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# An Introduction to Person-Centered Planning

#mhccHopeLives

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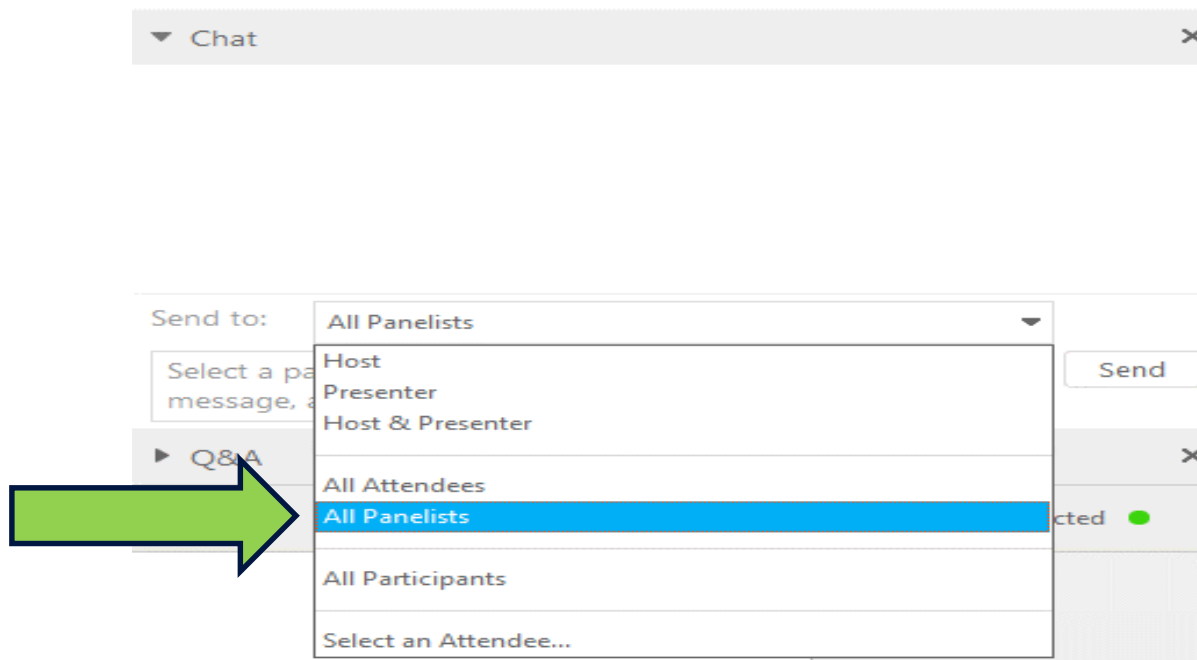
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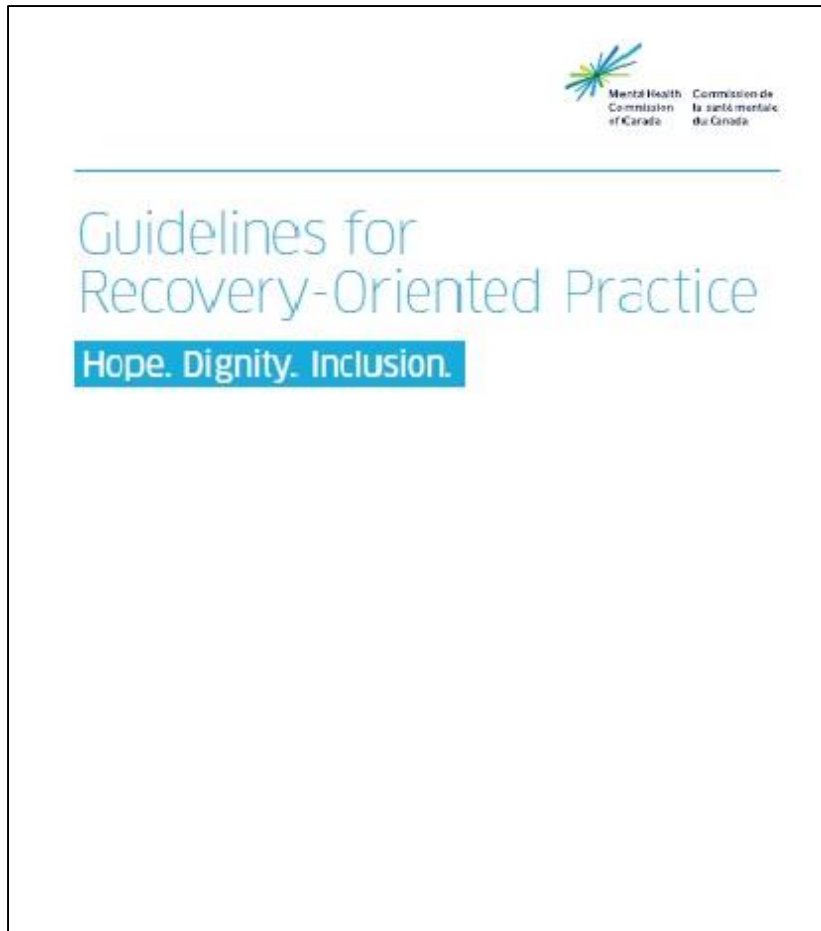
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Important! Send questions/comments to  
'All Panelists'



@mhcc\_ #workplaceMH #StandardCda

# Guidelines for Recovery-Oriented Practice



The *Guidelines* were released in June 2015 to provide a comprehensive document to understand recovery practice and promote a consistent application of recovery principles across Canada

<http://www.mentalhealthcommission.ca/English/initiatives/RecoveryGuidelines>

# Six Dimensions of Recovery-Oriented Practice

1. Creating a Culture and Language of Hope
2. Recovery is Personal
3. Recovery Occurs in the Context of One's Life
4. Responding to the Diverse Needs of Everyone Living in Canada
5. Working with First Nations, Inuit, Métis
6. Recovery is about Transforming Services and Systems

# Presenters

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Dr. Janis Tondora, Assistant  
Professor, Department of  
Psychiatry, Yale University  
School of Medicine

# *From Theory to Practice:* An Introduction to Person-Centered Planning



Dr. Janis Tondora  
Assistant Professor  
Department of Psychiatry  
Yale University School of Medicine


# Introductions and Background

Yale School of Medicine

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Enter keywords

First  
you leap,  
then  
you grow  
wings.



yale  
program  
for  
recovery  
and  
community  
health

About PRCH | People | Research & Evaluation | Training & Consultation | Tools | Contact Us

Yale Program for Recovery  
and Community Health  
Erector Square, Bldg. One  
319 Peck Street  
New Haven, CT 06513

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203-764-7594  
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203-764-7595

## 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:

Recovery Network listserv  
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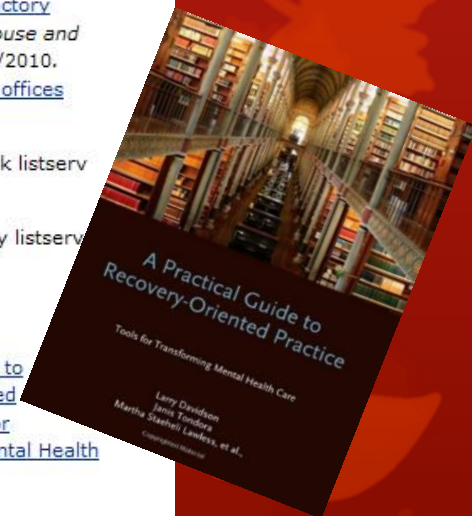
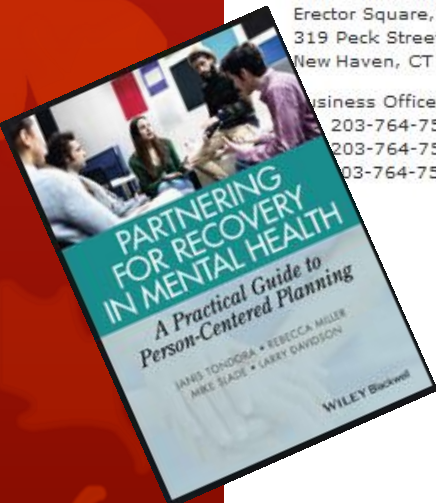
### LEARN:

New Book:

[A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care](#)

New Resource:

[Getting in the Driver's Seat of Your Treatment: A Toolkit for Person Centered Care \(.pdf\)](#)

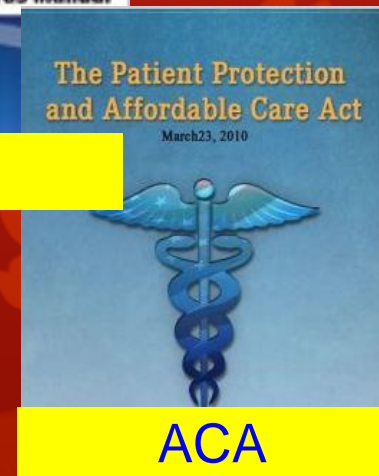
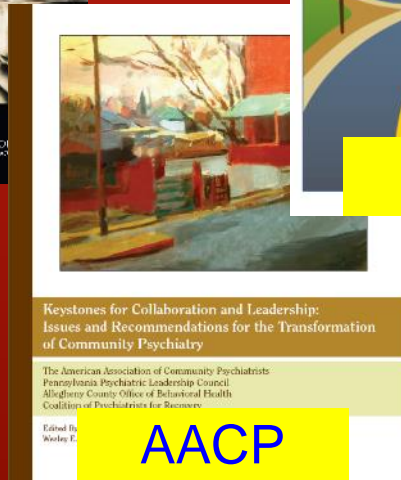
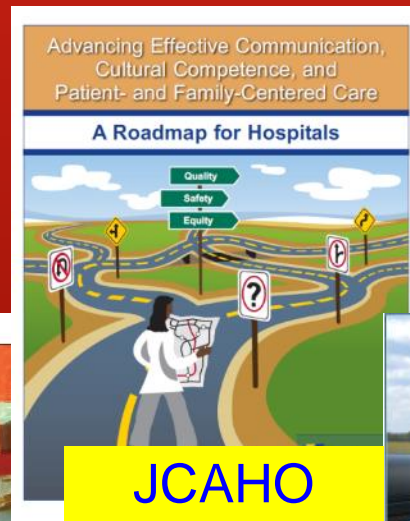
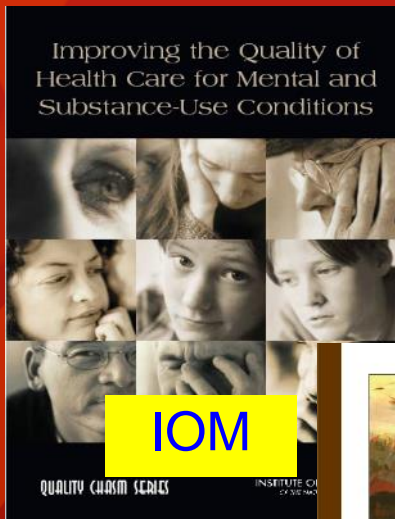


# Together We CAN 😊



# Person-Centered Planning: Who says so...??

# Person-Centered Planning: Who says so...?? US Perspective



# Canadian Perspective



## Guidelines for Recovery-Oriented Practice

Hope. Dignity. Inclusion.

- *Recovery is Person First and Holistic*
- *Affirming Autonomy and Self-determination*
- *Focusing on Strengths and Personal Responsibility*
- *Recognizing the Value of Family, Friends, and Community*
- *Supporting Social Inclusion*
- *Addressing Stigma and Discrimination*
- *Responsive to the Diverse Needs of Everyone Living in Canada*

# The MOST Important Voice...

- *You keep talking about getting me in the **driver's seat** when half the time I am not even in the damn car!*
- *PCRP gives me a **chance to speak** and talk about what I want and need to succeed in my recovery...*
- *It made such a **huge difference to have my pastor involved**. He knows me better than anyone else in the world and he had some great ideas for me.*
- *I had been working on my recovery for years. Finally, it felt like I was also **working on my LIFE!***
- *When I have a voice in my own plan, I feel a **responsibility to "work it"** in my recovery.*

# On the Flip Side...

## Common Concerns re: PCP



1. If given choice, people will make BAD ones
2. Payers won't let us do this; regs prohibit this
3. The forms/templates/EHRs don't have the right fields
4. Consumers aren't interested/motivated
5. It devalues clinical expertise; violates professional boundaries
6. Its what the clubhouse does...Not a part of core clinical/medical healthcare
7. Lack of time/caseloads too high/ "initiative fatigue"
8. "My clients are too sick/impaired"
9. It doesn't fit with focus on evidenced-based practices
10. Don't we already do ROC? Is it really any different?

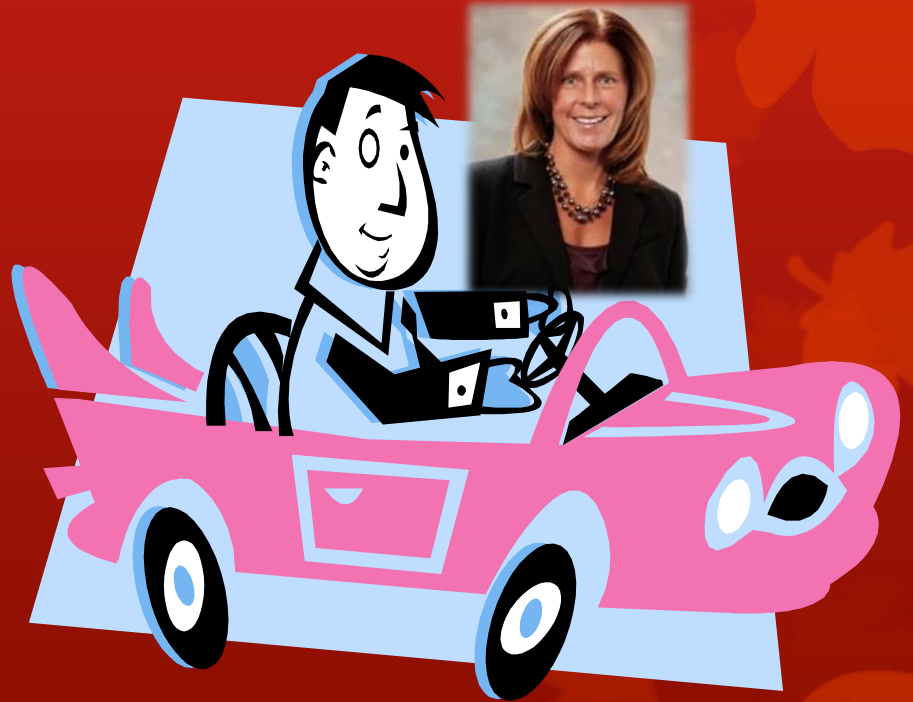
# Partnering With People So They Can Be In The Driver's Seat Of Their Treatment

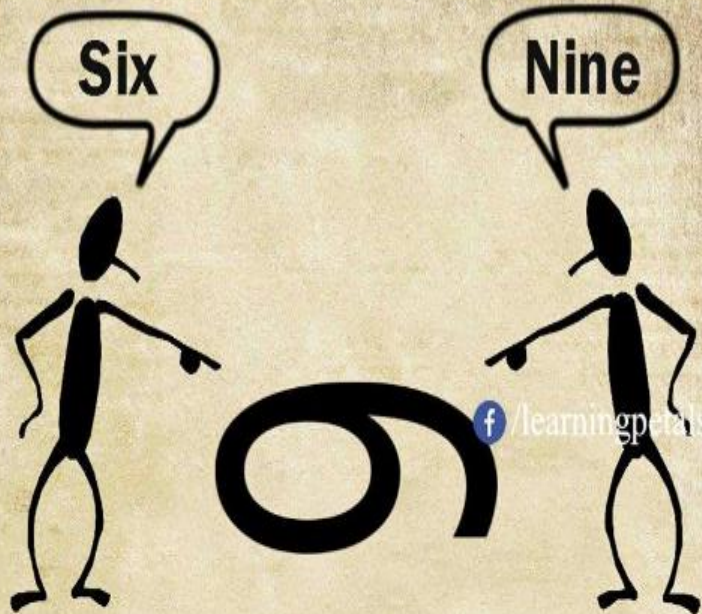
- PCP is based on a model of PARTNERSHIP...
- Respects the person's right to be in the driver's seat but also recognizes the value of professional co-pilot(s) and natural supporters



# Partnering With People So They Can Be In The Driver's Seat Of Their Treatment

- 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





Just because you're right  
doesn't mean i'm wrong, you  
just haven't seen life from my  
position.

fb/learningpetals

Partnering does  
not require that  
you always AGREE  
but it does require  
mutual respect and  
understanding

# Are some people “too sick” to engage in PCP?

- **Perception**

- Clients may be too sick to engage in this kind of partnership; have no goals; are unrealistic; comfortable in “system,” unmotivated



- **Reality**

- Need to communicate a message of hope and a belief that their life can be different, or offer education/training/tools on recovery-oriented care
- Need to assess and plan for stage of change
- Need to be creative in how we listen and solicit preferences

# PCP: Don't we already do it?

- 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. 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."						

Person-Centered Care Questionnaire: Tondora & Miller 2009  
<http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf>  
<http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQperson.pdf>

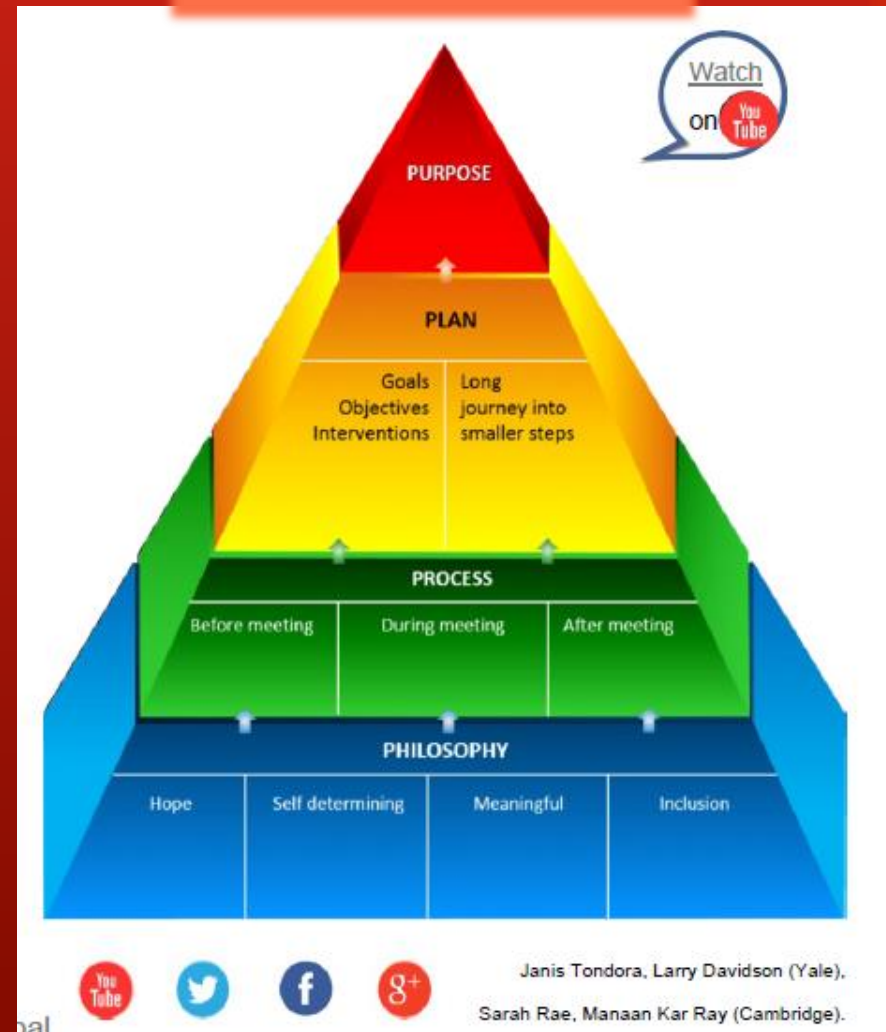
# The 4 “Ps” of PCP

- 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 the way people feel and think.
- \*4 Essential Ps:
  - Philosophy – core values
  - Process – new ways of partnering
  - Plan – concrete roadmap
  - Purpose – meaningful outcomes

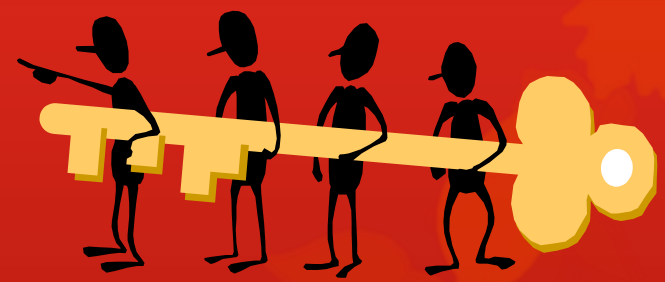
Recently Released Web-based  
Video Overview of PCP in  
Behavioral Health See:

<https://youtu.be/luNYB9Prnk0>

Tondora & Davidson (YALE) and  
Rae, & Kar Ray (CAMBRIDGE)



# The Process of PCP: Key Practices



- Person is a **partner** in all planning activities/meetings; advance notice (person-centeredness)
- 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
- Shift in **structure/roles** in planning meetings
- Capitalize on **role of peers** where possible
- **Strengths-based** approach in both language and assessment/planning

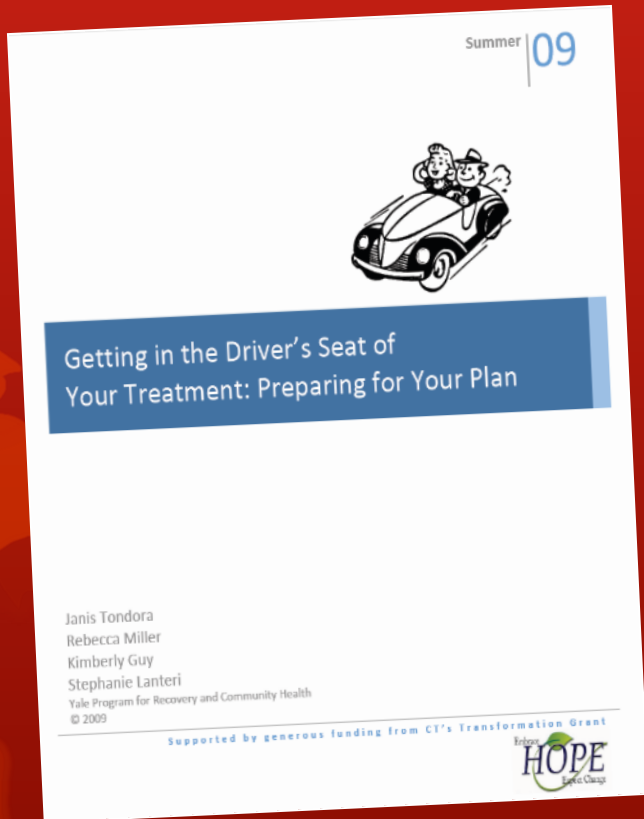
# Language Counts & Sets the Tone

- 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.

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

# Activation & Empowerment of the PERSON in PCP



- Invitation to partner and share decisions may not, in itself, be sufficient
- Offer education/support to prepare individuals to participate fully as equals
  - Driver's Ed & Rules of Road ☺
- Getting in the Driver's Seat Toolkit
  - Yale Program for Recovery and Community Health, © 2009

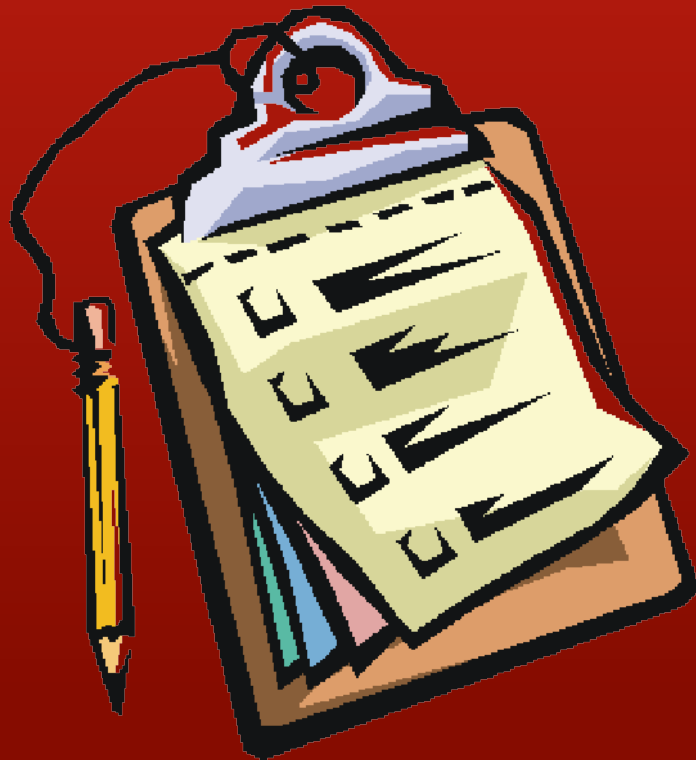
# The Process of PCP: Key Practices



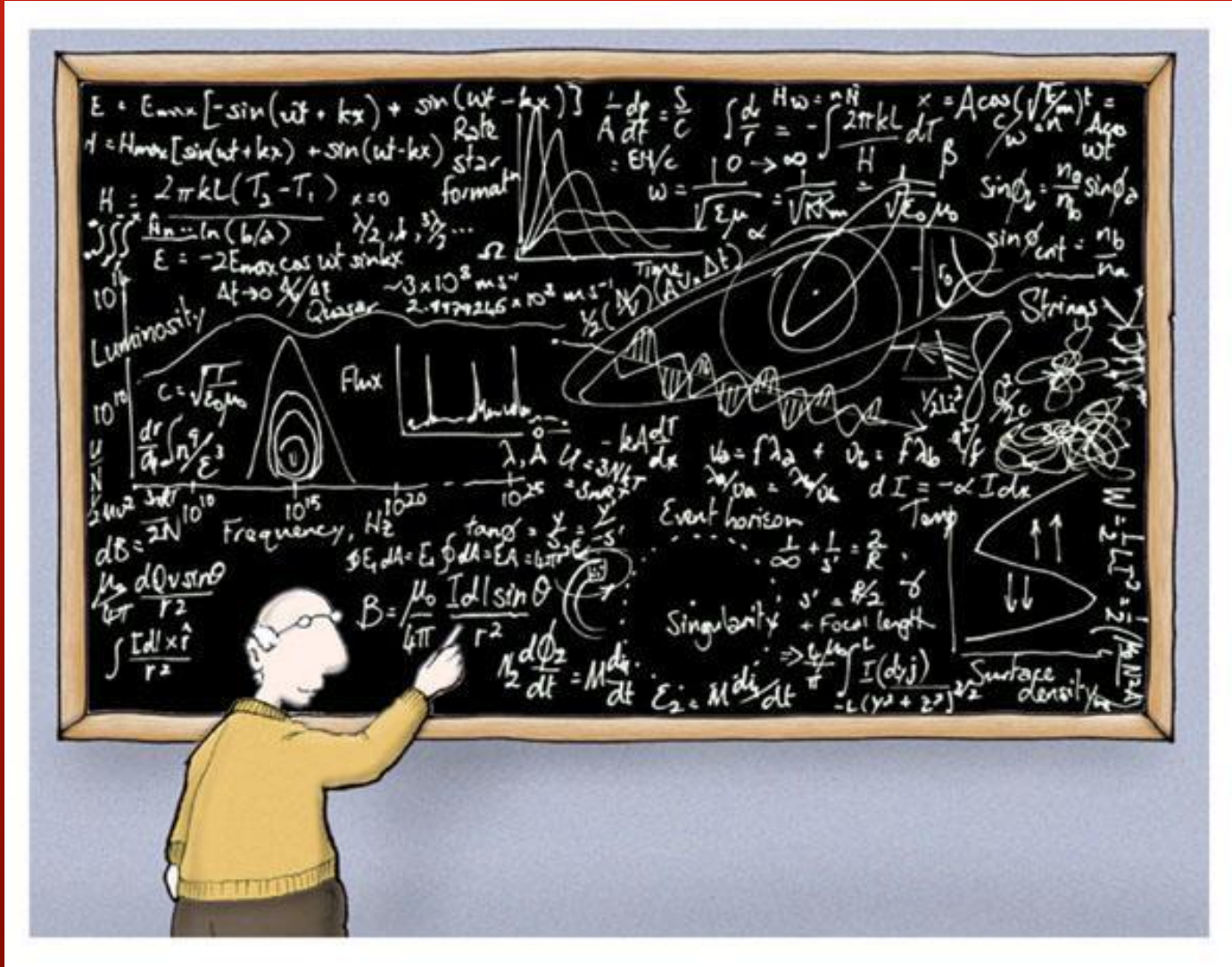
- Recognize the **range of contributors** to the planning process (e.g., peers, natural supporters)
- Understand/support rights such as **self-determination**
- Value **community inclusion/life** - “While,” not “after”
- **Enhance assessment** in 4 key areas :
  - strengths/interests (with attention to LANGUAGE), cultural preferences and treatment implications, stage of change/readiness
  - concludes with an integrated summary/formulation that goes beyond the data!

# The Documentation Challenge:

How can we include enough information to create an individualized & complete view of the person that ALSO meets regulatory/fiscal requirements?



... without creating plans so detailed, no one uses them?!



...and in a way that balances the spirit of person-centered care with the rigor required in clinical documentation?

**Regulations  
Required Paperwork  
Medical Necessity  
Compliance**



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

# Big Picture View PCP Elements

## **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

# Treatment vs. Person-Centered/Life Role Goals

- Focus on achieving/maintaining clinical stability; Address symptoms and illness
- Defined by the practitioner and in the practitioner's words; clinical language
- ***Ex: Participant will experience a reduction in auditory hallucinations and other psychotic symptoms.***

- Focus on improved functioning: employment, education, independent housing, participation in meaningful leisure activities, etc.
- Defined by the person & in the person's own words (with practitioner clarification if appropriate)
- ***Ex: I want a job as an office manager.***

# Short-term Objectives: What do they do?

- Divide larger goals into manageable steps of completion
- “Proof” you are getting closer; function as markers for assessing progress.
- Send a hopeful message we believe things can, and will, be different for the better!



# Objective Sample

**Goal: “I want to get back to being active at my church and teaching bible study.”**

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- **Anxiety, fear and distress** which increase during attempts to speak with her pastor or return to church-“I am so embarrassed and angry about the way I was treated. I am having a hard time going back.”

# Objective Sample

**Goal: “I want to get back to being active at my church and teaching bible study.”**

- **Anxiety, fear and distress** which increase during attempts to speak with her pastor or return to church-“I am so embarrassed and angry about the way I was treated. I am having a hard time going back.”

## **Objective:**

- Jill will be able to **better manage her anxiety and avoidance of social interactions** as evidenced by her **attending one service at her church** within the next 60 days.

# Interventions/Services



- **Actions** by staff, PIR, family, peers, other natural supports
- Specific to an objective
- Respect recovery choice and preference; Specific to the stage of change/recovery
- **Professional/Billable Services** must describes medical necessity
  - **WHO** will provide the service, i.e., name and job title
  - **WHAT:** The TITLE of the service, e.g., Health & Wellness Group
  - **WHEN:** The SCHEDULE of the service, i.e., the time and day(s)
  - **WHY:** The individualized INTENT/PURPOSE of service
- Self-directed steps and natural support actions are included too!

# Meet Mr. Gonzalez

Mr. Gonzalez, a 31-year-old married Puerto Rican man, is living with bipolar disorder and a co-occurring addiction to alcohol that he often uses to manage distressing symptoms. During a recent period of acute mania, Mr. Gonzalez was having increasingly volatile arguments with his wife in the presence of his two young sons. On one occasion, he pushed his wife across the room that prompted her to call the police. When the police arrived, Mr. Gonzalez was initially uncooperative and upset. After he calmed down, Mrs. Gonzalez agreed not to press charges, but insisted her husband leave the house and meet with his clinician the following morning.

# Meet Mr. Gonzalez (cont.)

Mr. Gonzalez's wife is actively involved in his recovery and treatment, and she is open to reconciliation. However, she made it clear that he would not be allowed to live at home, or visit with his sons, until he "gets control of himself." Upon visiting the Community Mental Health Center the following morning, Mr. Gonzalez tells his clinician repeatedly that his love for his family and his faith in God are the only things that keep him going when things are rough and he does not know what he will do without them. More than anything, 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 this is the Center Peer Specialist with whom he has a close relationship.

# Snapshot: A Traditional Plan

- **Goal(s):**

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

- **Objective(s):**

- Patient will attend all scheduled groups in program; patient will meet with psychiatrist and take all meds as prescribed; patient will complete anger management program; patient will demonstrate increased insight re: clinical symptoms; patient will recognize role of substances in exacerbating aggressive behavior

- **Services(s):**

- Psychiatrist will provide medication management; Social Worker will provide anger management groups; Nursing staff will monitor medication compliance; Psychologist will provide individual therapy

# Uh, excuse me...

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



- Comply with meds
- Stop drinking
- Reduce aggressive behavior
- Increase insight

## Recovery Goal:

*I want to get my family back.*

*I don't want the kids 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  
Center Peer Specialist;  
intelligent

### Barriers Which Interfere:

Acute symptoms of mania  
led to violence in the  
home; lack of coping  
strategies to manage  
distress from symptoms;  
abuse of alcohol escalates  
behavioral problems and  
family conflict

## Sample Short-Term Objective(s)

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

## Services & Other Action Steps

- Center doc to provide **med management** to reduce irritability & acute manic sx (1X/mos)
- Psychologist to provide **family therapy** to discuss Mrs. Gonzalez's expectations and feelings re: future reunification (every 2 wks)
- Rehab Specialist to provide weekly **Communication and Coping Skills Training** to teach/coach skills that will foster successful visits with wife and children
- Wellness Recovery Action Plan** (weekly group) with Peer Specialist to promote daily wellness through the use of self-directed strategies
- Center chaplain** to promote use of faith/daily prayer as a positive coping strategy to manage distress

# So, what do YOU think? Meet Gerry

Gerry reports he is very lonely. He used to go to the downtown jazz fests and meet lots of people, but now he feels like a “zombie.” He is not getting out of the group home to do much of anything other than come to the Center. He wonders if this is due to his meds... Although he would like a girlfriend, Gerry admits to being “terrified” to get out in community and meet women, and states that its been 10 years since he dated anyone. He wouldn’t know where to start...He is currently unable to take the bus and is afraid to go anywhere alone because he often gets confused or fears others might try to hurt him.

Which of the below is the best goal statement for Gerry's PCP?

1. I don't want to feel like a "zombie."
2. Gerry will better manage distressing symptoms of paranoia.
3. I want a girlfriend.
4. Gerry will voluntarily attend the Social Skills Group.
5. I just want to be happy.

# Gerry's PCP

**Goal:** I want a girlfriend...someone to share my life with.

- **Strengths:**

- Motivated to reduce social isolation; supportive brother; has identified community he enjoyed in past interests(e.g., music, Chinese restaurants) well-liked by peers; humorous

- **Barriers/Assessed Needs/Problems:**

- Intrusive thoughts/paranoia increase in social situations; possible negative symptoms of schizophrenia and/or med side effects result in severe fatigue/inability to initiate; easily confused/disorganized; need for skill development to: use public transportation/increase community mobility, develop symptoms management/coping strategies, improve communication and social skills, attend to personal appearance

- **Objective:**

- Gerry will effectively use learned coping skills to manage distressing symptoms to participate in a minimum of 1 preferred social activity per week for the next 90 days

# Services & Supports

- Jane Roe, Clinical Coordinator, to provide **CBT** 2X/mos. for 45 min for next 3 mos. to increase Gerry's ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)
- Dr. X to provide **Med Management**, 2X/mos for 30 min for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning
- John Smith, Peer Coordinator, will provide **travel training** 1X/wk. for 60 min 4 weeks to help him become independent with city bus (e.g., identifying most direct bus routes, rehearsing use of coping skills, role playing conversations if confused/lost, etc.)
- **Gerry's brother, Jim**, will accompany Gerry to weekly social outings over the next 3 months.
- **Gerry** will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

# You CAN Weave the Golden Thread of Medical Necessity in PCP

## Goal

- Person directed/own words
- Big picture/life role

## Objective

- Written **to overcome MH Barriers** which interfere with Goal:
- to **address symptoms/functional impairments** as a result of diagnosis
- Reflect a **change** in behavior/status/level of functioning; **beyond maintenance**

## Services

- Paid/professional services to help person achieve the specific objective
- Tip: Read your plan from the “bottom up” to ensure the intervention is directly linked to the objective above
- Tip: Document WHO provides WHAT service WHEN (frequency/duration/ intensity) and **WHY (individualized purpose/intent as it relates to the linked objective)**
- Natural support/self-directed supports to help person achieve the specific objective

# Take Home Message

- We can balance person-centered approaches with medical necessity/regulations in creative ways to move forward in partnership with persons in recovery.
- **We can create a plan that honors the person and satisfies the chart!**
- In other words: PCP is not soft!



# Sample Tools to Support PCP Implementation



# Sample PCP Meeting-Observation Tool

## Person Centered Approach Assessment Toolkit Team Meeting Assessment Guide

As part of the Person Centered Approach assessment, assessors observe a team meeting to look for information regarding the interactions between staff and the individual and the planning process. Below are the specific areas for which the assessor will be reviewing. Scoring includes indicating whether a particular aspect was not present (0) during the meeting, somewhat present (1), present (2), not applicable (N/A), or not able to be scored (888).

	0	1	2	N/A
	Not Present	Somewhat Present	Strong Presence	
<b>TONE AND RELATIONSHIP</b>				
Interactions between providers, person served and others is warm and respectful				
Individual is addressed directly				
Common, understandable language is used – not unnecessary medical or clinical words				
Individual appears to feel comfortable raising concerns				
<b>GOALS</b>				
Team members developed the recovery plan in partnership with the individual				
Individual determined in what life areas planning would occur				
Stated goals are those of the individual in his/her own words				
Recommended programming (inpatient) was discussed and purpose explained with individual				
Individual's goals are respected even if they differ from the goals recommended by providers				
Goals are about having a meaningful life in the community (home, job/community contribution...)				

- The plan document is only as good as the PROCESS/ RELATIONSHIP it is based on!

What does a person-centered planning meeting look like?

# Sample PCP Plan Audit Tool

Person-Centered Recovery Planning Indicators: Documentation Quality			
Item #	Documentation Indicator	Yes	No
1	The assessment (can include a biopsychosocial assessment/ assessment update/narrative summary /comprehensive psychiatric rehabilitation assessment, interpretive summary, etc.) includes the person's strengths. Strengths include, but are not limited to: environmental strengths, positive previous treatment experiences, interests/ hobbies, abilities and accomplishments, unique individual attributes, recovery resources/assets.		
2	The plan/plan update actively incorporates the person's identified strengths into the goals, objectives, or interventions. .		
3	The narrative/interpretive summary includes the following required elements: <ol style="list-style-type: none"> <li>1. Strengths, interests, and current and/or desired life roles and priorities.</li> <li>2. Any interfering perpetuating factors, e.g., trauma history, co-occurring medical or substance use disorders, etc. These are the barriers that get in the way of the person achieving their goal on their own.</li> <li>3. Individual's stage of change/stage of recovery (Stage of readiness for any relevant behavior change that could help them move towards their goal)</li> <li>4. Available natural supports or community resources</li> <li>5. Cultural factors and any impact on treatment</li> <li>6. A clinical hypothesis/understanding/core theme re: what drives the individual's experience of illness and recovery -the "why" question</li> </ol>		
4	The plan/plan update is developed collaboratively and there is evidence of direct input from the person, e.g., includes quotes from the individual and/or statements such as "Jose stated..."		
5	The goal statements on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance. Ideally, the goal reflects something "higher" – a valued community/life role that they want to obtain, and are in the individual's own words. The goal statements may not have a time frame.		
6	The plan/plan update includes interventions of all professional clinical/rehab services and goes beyond those interventions to note at least one self-directed action step and at least one action step by natural supporters, as available. (Note: These are typically identified within the assessment process and build upon the person's strengths.)		
7	The plan/plan update uses "person-first" language (i.e., a <i>person living with schizophrenia</i> NOT a <i>schizophrenic</i> ) and/or the individual's name throughout the document.		
8	There is evidence in the record that the person was offered a copy of their plan. (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)		
9	<b>Objectives</b> meet the <u>SMART</u> criteria. They are written <u>simply</u> (understandable to the person), are <u>measurable</u> (they happened or not, " <u>as evidenced by...</u> "), are <u>achievable</u> , <u>realistic</u> , and <u>time limited</u> .		
10	The target dates of short-term objectives on the plan/plan update are individualized rather than all objectives defaulting to a standard update cycle, e.g., every 90 days.		
11	The plan/plan update describes attempts to help the person to connect with chosen activities in the community rather than relying on social supports coming solely from behavioral health agencies. (This is usually found in the interventions)		
12	Interventions meet the criteria of the 5 W's: <b>what</b> ( billable service), <b>when</b> (frequency), <b>where</b> (location), <b>why</b> (purpose and intent) of the service and <b>who</b> is providing the service. Interventions do NOT reflect ONLY participation (i.e. Jose will attend individual therapy.....)		

PCP Plan  
Documentation:  
What does it  
look like?

# Don't Forget the PERSON'S View in PCP!

## Yale/CT DMHAS PCCQ

Please indicate the degree to which you agree or disagree with the following statements about your experiences of care or treatment planning.

The scale ranges from 1 for strongly disagree to 5 for strongly agree, with the following options in between. It also is possible to check DK if you feel you do not know how to rate a specific item.

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.	My provider reminds me that I can bring my family, friends, or other supportive people to my treatment planning meetings.						
2.	I get a copy of the treatment plan to keep.						
3.	My goals are written in my own words in the plan.						
4.	My treatment plan is written so that I can understand it. Words that I don't understand are explained to me.						
5.	I was able to include healing practices based on my culture in the plan.						
6.	I can invite other providers, like my vocational or housing specialist, to the meeting if I want.						
7.	My strengths and talents are talked about in my plan.						
8.	In my plan, I can see how I'll use my strengths to work on my goals.						
9.	In my plan, there are next steps for me and my provider to work on.						
10.	Those areas of my life that I want to work on (like health, social relationships, getting a job, housing, and spirituality) are talked about and included in my plan if I want them.						
11.	My treatment team really understood how I explained what was going on for me, based on how I see it in my culture.						
12.	The goals in my plan are important to me.						
13.	I feel like when my provider and I work on a treatment plan, we work together as a team.						
14.	I decide how the meeting is run and what we'll talk about during my treatment planning meeting.						
15.	In my plan, my provider refers to me as "a person with" a mental health issue and does not define me by a label, e.g., "a schizophrenic" or "a bipolar."						
16.	Cultural factors (such as my spiritual beliefs and my cultural views) are considered in my plan.						

## NYAPRS PCP Review Sub-scale

*We Want to Know: Tell us about your experience in treatment/recovery planning...*

As part of a broader effort in \_\_\_\_\_, our agency is working hard to re-design our services so that they are consumer-centered, and driven by the needs and preferences of the people we serve. One important part of this effort is thinking about how we go about the process of treatment planning – sometimes also called service planning or recovery planning. We would like to hear from you about your experiences planning with your team, and would appreciate your feedback on the items listed below.

Person-Centered Planning Indicators: Person In Recovery Perspective				
Item #	RESPONSE	Yes	No	I Don't Know
A1	My provider reminds me that I can bring my family, friends, or other supportive people to my treatment planning meetings.			
A2	My plan has goals (hopes and dreams) that are important to me and they are about more than just symptom management. My plan focuses on things like making friends, getting a job, and pursuing new interests			
A3	My provider asked me about parts of my culture (such as my spiritual beliefs and my cultural views) that she or he did not understand to make the treatment/service/recovery plan better for me.			
A4	I am offered education about personal wellness, advanced directives, personalized relapse prevention plans, and Wellness Recovery Action Planning (WRAP) as part of my planning meeting.			
A5	I have the opportunity to work with a Peer Specialist/Coach if I want help getting ready for my planning meeting.			
A6	I am offered a copy of my plan to review and keep.			
A7	Staff support me in making my own decisions/choices to take risks/try new things (e.g., work, hobbies, relationships, a new apartment) instead of delaying/waiting until my symptoms are better.			

# 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/](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-implementation/>

- **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](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](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)



# Questions?





Mental Health  
Commission  
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# Next Recovery-Oriented Practice Webinar

**Date:** Thursday, November 17<sup>th</sup>, 2016 at 1:00pm to 2:30pm  
ET

To rewatch or share this webinar visit:  
[www.mentalhealthcommission.ca/English/recovery](http://www.mentalhealthcommission.ca/English/recovery)





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# Thank you!

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