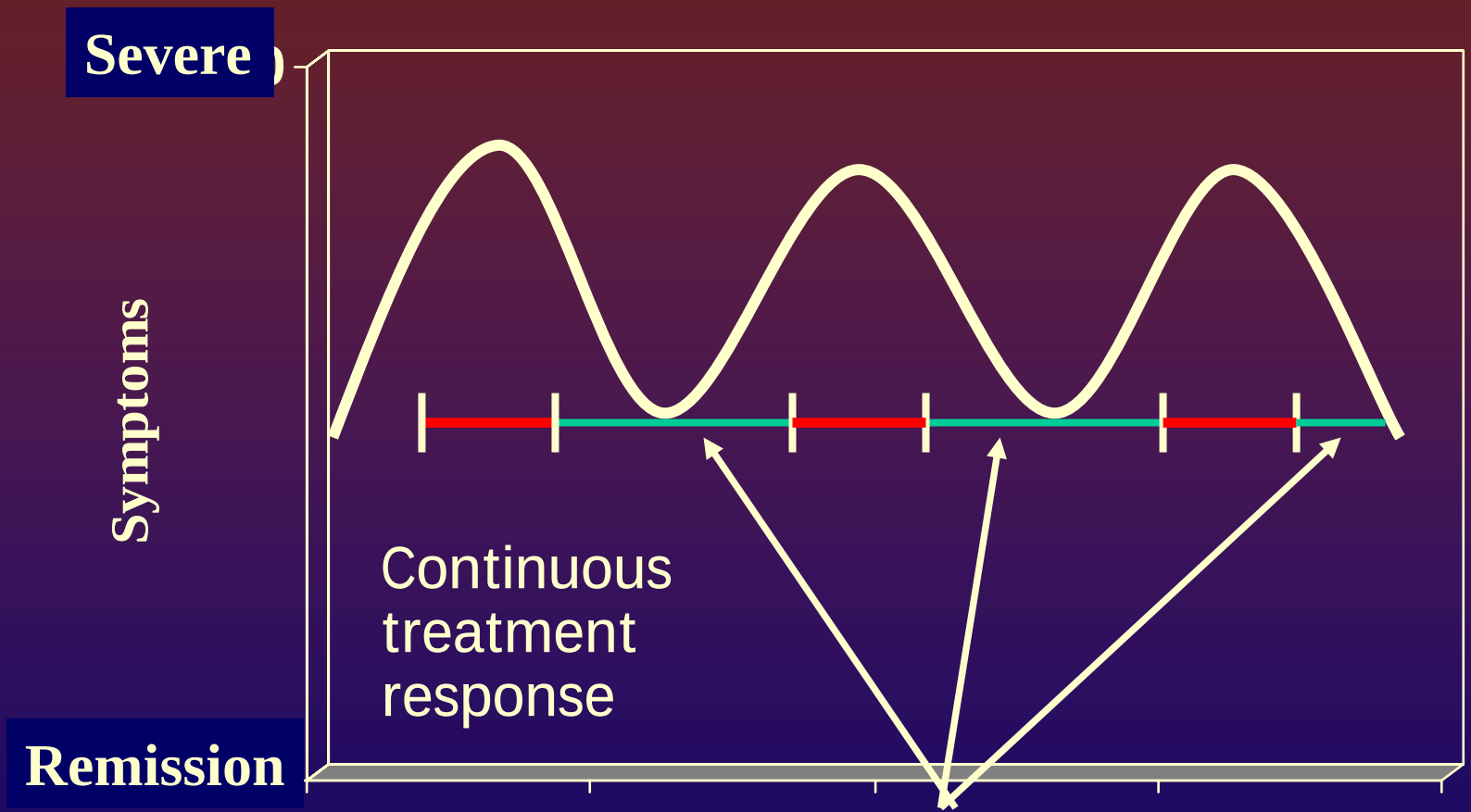
Recovery “From” vs. Recovery “In”

- Recovery “from” mental illness involves the amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they NO LONGER INTERFERE WITH DAILY FUNCTIONING, ALLOWING THE PERSON TO RESUME PERSONAL, SOCIAL, AND VOCATIONAL ACTIVITIES WITHIN WHAT IS CONSIDERED A NORMAL RANGE.

- Recovery “in” mental illness involves a process of RESTORING OR DEVELOPING A POSITIVE SENSE OF IDENTITY and meaningful sense of belonging APART FROM one’s condition while REBUILDING A LIFE despite or within the limitations imposed by that condition

- A “Recovery-oriented system” values the importance of BOTH recovery FROM and recovery IN mental illness… our mission to assist people in *regaining a meaningful, constructive, sense of membership in the broader community.”*

Recovery-oriented response



Promote Self Care, Rehabilitation

Single Overarching Goal: A Value-Driven, Recovery-Oriented Healthcare System

How do you get there???

What might get in your way…

- Anticipate concerns and address the tough questions, early on and throughout…
- Often these relate to "systemic" level issues that providers feel are, to some extent, beyond their control
- Align with provider community. Do not overlook organizational context and barriers while trying to "fix" individual providers…
  - *"When you pit a bad system against a good performer, the system always wins…(Rummler, 2004).*
- Pay attention to the "Top Ten Concerns About Recovery"

The Top 10 Concerns About Recovery

<u>Concern # 5</u>: *Who's going to pay for it? Medicaid can only pay for active treatment.*

<u>Recovery perspective</u>: Medicaid has been used in many creative ways.

<u>Strategy</u>: Use federal dollars to fund whatever they can, and use general fund dollars to fund other services that are not reimbursable under Medicaid.

The Top 10 Concerns About Recovery

<u>Concern #3</u>: *Recovery conflicts with other DMHAS initiatives. There are too many conflicting and fragmented efforts.*

<u>Recovery perspective</u>: Each initiative is compatible with a recovery perspective

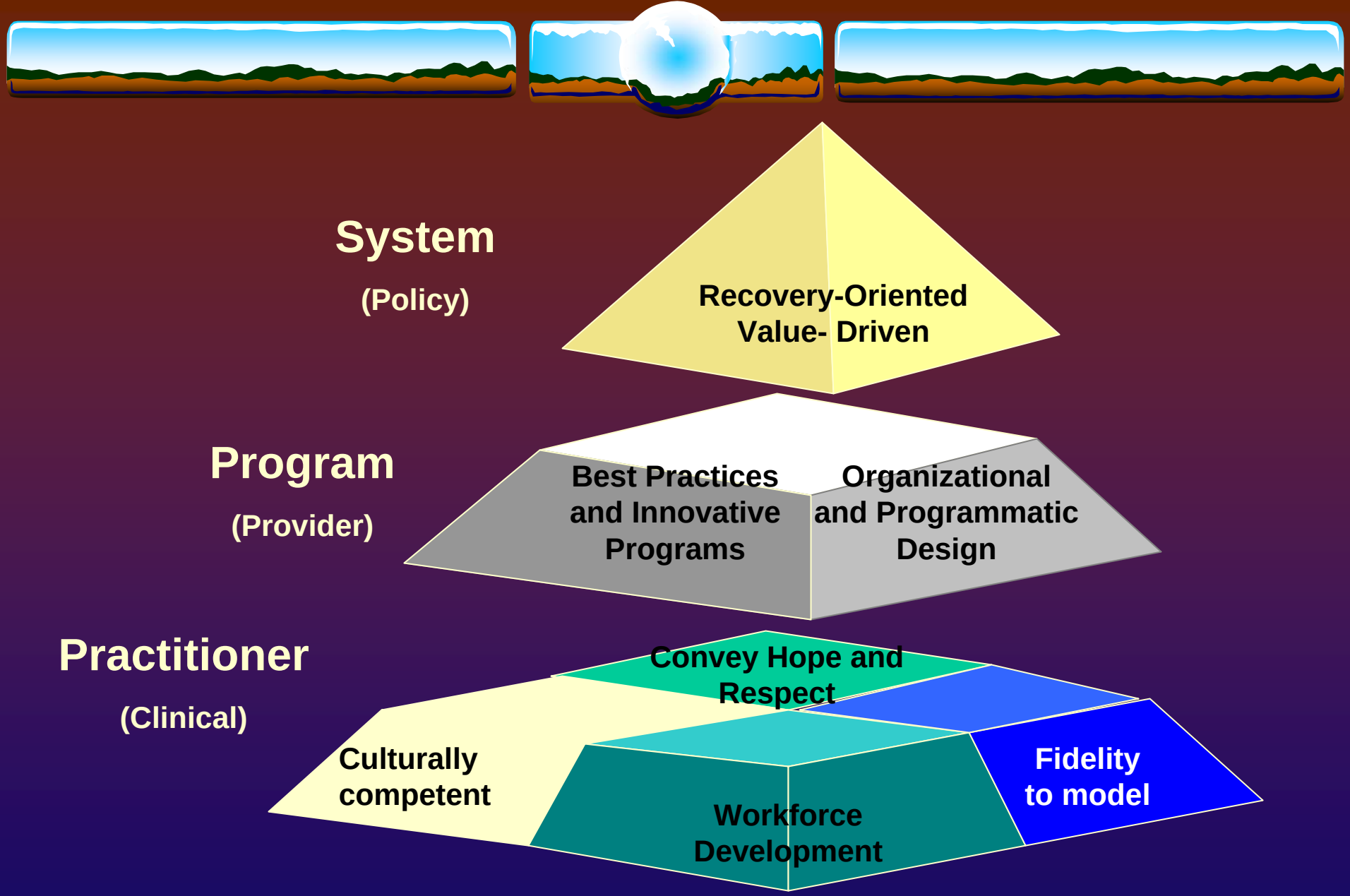
<u>Strategy</u>: For example, person-centered planning should be part of Integrated Dual Diagnosis Treatment. In order to be recovery-oriented, services must be culturally competent.

The Top 10 Concerns About Recovery

<u>Concern #2</u>: *Recovery devalues the role of professionals. Recovery can appear anti-treatment or anti-provider in tone.*

<u>Recovery perspective</u>: Recovery moves behavioral health much closer to other medical specialties where the Doctor presents “treatment choices.”

<u>Strategy</u>: Recovery-oriented care requires a higher level of professional knowledge and expertise.



Multi-level Change Efforts

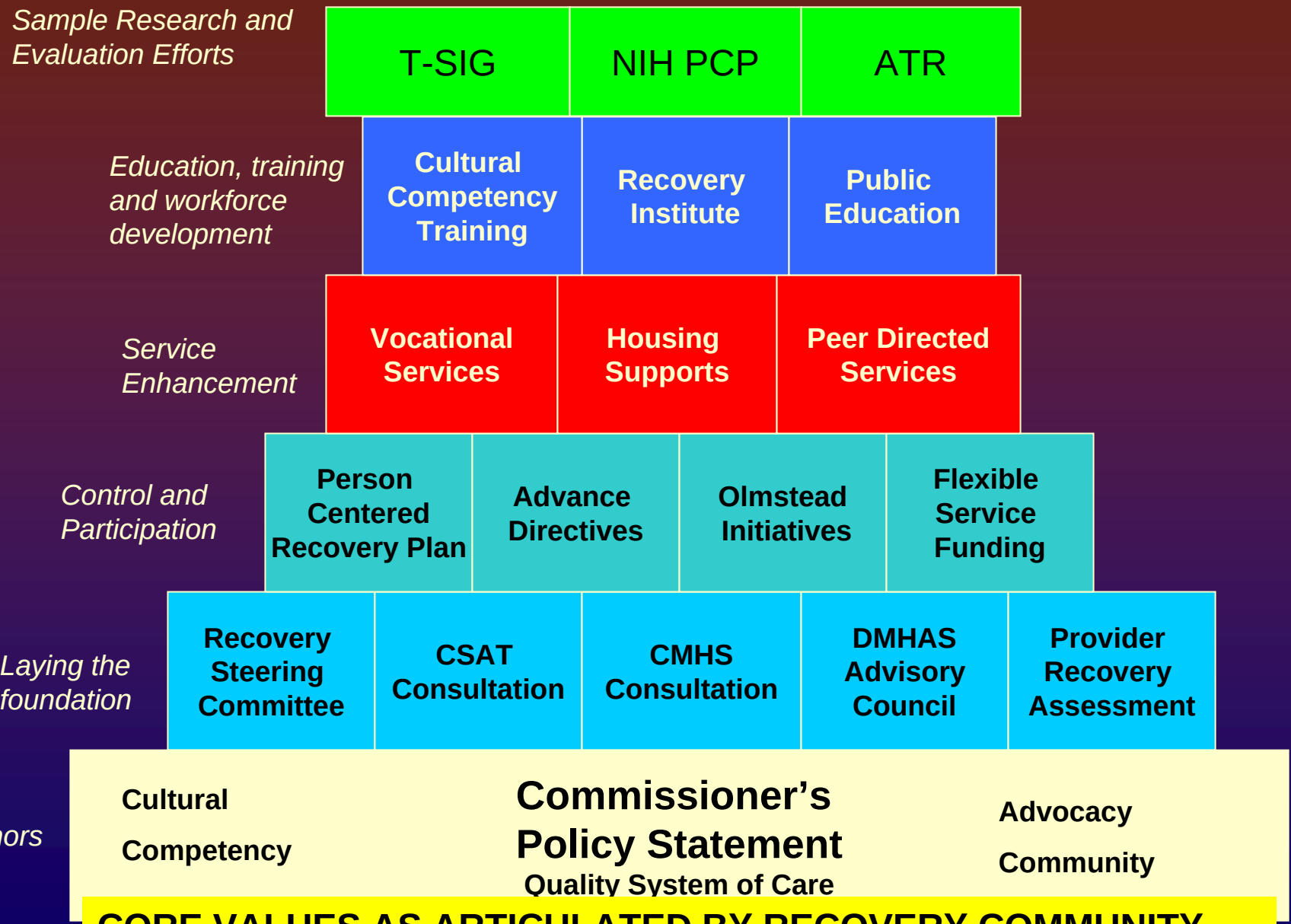
Setting the Tone Through Policy

- Commissioner's Policy Statement #33, Individualized Recovery Planning, March 27, 2007
  - *…The Plan of care shall be developed in collaboration with the person… with provisions to ensure that they have the opportunity to play an active, meaningful role in the decision-making process.*
  - *…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…Given this community focus, one tool required is an adequate knowledge of the person's local community and its opportunities, resources, and potential barriers.*

Strategies for Change

- Ground all efforts in a commitment to listen and respond to the voice of recovery community
  - in policy development, e.g., CORE RECOVERY VALUES as the foundation which has informed all subsequent building blocks, including the Commissioner's policy
  - in service design and delivery, e.g., peer specialist model
  - in research and evaluation, e.g., DMHAS/Yale NIMH grant
  - in training and educational efforts, e.g., CT Recovery Institute (teachers & learners)
- Use technology transfer strategies to identify develop, implement, and sustain "best practices"
- Incorporate existing initiatives
- Re-orient all systems to support recovery
- Transition to recovery-oriented performance outcomes in non-punitive approach

CT Implementation Process



Recovery Core Values

Direction

- Equal opportunity for wellness
- Recovery encompasses all phases of care
- Entire systems to support recovery
- Input at every level
- Recovery-based outcome measures
- New nomenclature
- System wide training culturally diverse, relevant and competent services
- Consumers review funding
- Commitment to Peer Support and to Consumer-Operated services
- Participation on Boards, Committees, and other decision-making bodies
- Financial support for consumer involvement

Recovery Core Values

Participation

- No wrong door
- Entry at any time
- Choice is respected
- Right to participate

Programming

- Individually tailored care
- Culturally competent care
- Staff know resources

Funding-Operations

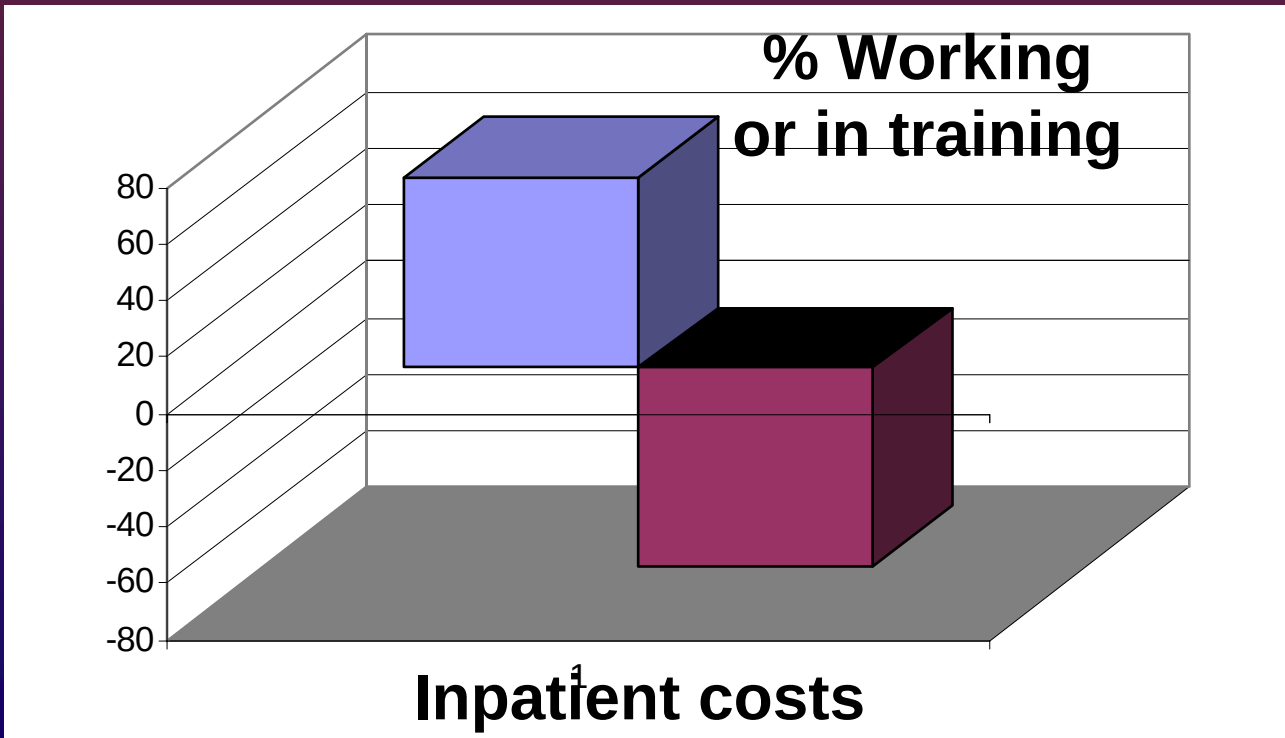
- No outcomes, no income
- Person selects provider
- Protection from undue influence
- Providers don't oversee themselves
- Providers compete for business

Systems Change & What Works: Lessons Learned

1. *Emphasizing community life and natural supports*
2. *Recognizing that people in recovery have valuable and useful contributions to make*
3. *Using multiple forms of "evidence" to guide policy*
4. *Using a combination of approaches to address cultural needs and elimination of health disparities*
5. *Establishing clear service expectations for providers and monitoring outcomes*
6. *Using "Practice Management Tools"adapted from the private sector to improve outcomes for people using public sector services*

Lesson 1:
Focus on community life and natural supports – Example 1: Supported Housing and Employment

More people working, less inpatient costs

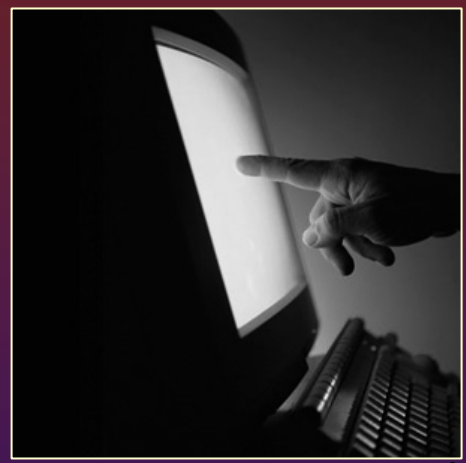


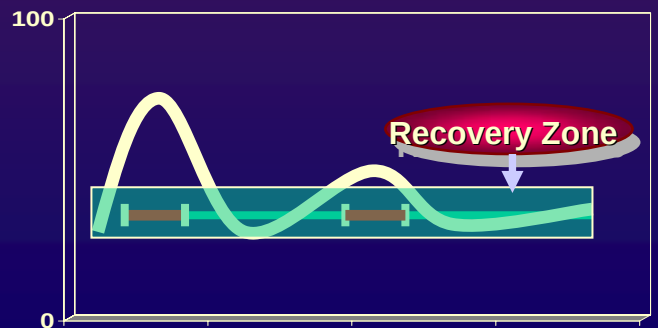
DMHAS established new supportive housing units for over 550 people with psychiatric or substance use disorders. Over 60% of these people are now working or in training, and their inpatient costs have decreased 70%.

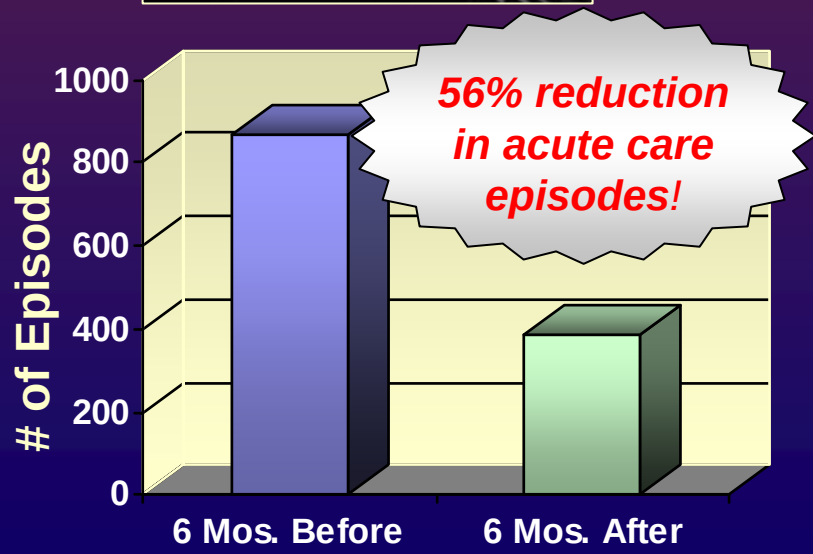
Based on a Corporation for Supportive Housing study, these supportive housing units are projected to generate over $140 million in direct and indirect economic benefits for the state.

Lesson 1:
Focus on community life and natural supports – Example 2: Specialized Intensive Supports

- ASO identifies people with 3 or more acute hospital admissions within 90 days
- Recovery manager initiates contact while person is still in hospital
- Recovery plan developed to fill support gaps
- Recovery manager helps with transition to community care





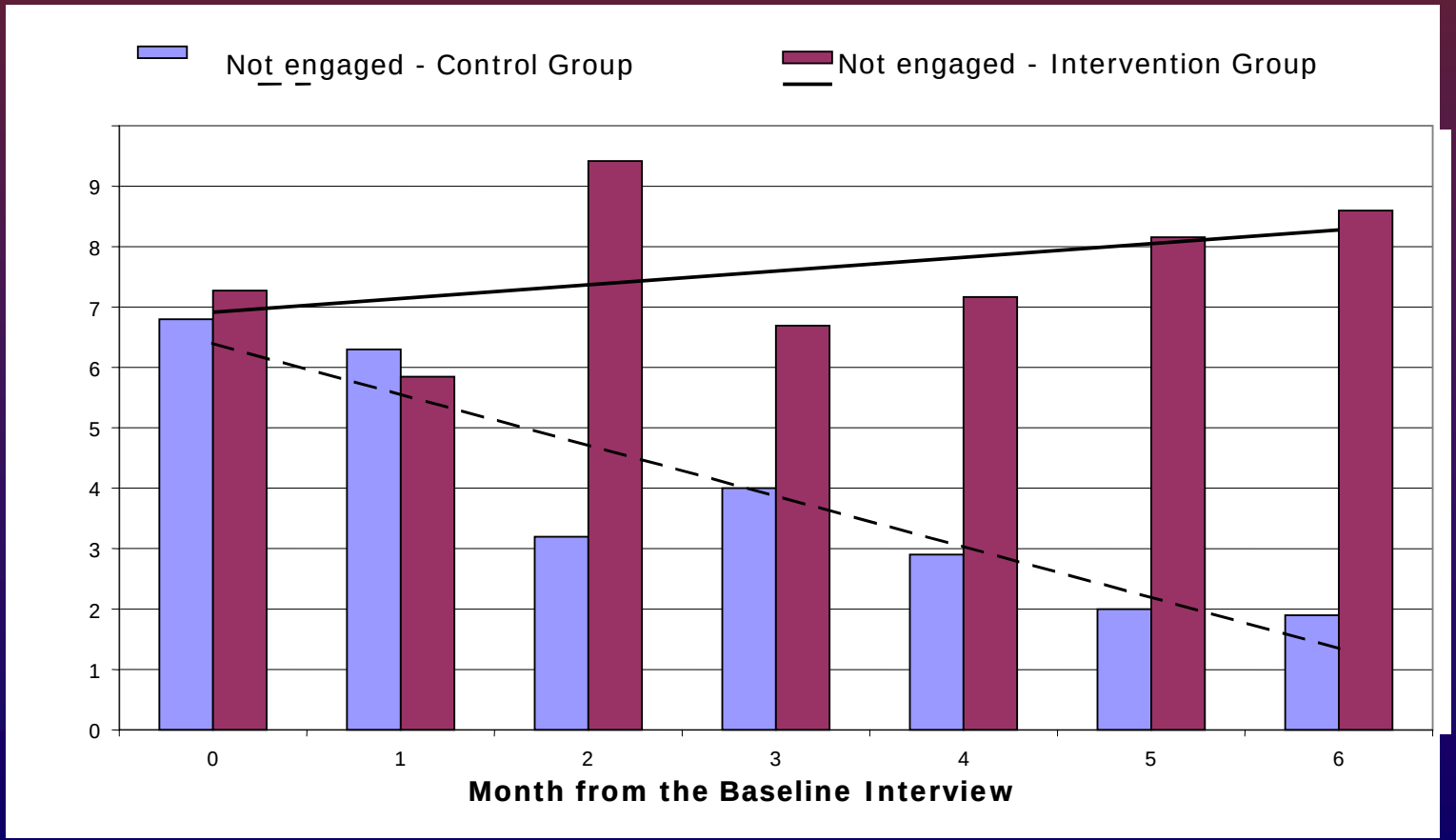


Lesson 2:

People in recovery make valuable contributions

Peer Engagement Specialist Initiative

Agency Contacts for the Least Engaged Clients



Source: 2002 Annual report to CT Legislature

Lesson 5:
Necessity of Clear Expectations and Guidelines

- Provider Recovery Self-Assessment
- Consumer survey and language required by contracts
- Recovery-oriented performance measures
- Recovery-Oriented Practice Guidelines

  - Primacy of participation
  - Promoting Access and engagement
  - Ensuring Continuity of care
  - Employing Strength-based assessments
  - Community mapping and development
  - Identifying and addressing barriers to recovery
  - Functioning as a recovery guide
  - **Offering Individualized recovery planning**

Person-Centered Planning: A Window of Opportunity

. . .The plan of care will be at the core of the consumer-centered, recovery-oriented mental health system. The plan will include treatment, supports, and other assistance to enable consumers to better integrate into their communities and to allow consumers to realize improved mental health and quality of life.

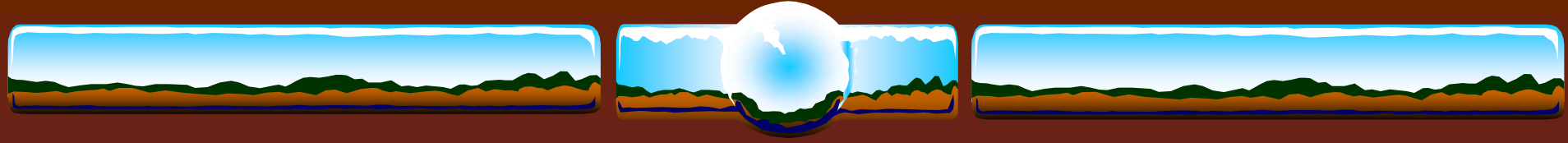
- New Freedom Commission Report on Mental Health, 2003

Recovery for “them”…

- ✓Compliance with treatment
- ✓Decreased symptoms
- ✓Stability
- ✓Better judgment
- ✓Increased Insight…Accepts illness
- ✓Follows team’s recommendations
- ✓Decreased hospitalization
- ✓Abstinent
- ✓Motivated
- ✓Increased functioning
- ✓Residential Stability
- ✓Use services regularly/engagement
- ✓Cognitive functioning
- ✓Realistic expectations
- ✓Attends the job program/clubhouse, etc.

Wellness for “us”

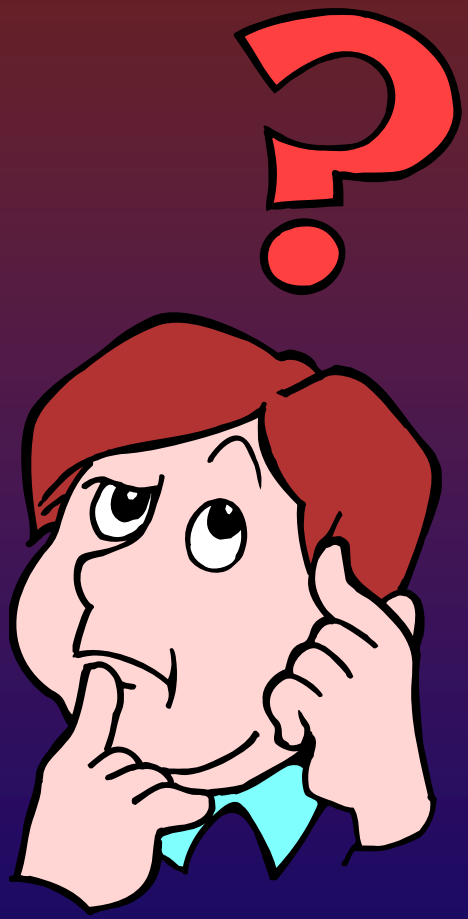
- ✓A home to call my own
- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daugther
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓Love…intimacy…sex
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning



PCP as a tool to get beyond Us and Them

- Person-centered planning, at its core, is about recognizing that people with mental illnesses generally want the exact same things in life as ALL people.
- Clinical “stability” may be valued, but, for many, it is not enough. People want to thrive, not just survive…
- PCP is one tool the system can use to help people in this process!

PCP…Don’t we already do this??



- *“If everybody’s doing it, how come nothing is getting done??”*

  Joe Marrone, ICI

- *“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

- So, no, we don’t “already do this.”
  - Not according to consumer/survivors…
  - and not if you take a close look at concrete implementation strategies.
  - “old wine…new bottles”

The Utility of Practice Guidelines

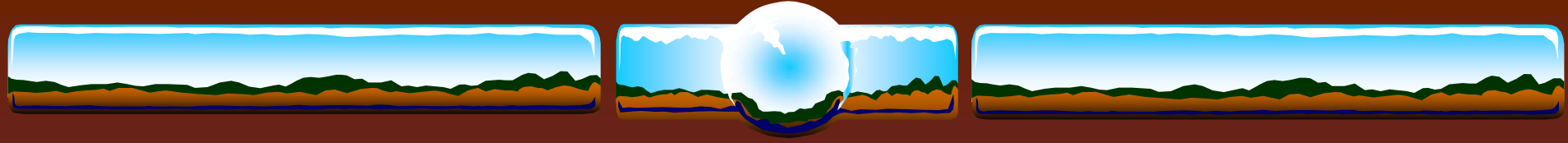
- Promote increasing accountability among providers and system as a whole
- Provide a road-map for trainees/providers who WANT to make changes, but they feel un/under-prepared (C-H-O-W)

- Assist in prioritizing training & consultation objectives
- Educate consumers and families re: what they can/should expect from supporters and the system at large, e.g., our Recovery Mentors

Guidelines can be a useful blueprint for desired change!

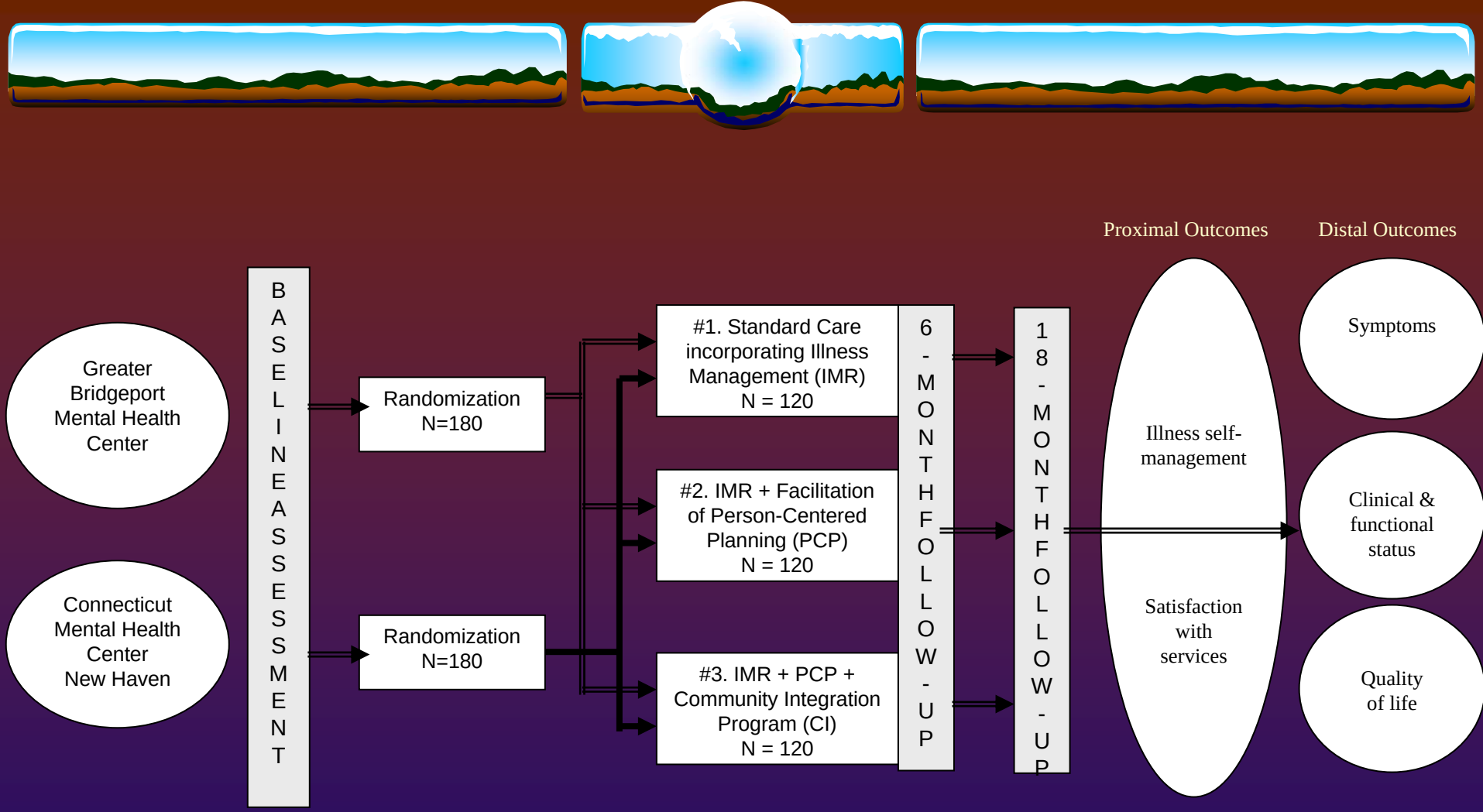
Collaborative Research & Evaluation

- NIH-funded R01, Culturally Responsive Person-Centered Care for Psychosis
- Awarded to Connecticut DMHAS; carried out in collaboration with the Yale Program for Recovery and Community Health
- Overarching aim is to examine a model of person-centered care which incorporates much of what has been learned in recent years regarding the effectiveness of self-directed wellness strategies, community integration programs, peer-support services, and collaborative treatment planning.



Why people of color with psychosis?

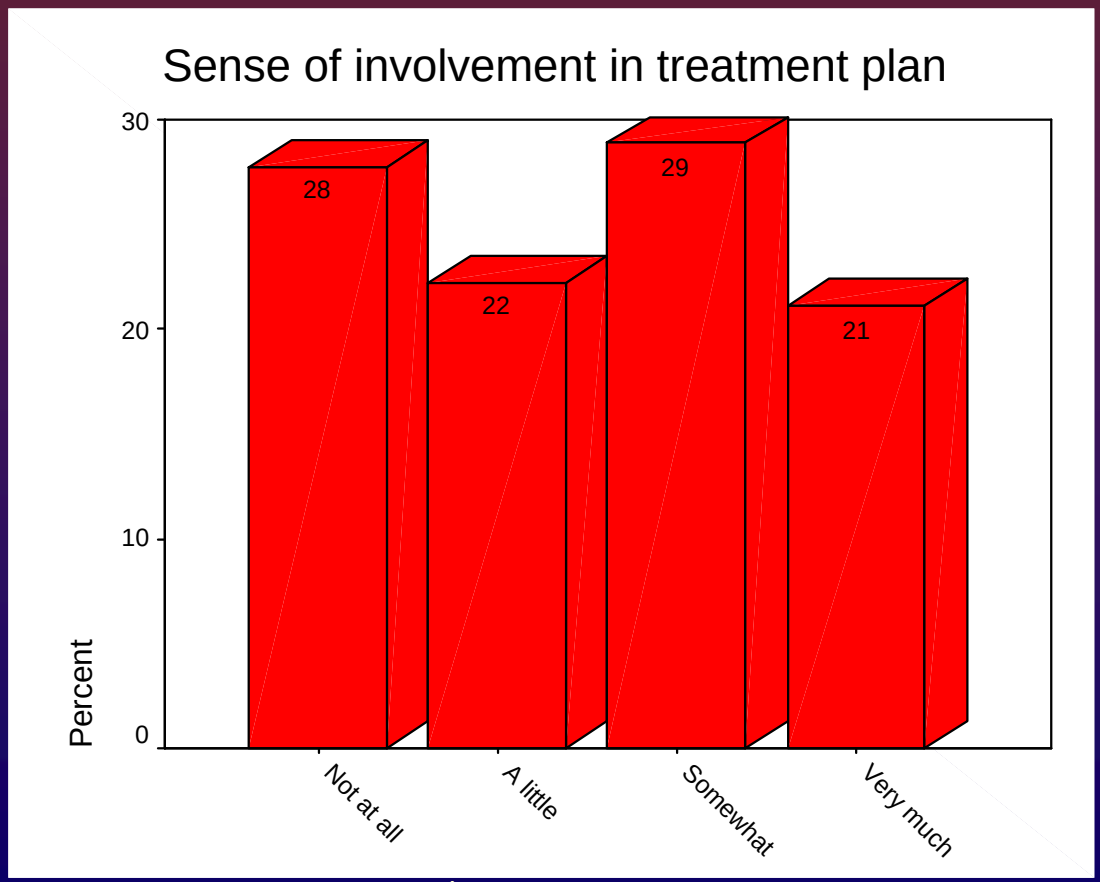
- Health disparities research: People of color experience significant inequality in terms of access to care, quality of care, and response to care
- People with psychosis are particularly vulnerable to having certain protections (e.g., the right to self-determine and to make treatment choices) taken away based on assumptions re: mental illness
- Taken together, this suggests that this target group represents one of the most disenfranchised populations in American medicine.



Culturally Responsive Person Centered Care for Psychosis

The Nature of the Problem

- 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”.



- Only 21% of participants report being “very much” involved
- Only 12% of people invited someone to their last treatment planning meeting
- Over half were not offered a copy of their plan
- People aren’t even in the car, let alone the driver’s seat!

Does Involvement Really Matter?

	Involvement	TPQ2 Planning	TPQ3 Running	TPQ5 Agenda
Hope Scale Total	Pearson Correlation	.263(**)	.306(**)	.197(*)
	Sig. (2-tailed)	.008	.002	.047
Pathways Factor	Pearson Correlation	.312(**)	.297(**)	.187
	Sig. (2-tailed)	.002	.003	.060
Agency Factor	Pearson Correlation	.179	.269(**)	.177
	Sig. (2-tailed)	.075	.007	.074

Hope sustains, even during periods of relapse. It creates its own possibilities. Hope is a frame of mind that colors every perception. By expanding the realm of the possible, hope lays the groundwork for healing to begin. (Jacobson & Greenley, 2001, p 483)

Yellow = Correlation is significant at the 0.05 level (2-tailed).
Orange = There is a trend for significance.

The Power of “Peer Services”

“The peer-to-peer model is an exceptional example of the innovative ways in which we can help the system overcome its own barriers. Peer-support programs are not just empowerment programs. They are an expression…and an example…of the way the system is going to have to fundamentally change to foster healing relationships, and create an environment conducive for recovery.”

- A. Kathryn Power, CMHS

Who is a Recovery Mentor?

Someone who:

- Has personal experience receiving mental health services
- Wants to give back to others in recovery
- Has been trained to protect your confidentiality and your rights as a research participant
- Is dedicated to your recovery

Recovery Mentors

Partners in Your Recovery!

Your Recovery Mentor: _____

Phone Number: _____

What does a Recovery Mentor do?

A Recovery Mentor can:

- Get to know you and the things that are important to you and your recovery
- Encourage you to speak up about your priorities and goals
- Help you figure out how your team can best support you
- Point you to resources in your community
- Help you work with your team to create a "person-centered" plan

Who is a Community Connector?

A Community Connector is someone who:

- Has personal experience receiving mental health services
- Wants to give back to others in recovery
- Has received training in protecting your confidentiality and your rights as a research participant
- Is available to help you reconnect with things you like to do in the community

Community Connections Program

Getting Out & About in Your Community!

Community Connector:

Phone Number: _____

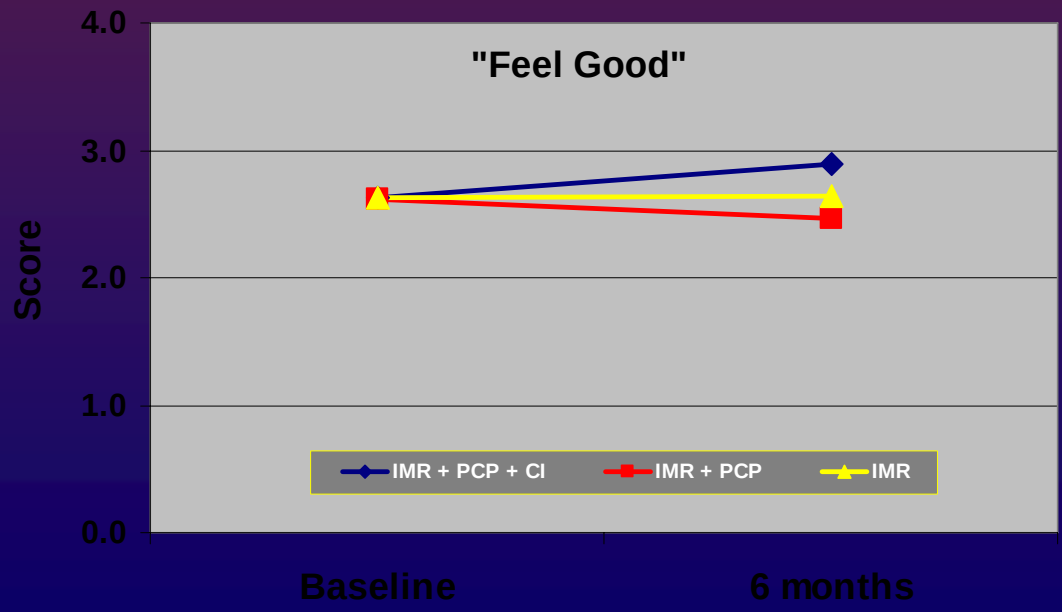
How can I make use of this program?

You can:

- Get to know your local community and all it has to offer you
- Have leaders or others accompany you on fun and interesting community outings
- Connect to people, places, and things where you feel welcomed and valued

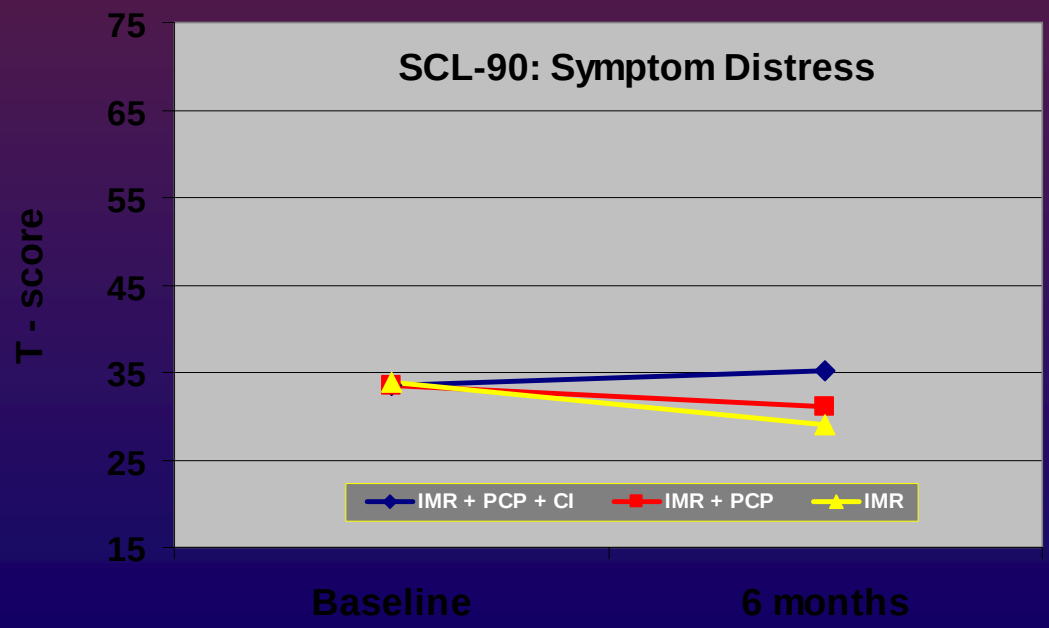
Preliminary Results

- IMR+PCP+CI reported significantly greater increase in positive feelings (e.g., feeling good about oneself and one's future) over time, compared to IMR and IMR+PCP.



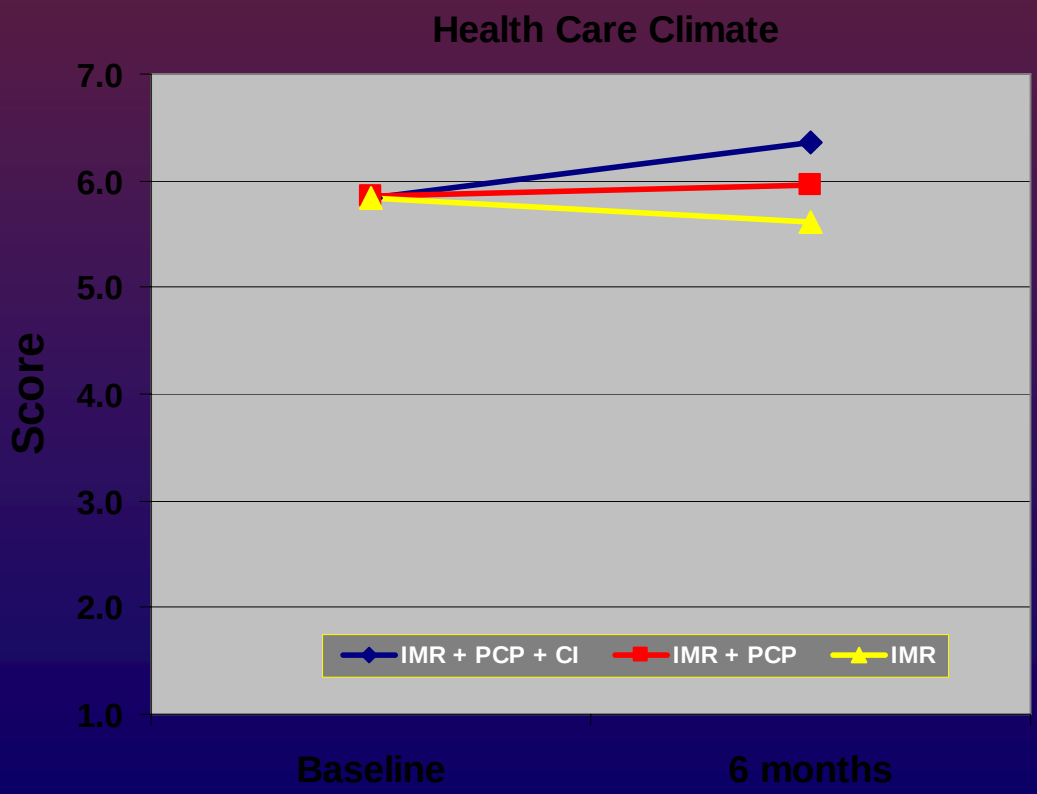
Preliminary Results

- IMR+PCP+CI also reported a significantly greater increase in Symptom Distress over time compared to IMR and IMR+PCP.
- Combined with the previous slide about "feeling good," this is precisely what *resiliency* and *recovery* are about, feeling good and positive DESPITE the presence of symptoms.



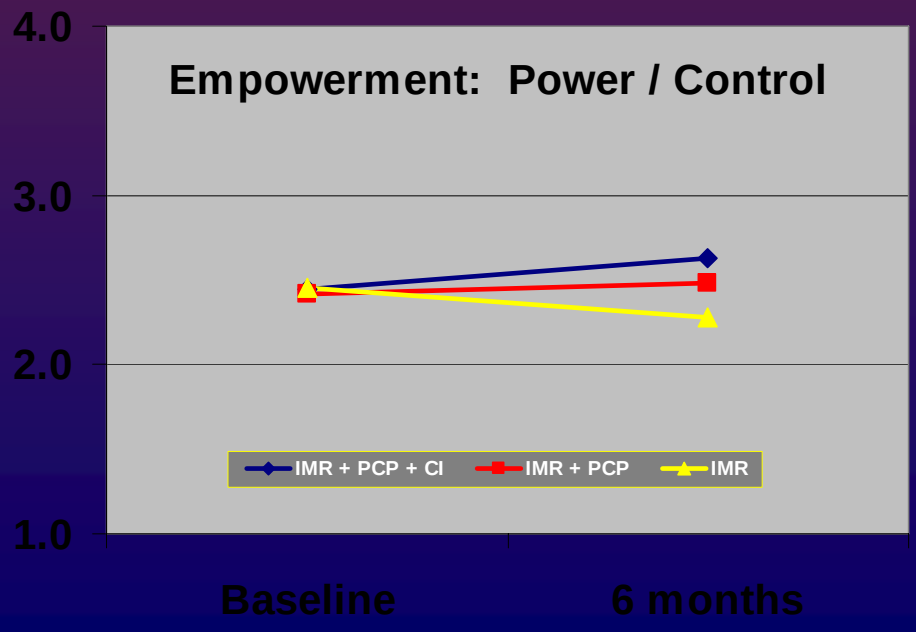
Preliminary Results

- IMR+PCP+CI participants reported a significant increase in feeling that their clinicians were responsive to their needs over time compared to IMR alone, not significantly different from IMR+PCP.



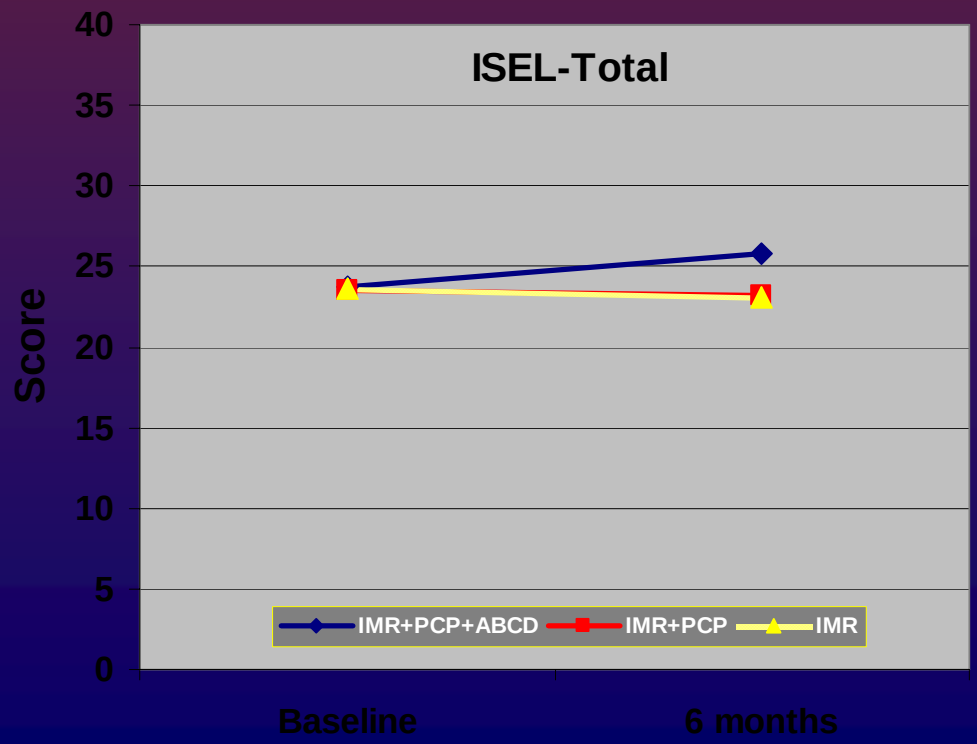
Preliminary Results

- IMR+PCP+CI and IMR+PCP participants both showed increases in sense of power/control over their lives over time, in comparison to IMR alone.



Preliminary Results

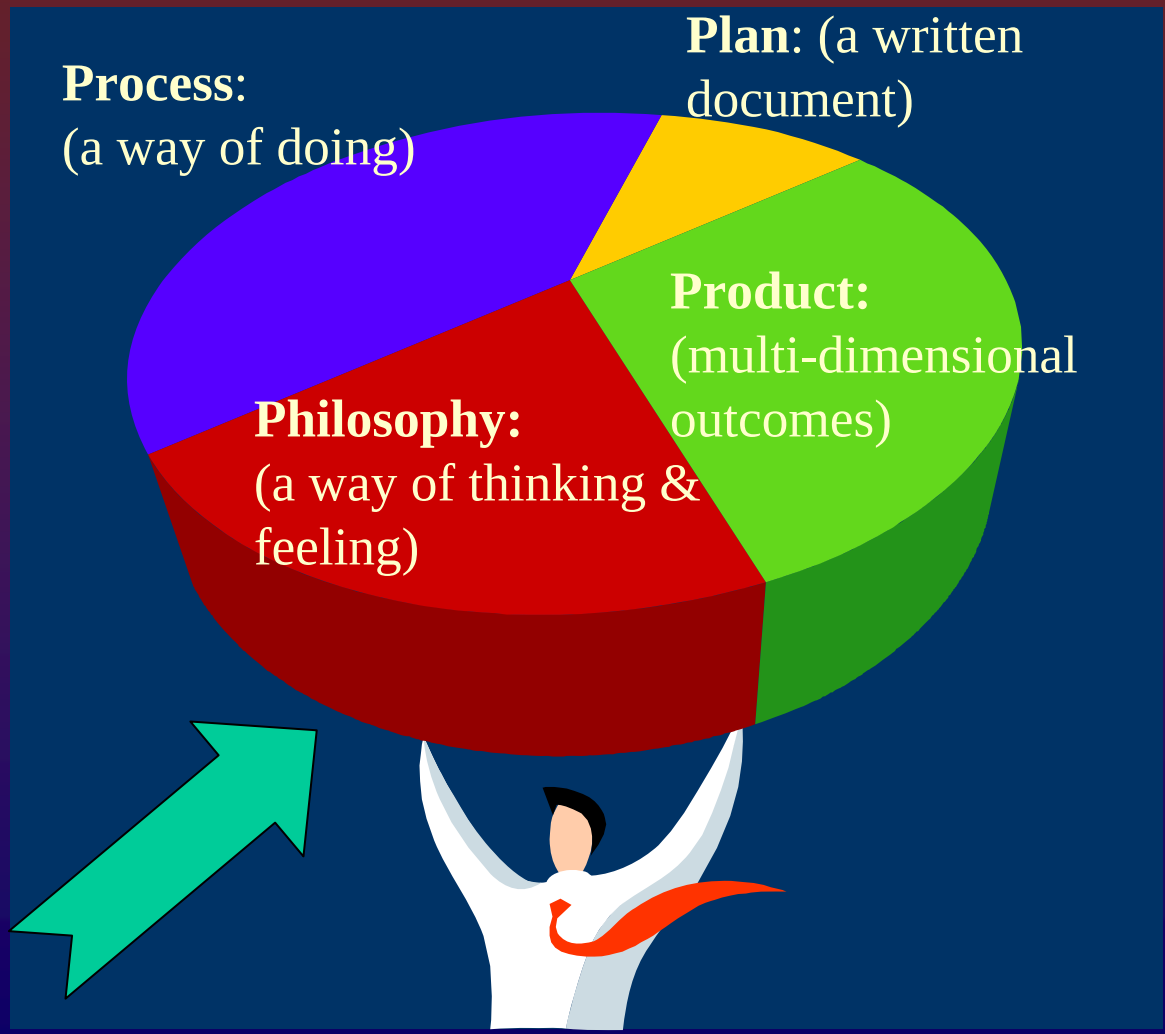
- IMR+PCP+CI reported a significant increase in overall social support over time, in comparison to IMR and IMR+PCP groups.



The “Nuts and Bolts” of PCP

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 way people feel and think (hearts and minds).



Key Practices in Implementation

- Make continuous use of strengths-based assessment strategies
  - e.g., A discussion of strengths is a central focus of every assessment
- Adhere to person-centered principles in the process
  - e.g., Plans are written together and person ALWAYS has a copy

Key Practices in Implementation

- Recognize the range of contributors to the planning process
  - e.g., Plans reflect (in attendees and interventions) a wide range of both professional supports and alternative strategies
- Value community inclusion
  - e.g., Plans respect the fact that services and professionals should not remain central to a persons' life over time

Community Life: What does it have to do with *Recovery??*

EVERYTHING! If we listen to the voice of people in recovery…

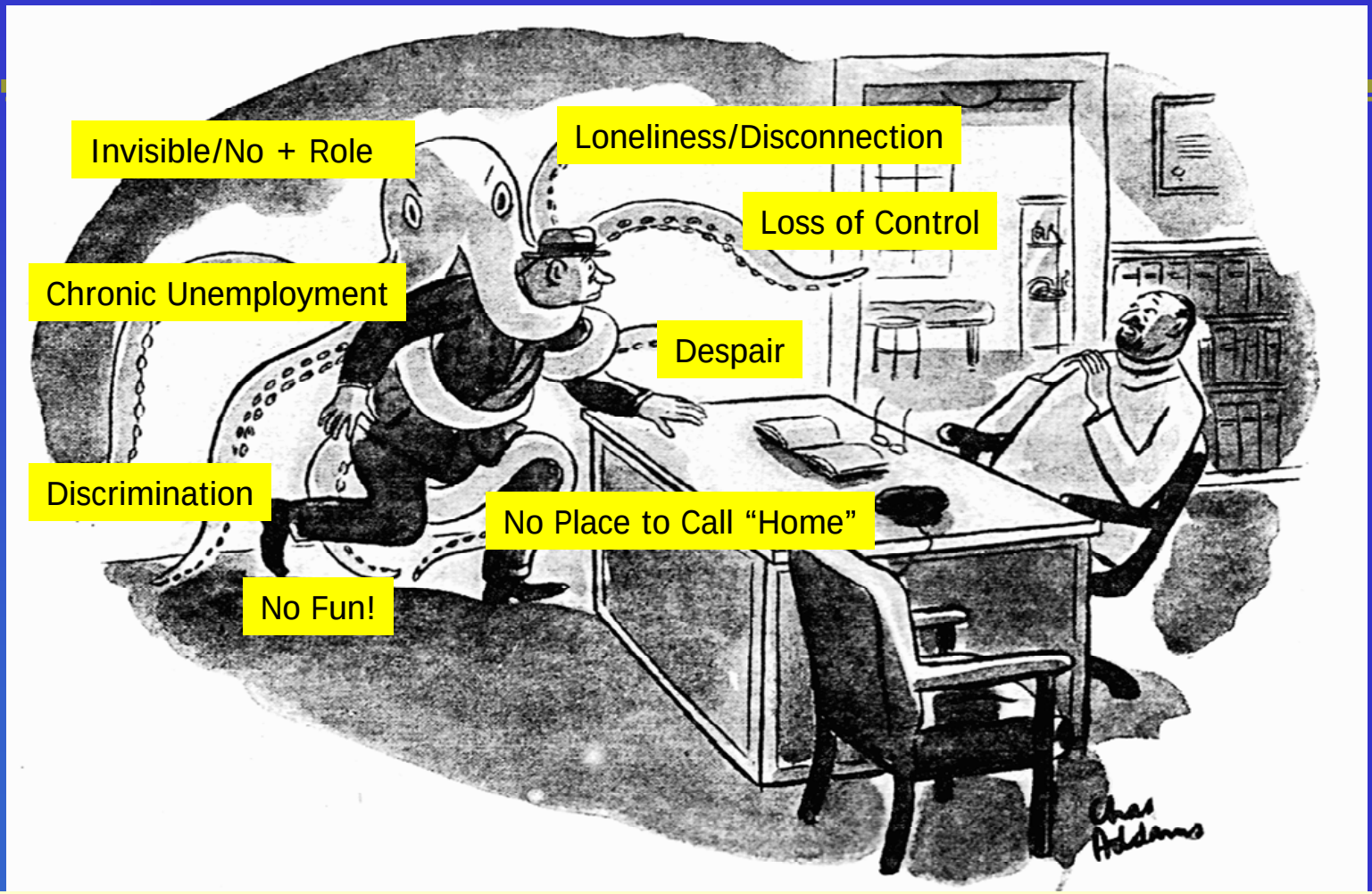
Part of healing and recovery is the ability to participate as full citizens in the life of the community. (Walsh, 1996)

To join the dance of life…

There is this little pub down the street that I just love. I like to go there and have a tonic and lime and just chat with the patrons. I am not sure what it is about that place?? But it makes me feel good. Maybe…maybe it's a lot like 'Cheers' – you know, a place where everybody knows my name… I am just Gerry, period. Not "Gerry the mental patient…"

(Man in recovery on finding his niche…)

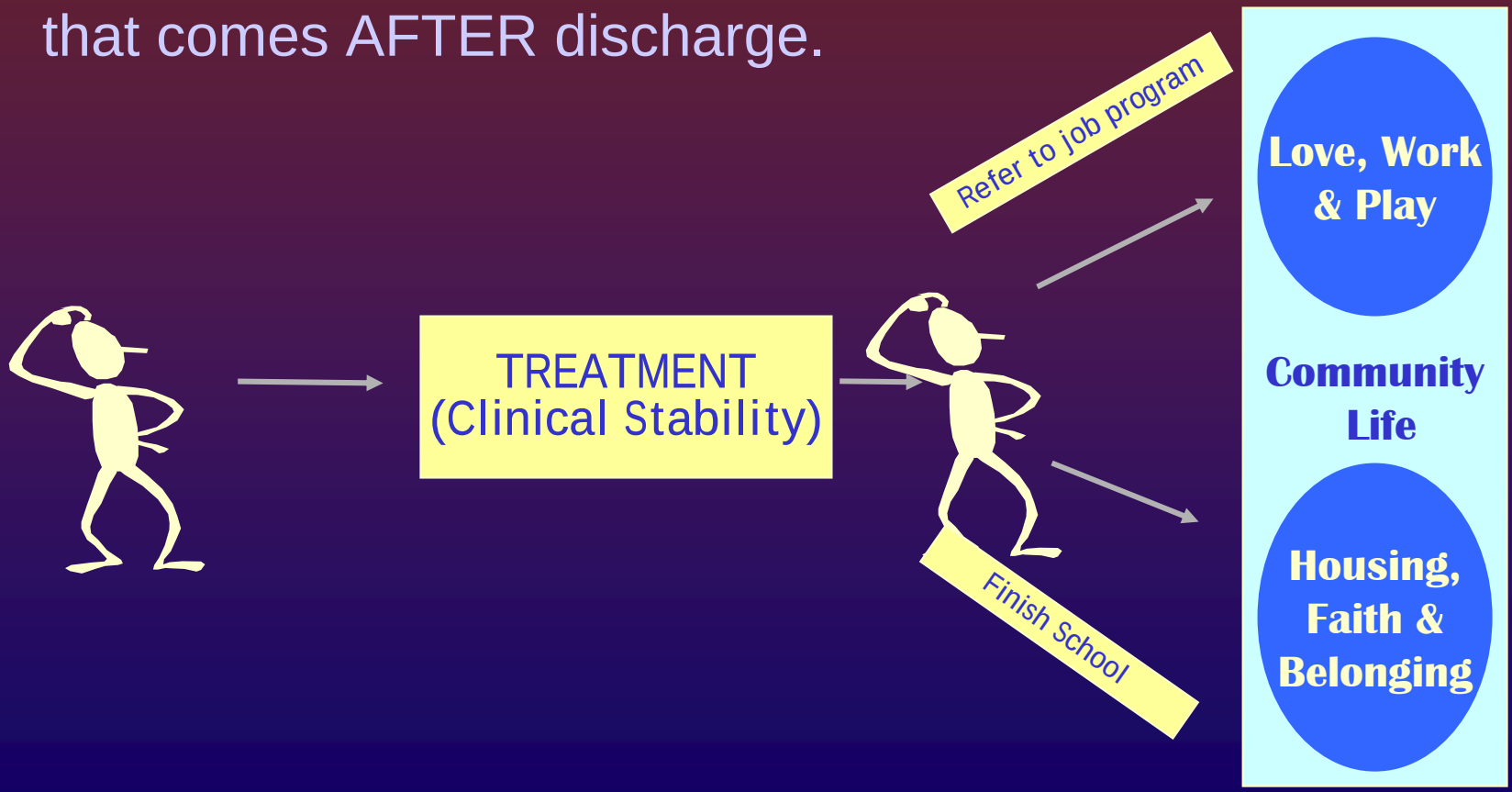
Missing the Obvious



“Now just sit down and tell me what seems to be the trouble…”

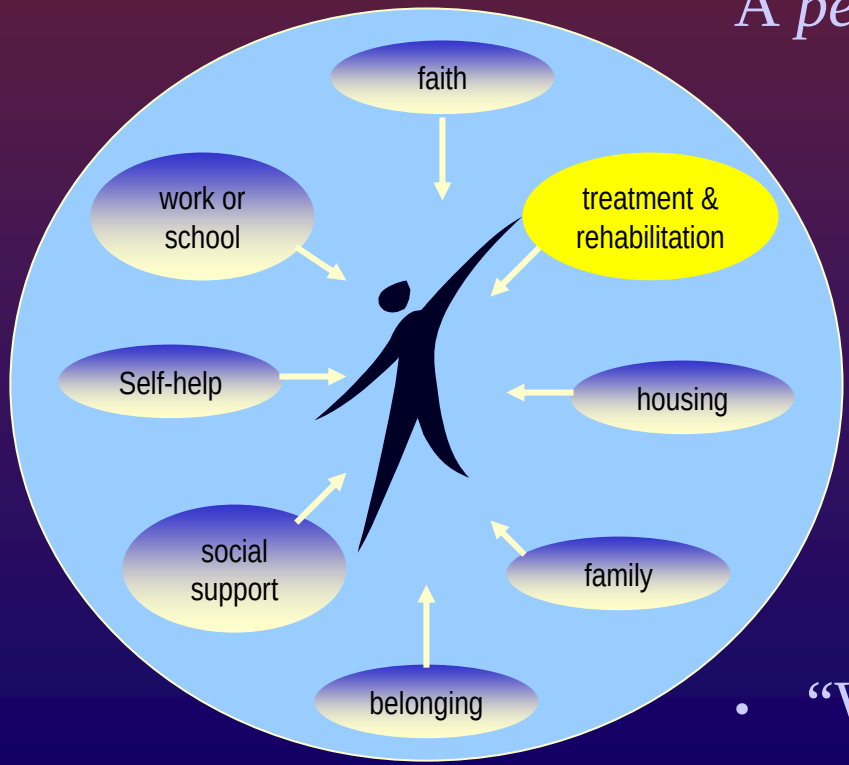
A word of caution...

Building a life in the community is NOT a task that comes AFTER discharge.



Instead...

The pursuit of meaningful community life must be at the heart of the care and planning process throughout!



A *person-centered* system of care supports the person's efforts in managing his or her condition *while* s/he is regaining or establishing a whole life and a meaningful sense of membership in the broader community.

- "WHILE" not "AFTER"!

A word of caution...

Just as community life is not what comes AFTER discharge, it is also NOT something that service systems can, or should, artificially create FOR people!

But what about stigma? How do we protect people from NIMBY?

A word of caution...

- Stigma and discrimination are NOT a reason to deny people access to, or to “protect” people from, the pitfalls (or potential joys) of community life.

- Be careful to avoid the “one stop shop” (danger of good intentions)

- Ask yourself: Am I about to recommend or create, in an artificial or segregated setting, something that can already be found naturally in the community?
  - Sheltered workshops/real jobs for real pay
  - Movie nights at the LMHA/passes to the local theatre
  - Construction of fitness facilities/reduced rates to the local gym
  - Internal GED classes/local Adult Education facilities
  - Referral to the “current events group”/Barnes & Noble book club
  - On-site medical facilities/ use of Community Health Advocates

Consider instead…

- Teaching providers to
  - Collaborate with/consult to community partners
  - understand relevant disability legislation
  - recognize instances of discrimination
  - effectively utilize state and local resources

- Building this same kind knowledge/skill within the consumer community!

Key Practices in Implementation

- Demonstrate a commitment to both outcomes and process
  - e.g., Expectations are high for successful outcomes in a broad range of QOL dimensions; Process tools (quality indicators, checklists) are flexibly applied to promote quality care.

- Understand and support human rights such as self-determination
  - e.g., People are encouraged to write their own crisis and contingency plans/advance directives

Practice Implications: Dealing with "*RISK*"

RISK v. SAFETY

- People are presumed competent and entitled to make their own decisions. They are encouraged and supported to take risks and try new things. (RISK)
- Person-centered care does not take away the provider's right, and responsibility, to take action to protect the person or the public in the event of emergency or crisis situations, but limits the authority of providers to narrowly defined circumstances as defined by statutory laws. (SAFETY)
- In all other cases, providers are encouraged to offer their expertise respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and their respective (potential) consequences and rewards.
- Make use of tools/safeguards that assist with decision-making and advance planning, e.g., pay-off matrix, psychiatric advance directives

NRC•PAD

National Resource Center on Psychiatric Advance Directives

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PAD STORIES

"....it was really crowded in the ER so I showed intake my psychiatric advance directive and told them that I needed to go somewhere quiet....so that I could calm down....The intake nurse sat with me in a quiet room until I calmed down." **Click for more...**

Home

Welcome to the National Resource Center on Psychiatric Advance Directives

Click state to view statute information.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit advance directives for healthcare, which can be used to direct at least some forms of psychiatric treatment. In the past decade, twenty-five states have adopted specific psychiatric advance directives statutes.

This site offers an introduction to psychiatric advance directives, state-by-state information about advance directives, instructions and forms, discussion forums, educational webcasts, current research, links to other websites, and more!

Do you want to learn how to write Psychiatric Advance Directives? **View webcast**

“Risk” is Inherent in Recovery…

“We’ve considered every potential risk except the risks of avoiding all risks.”

TOOLS AND RESOURCES

UIC University of Illinois at Chicago
Department of Psychiatry

UIC CMHSRP Home | UIC RTC on Self-Determination | UIC EIDP | UIC Publications | Search

SAMHSA Substance Abuse and Mental Health Services Administration

CMHS

NIDRR

Search P/FCP pages

Google Search

National Consensus Initiative on Person/Family-Centered Planning

/ INTRODUCTION

The purpose of this initiative was to plan and convene a consensus meeting on December 8, 2005 to identify model approaches to individualized, person/family-directed planning. The initiative targeted approaches that facilitate recovery and resiliency for children and adults with mental health problems. Presentations made at this meeting and final papers commissioned for the initiative are now available. A series of recommendations on how to implement and monitor quality individualized recovery and resiliency planning for youth and adults will be posted to this website. The initiative is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS).

To find out more about the Initiative, click on one of the links below.

HISTORY AND BACKGROUND OF THE NATIONAL CONSENSUS INITIATIVE ON PERSON/FAMILY-CENTERED PLANNING

CONFERENCE PLANNING COMMITTEE MEMBERS

CONFERENCE PAPERS, PRESENTATIONS, AND PRESENTER BIOS

PERSON/FAMILY-DIRECTED PLANNING RESOURCES

PRESIDENT'S MENTAL HEALTH COMMISSION FINAL REPORT

NATIONAL CONFERENCE AGENDA: NOTES AND RECOMENDATIONS

www.psych.uic.edu/uicnrtc/cmhs/pfcphome.htm

TOOLS AND RESOURCES…

The Glass Half Empty… The Glass Half Full

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following…
**An addict/junkie	**A person diagnosed with an addiction who experiences the following…
Clinical Case Manager	Recovery Coach/Recovery Guide (*I'm not a case, and you're not my manager!*)
Front-line staff/in the trenches	Direct care/support staff providing compassionate care
Substance abuse/abuser	Person with an addiction to substances; substance use interferes with person's life
Suffering from	Working to recover from; experiencing; living with
Treatment Team	Recovery Team, Recovery Support System
LMHA Local Mental Health AUTHORITY	Recovery and Wellness Center
High-functioning vs. Low Functioning	Person's symptoms interfere with their relationship (work habits, etc.) in the following way…
Acting-out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups/mutual aid groups
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis; does not agree that they have a mental illness pre-contemplative stage of recovery
Resistant	Not open to… Chooses not to… Has own ideas…
Weaknesses	Barriers to change; needs
Unmotivated	Person is not interested in what the system has to offer; interests and motivating incentives unclear
Clinical decompensation, relapse, failure	Person is re-experiencing symptoms of illness/addiction; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event: Re-occurrence
Maintaining clinical stability/abstinence	Promoting and sustaining recovery
Untreated alcoholics	People not yet in recovery; precontemplative/comtemplative stage of recovery
Prevent suicide	Promote life
Puts self/recovery at risk	Takes chances to grow and experience new things
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; beginning to think for oneself

The Glass Half Empty… The Glass Half Full

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
Minimize risk	Maximize growth
Consumer (in addictions community)	Person in recovery, person working on recovery
Patient (in mental health community)	Individual, consumer, person receiving services
Treatment works	Person uses treatment to support his/her recovery
Treatment system	Recovery Community
Discharged to aftercare	Connected to long-term recovery management
Enable	Empower the individual through empathy, emotional authenticity, and encouragement
Frequent Flyer	Takes advantage of services and supports as necessary
Dangerous	Specify behavior
Manipulative	Resourceful; really trying to get help
Entitled	Aware of one's rights
DTO/DTS/GD	S=Describe behaviors that render one danger to self/others, etc.
Baseline	What a person looks like when they are doing well
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
Grandiose	Has high hopes and expectations of self
User of the system	Resourceful; good self-advocate

**The Language of Recovery*, William White, Chestnut Hill Health Systems; * *Recovering Services,* National Institute of Mental Health – England; META Services, Phoenix, AZ.

Manuscript available for download at:
www.**dmhas**.state.ct.us/documents/**practiceguidelines**.pdf

TOOLS AND RESOURCES

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of
Mental Health and Addiction Services

Your Treatment Plan & Meeting:

Making it work for you and your recovery

What is a "treatment plan"?
A treatment plan:

- is sometimes also called a service plan or a recovery plan.
- is a document that you create with your team to help plan for your recovery and services.
- identifies goals that are important to you in your recovery and well-being.
- identifies the things that you and your team need to do to help you achieve these goals.
- is the document that your clinical team uses to get payment for the supports they provide to you.

What is a "treatment planning" meeting?
It is a meeting:

- where you work in partnership with others to create your treatment plan.
- that happens on a regular basis – usually every 6 months (although the plan can be updated as needed).
- where you have a right to invite anyone you believe is supportive of your recovery – including your recovery mentor!
- that your mentor can attend and help you speak up about things that are important to you.

What is YOUR role in this meeting?:
For this meeting, it is useful to:

- think about your priorities and goals ahead of time.
- ask for the types of support that would be most helpful to you.
- SPEAK UP and share your ideas and needs with your team!
- think about your own responsibilities in working towards your goals.

What kinds of things can I bring up at this meeting?
This is YOUR meeting. You can:

- bring up anything you think is important in your recovery
- discuss ways to pursue your goals, both clinical treatment goals and also your goals and dreams for employment, education, social activities, and your living space.

What happens after this meeting?
After this meeting:

- Your clinician will work to include the things you talked about in a written document.
- This document is both a summary of the meeting and an outline of upcoming action steps for you and your team members.
- You should review the written plan with your clinician and make sure you understand it. Ask questions if you don't.
- You should sign the plan and ask for a copy for your records. Keep it in a safe place to protect your confidentiality.
- WORK YOUR PLAN! Follow through on your personal action steps and take charge of your recovery!

TOOLS AND RESOURCES

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."

TOOLS AND RESOURCES…
Automated Recovery Plan

- Incorporates Recovery Principles
  - Encourages planning in multiple domains beyond symptom management
  - Elicits consumer satisfaction which in turn drives formulation of plan
  - Provides opportunity for prioritization
  - Allows consumer to build a “recovery team”
  - Utilizes a strengths-based model
  - Prompts a recovery dialogue between the consumer and the provider
  - Uses consumer-friendly language
  - Specifies clear action steps and encourages all members of the team to contribute to those steps
- Supports Accreditation and Third-Party Billing Requirements
- Generates Aggregate Planning and Quality Improvement Data
- User friendly and time-efficient

For more information, contact daniel.wartenberg@po.state.ct.us

Lessons Learned

- At the system level - Don’t put your head in the sand! Anticipate concerns and address the TOUGH questions!
- Align with provider community. Do not overlook organizational barriers while trying to “fix” providers…
- BUT… also take a good hard look at the “internal” barriers. (The former can be a red herring – e.g., “keys”, HIPAA)
- Keep it real and “walk the walk” e.g., direct recruitment, HIC training expectations, meeting structures/feedback mechanisms, etc.

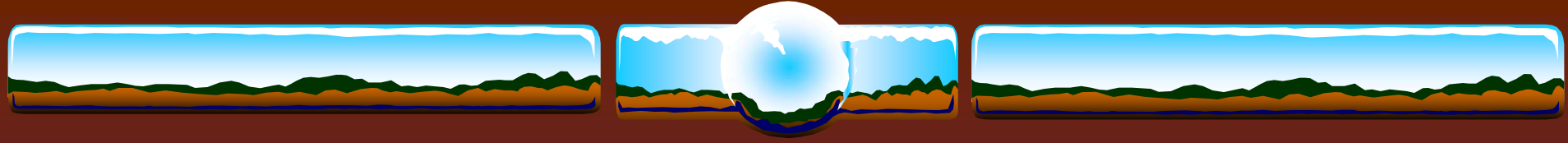
Lessons Learned

- It's a slow, long road… importance of:
  - sharing success stories
  - prioritizing action steps and GETTING OUT OF THE GATE!!
  - Avoid "perpetuating pessimism." Given guidance and user-friendly tools that support the work…many people embrace new ways of thinking/doing.
- Take the time and make it stick! Avoid Train and Run…while offering on-site consultation/technical assistance. A front-end investment for long-term gain.
- Implementation requires flexibility, innovation, and a continuous commitment to learn from all stakeholders!

There is no one “right” way to do PCP!

- Intention is *NOT* to endorse one standardized model or way of doing things. Rather…

- To “encourage the flowering of diverse methods…that express the many different gifts of those people who accept responsibility for the work” (O’Brien, 2002), and the responsibility to walk beside people on their unique paths to recovery, wellness, and better lives



For Slides & Information

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