

Being Person-Centered...

Mapping the Road to Recovery, Resilience and Wellness



ASOC Partnership Conference

2007

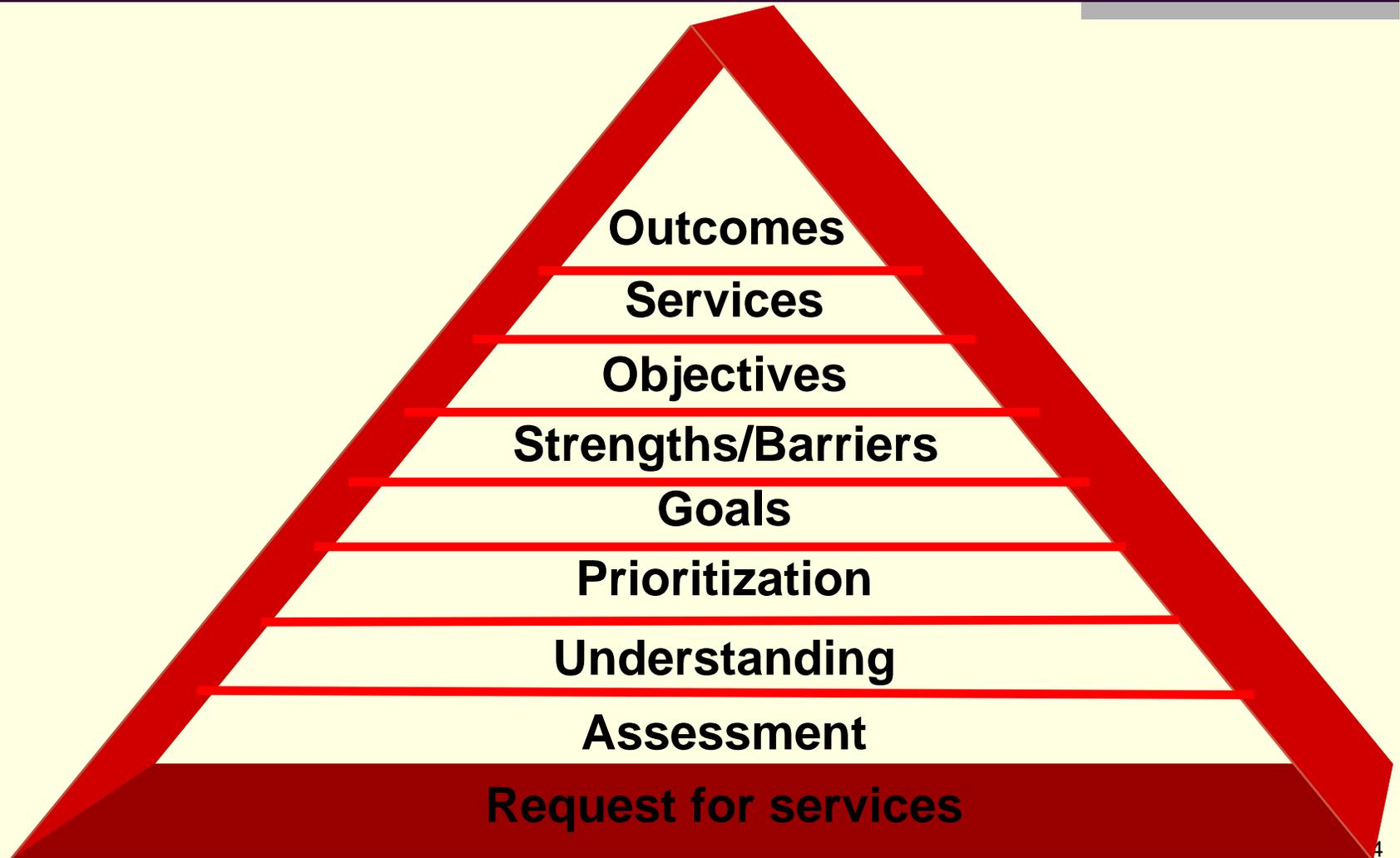
Ed Diksa, ScD.

Training Objectives

- **Identify how emerging new frameworks of person-centered recovery, resiliency and wellness differ from past and current practice to guide the plan of care and meet medical necessity**
- **Understand the importance of a clinical formulation from assessment data**
- **Define the key elements of a treatment/recovery plan as a roadmap to recovery and wellness**

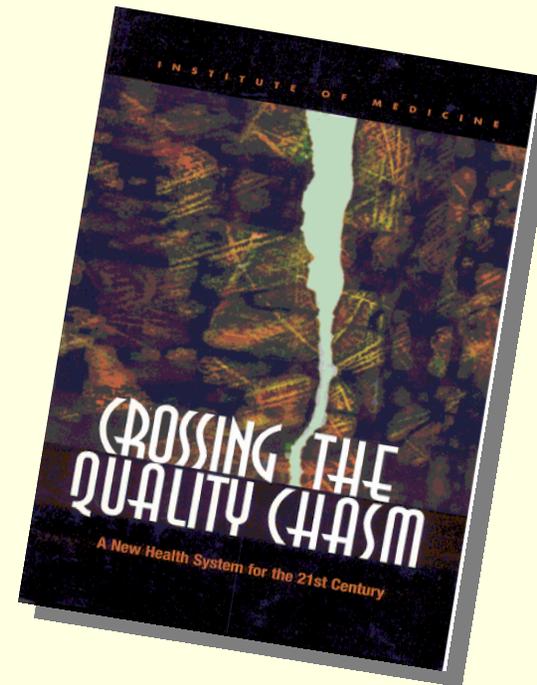


Building a Plan



History of PCP

- 20 years in the DD field
- IOM Report – 2001
- New Freedom Commission – 2003
- IOM for MH/SU - 2005
 - All say MH care should be transformed and be Person-centered





Focus Group Findings N= 9

Q. *Do you feel involved in your treatment planning? What is your role in determining the specific services you receive?*

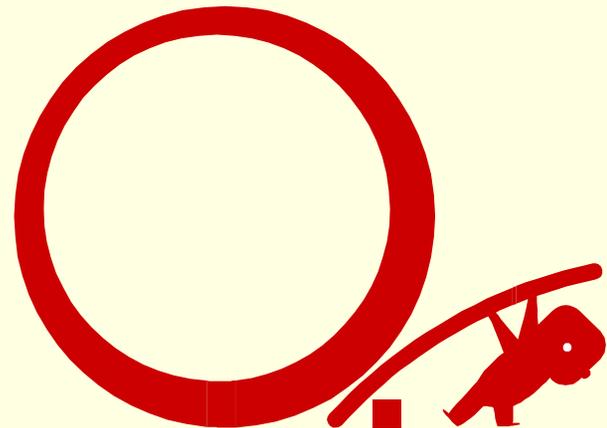
- 3 people did not have a plan/ did not know about a plan.
- 6 people had a plan
- One consumer reported “I play a big role in it.”
- Another reported “No. I just tell them how I feel and what I do and they write it down.”
- Family members felt uninvolved though they would like to be more involved
- Some participants indicated that their treatment plans did not contain positive or clear goals other than to “stay stable.”

Focus Group Findings

- **Q. *Did you receive a copy of your treatment plan?***
 - 2 people received copies
 - one didn't know, one didn't want one
 - 2 did not receive one.
 - one parent stated "As my son's conservator, no, I have never seen his treatment plan."

Hypothesis

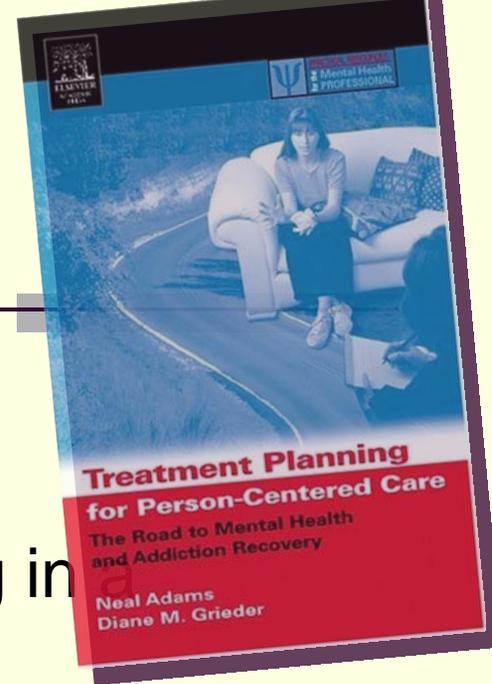
- **Person-centered treatment plans are a *key lever* of personal and systems transformative change at all levels:**
 - Individual and family
 - Provider
 - Administrator
 - Policy and oversight



The road to recovery...

■ **Person-centered planning**

- is a collaborative process resulting in a recovery oriented treatment plan
- is directed by consumers and produced in partnership with care providers for treatment and recovery
- supports consumer preferences and a recovery orientation

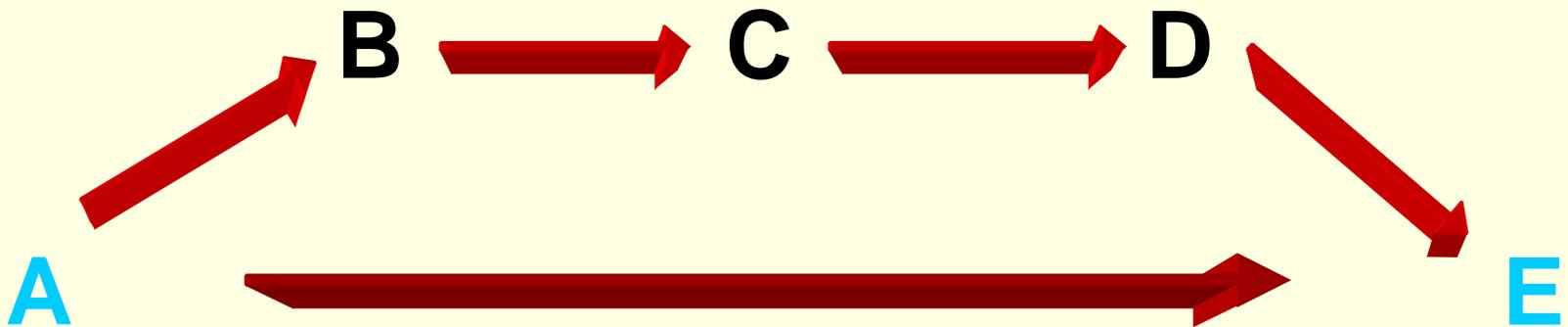


Person-Centered

- **There is agreement on**
 - Goals
 - Tasks
 - Participation and roles
- **The relationship with the provider is experienced as**
 - Collaborative
 - Respectful
 - Understanding
 - Encouraging
 - Empathic
 - Trusting
 - Hopeful
 - Empowering

A Plan is a Road Map

- Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the provider and the person served



“life is a journey...not a destination”

Building a Plan



What Do People Want?

■ Commonly expressed goals of persons served

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

... to be part of the life of the community

example

■ Goal

- *Stuart will receive the assistance he needs to make decisions that best meet his needs and to keep his entitlements current*

■ Objectives

- *Stuart will be...*
 1. compliant with meds
 2. compliant with scheduled appointments
 3. compliant with having his blood drawn

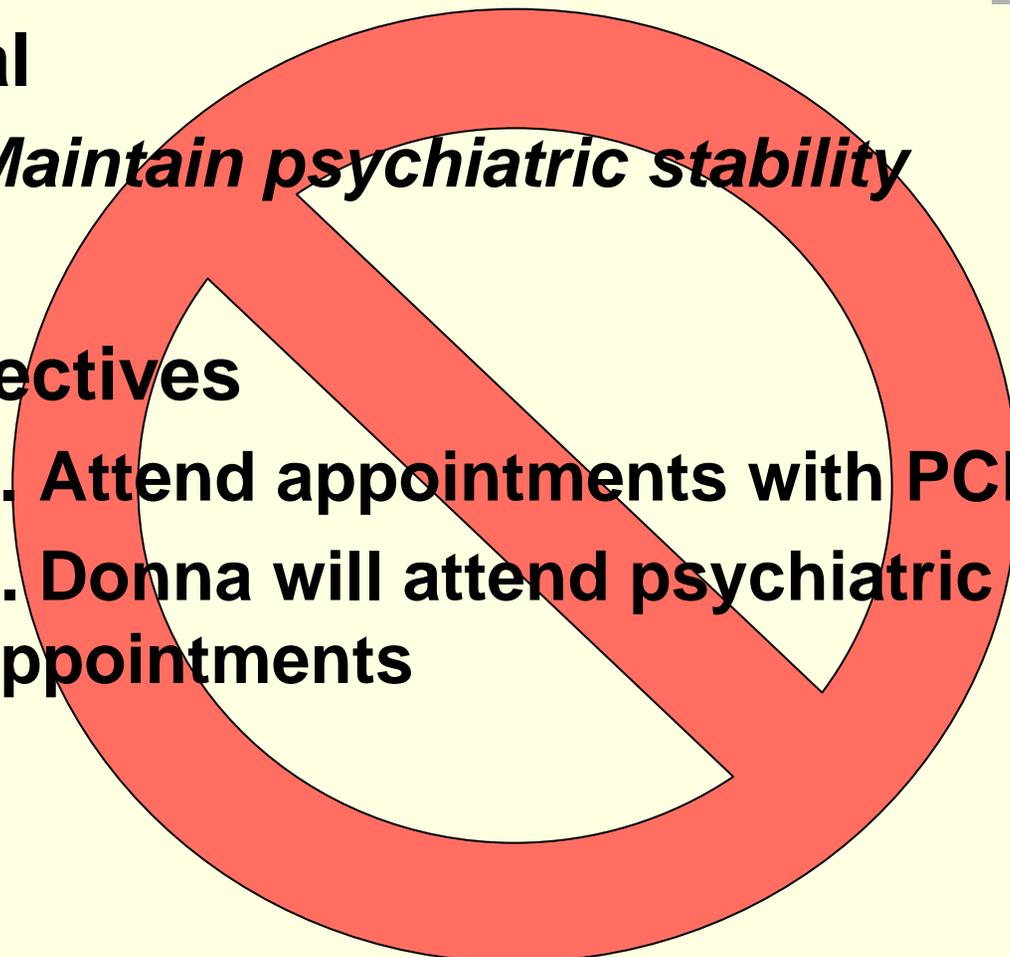
Example

- **Goal**

- ***Maintain psychiatric stability***

- **Objectives**

- 1. Attend appointments with PCP**
- 2. Donna will attend psychiatric appointments**



example

- Goal

- *To comply with medications and follow-up treatment as needed*

- Objectives

1. *Pt. will take medications 5 out of 7 days a week over the next 6 months*
2. *Over the next 6 months, pt. will require only one verbal reminder a month to keep follow-up appointments*

Example

- **Goal**

- ***Decrease depression***

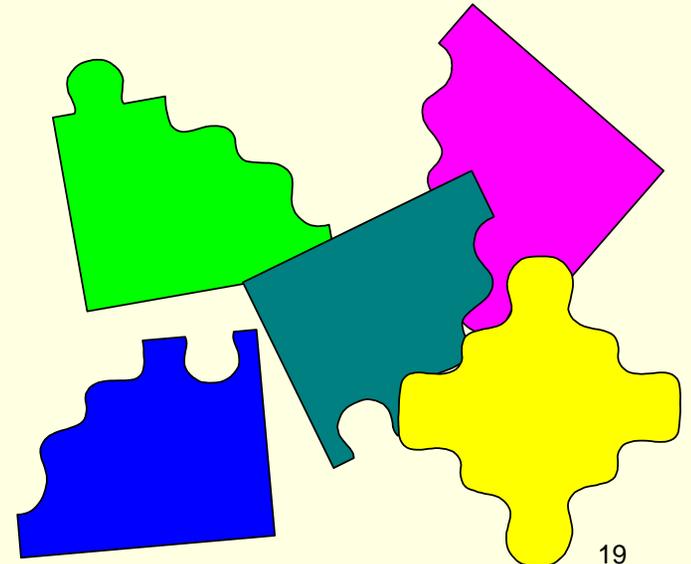
- **Objectives**

- 1. assess medication needs***
- 2. improve finances***
- 3. develop appropriate vocational goals***



Medical Necessity

- ***Doing the right thing, at the right time, for the right reason***
- **Standard of service and quality**
- **Five elements**
 - Indicated
 - Appropriate
 - consider issues of culture
 - Efficacious
 - *Effective*
 - *Efficient*



Serving Two Masters



Plan Development

- **Acquired skill / Art form**
 - Not often taught in professional training
 - Often viewed as administrative burden and paper exercise
 - Requires flexibility
- **Opportunity for creative thinking**
- **Integrates information about person served**
 - Derived from formulation and prioritization
 - Information transformed to understanding
- **Strategy for managing complexity**

Service Plan Functions

- **Specifies intended outcomes / transitions / discharge criteria**
 - Clearly elaborates expected results of services
 - includes perspective of person served and family in the context of the person's culture
 - Promotes consideration and inclusion of alternatives and natural supports / community resources
- **Establishes role of person served and family in their own recovery / rehabilitation**
 - Assures that services are person-centered
 - Enhances collaboration between person served and providers

Service Plan Functions

continued

- **Identifies responsibilities of team members--
*including person served and family***
 - Increases coordination and collaboration
 - Decreases fragmentation and duplication
 - Coordinates multidisciplinary interventions
 - Prompts analysis of available time and resources
- **Provides assurance / documentation of medical necessity**
 - Anticipates frequency, intensity, *duration* of services
- **Promotes culturally competent services**

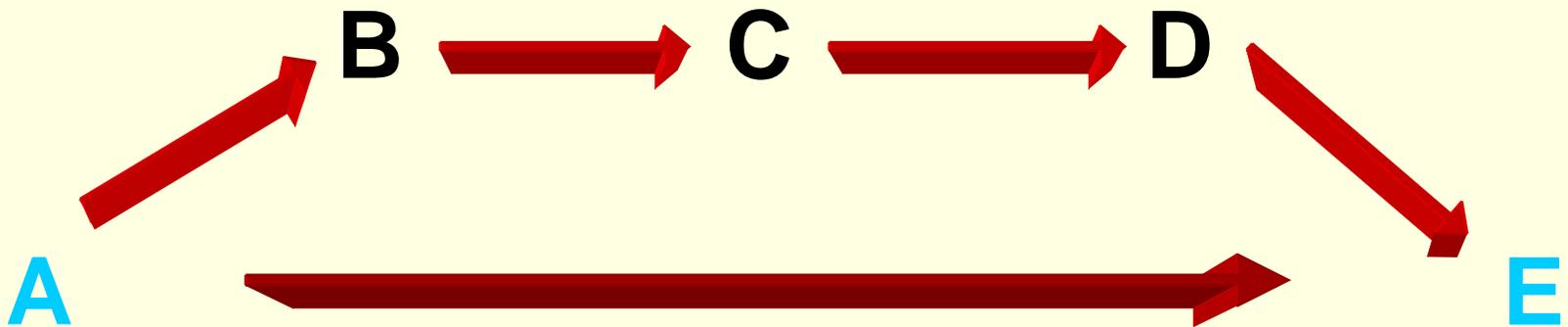
Service Plan Functions

continued

- **Supports utilization management**
 - Services authorization, communication with payors and payment for services
 - Allocation of limited resource

A Plan is a Road Map

- Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the provider and the person served



“life is a journey...not a destination”

THE ASSESSMENT



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

Assessment

- **Initiates helping relationships**
 - Ongoing process
- **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**

Cultural Factors in Assessment

- **Begin with cultural and demographic factors**
 - Clarify identity
 - *“how do you see yourself?”*
 - race, ethnicity, sexual orientation, religion, color, disability reference group
 - Specify language
 - fluency
 - literacy
 - preference



Importance of Understanding

- **Data collected in assessment is by itself *not sufficient* for service planning**
- **Formulation / understanding is essential**
 - Requires clinical skill and experience
 - 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

Understanding

- **Identifies individual's and family's strengths**
- **Identifies stages of change/recovery**
- **It helps determine priorities**
 - Accounts for choice and preference
- **Enables everyone to see the interrelationships in the person's life**
- **It serves as the context for the plan**
- **It clarifies the order in which objectives need to be addressed – sequential or concurrent**
- **It is the bridge between the data and the creation of the plan**

Prioritization by Person Served

- **What comes first?**
 - Personal / family values need to be considered
 - Cultural nuances are significant
- **Must be the driving force**
 - Consistent with concerns / perspective of person served (and family *as appropriate*)
 - Builds upon person served's own expertise

Provider Perspectives in Prioritization

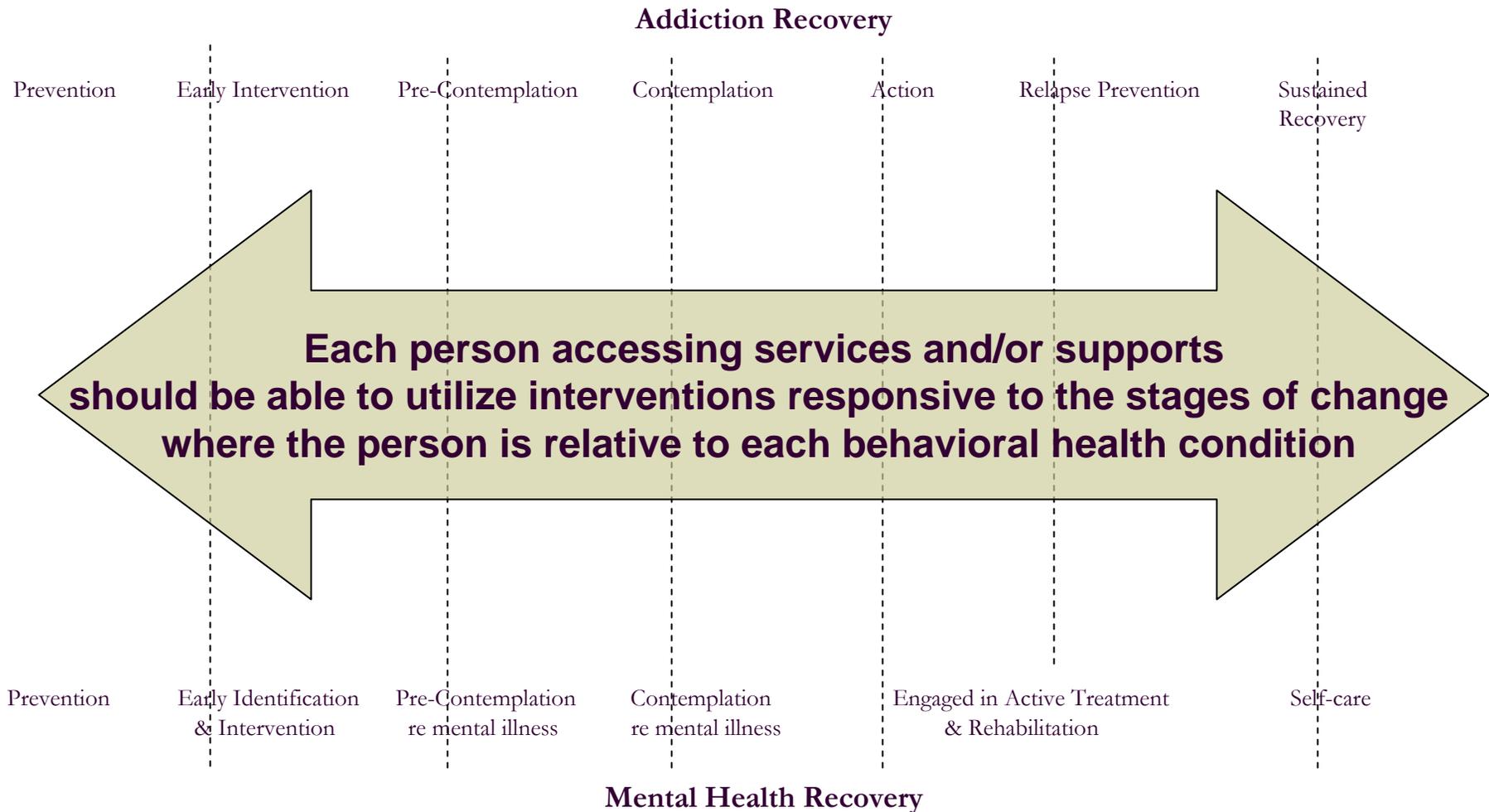
- **Basic health and safety**
 - Maslow
 - food, clothing, shelter
 - affection, self esteem
 - freedom, beauty, goodness, justice
 - self-actualization
 - self-transcendence
 - Harm reduction
- **Legal obligations and mandates**

***Negotiation and dialogue with individual and family
is essential***

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

Stages of Change Framework: “Meeting the client where s/he is at”



Vignette--Carmen

- **18 year old Latina**
 - High school senior
 - preparing for graduation
 - First generation
 - parents monolingual Spanish speaking
 - client bilingual
 - observant Catholic family
 - Lives in predominantly Anglo-American community

Vignette *continued*

- **Excellent student**

- Active in school and social activities
- Recently unable to attend school because of distress
- Graduation from high school and college attendance is core value for Carmen and family

- **Recent physical problems**

- Nausea, vomiting, dizziness, headaches

- **Parents believe she is suffering from *susto***

- Treatment from *curandero*

Vignette *continued*

- **Recent crisis**

- Acute physical distress
- Admitted to hearing a baby cry while at school
- Reported feeling sad and blue

- **Referred to mental health**

- Embarrassed and resistant
- First family member to seek MH services

Vignette *continued*

- **Assessment with Latina provider in Spanish**
 - Revealed she had a miscarriage a year ago
 - Feeling increasingly guilty and troubled
 - Wants to die and join her baby
 - Relationship with parents has become distant and conflictual
 - father refusing to speak with her

Vignette Formulation

■ Identity

- First generation Latina
- Bilingual

■ Explanation of Illness

- What appeared to be a physical problem is a mental health problem
 - somatization is idiom of distress
 - shame, guilt and embarrassment are key themes

■ Provider relationship

- Spanish preferred
- More open with Latina clinician

Vignette Formulation

continued

■ **Psychosocial environment**

- Lives with family, first generation
- Some degree of acculturation and distance from parents
 - difficult and painful

■ **Diagnosis**

- Consider possibility of culture bound syndrome
 - *Susto*
- Possible depression with psychotic features
- Understanding her beliefs may be key to treatment

Vignette Formulation

continued

■ Hypothesis

- Intergenerational issues of acculturation are a major factor
 - Age appropriate issues of individuation and separation
- She is between contemplative and active stage—some ambivalence about help-seeking
- School completion and education opportunity and advancement are shared values /strengths to build upon
- Need to help her reconcile feelings of guilt and remorse
 - Religious and spiritual factors may be significant

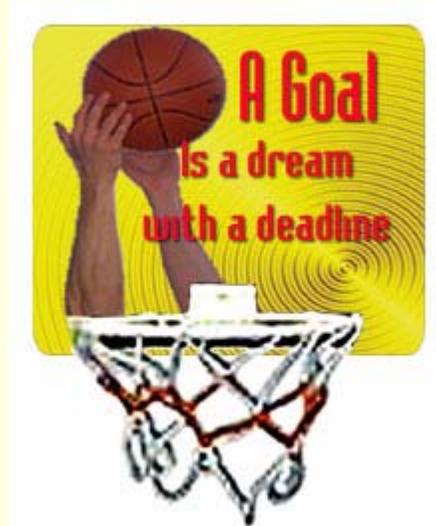
Goals



- Long term, global, and broadly stated
 - the broader the scope the less frequently it needs to change
 - perception of time may be culture bound
 - may influence expectations and participation
- Life changes as a result of services
 - focus of alliance / collaboration
 - readily identified by each person
- Linked to discharge / transition criteria and needs
 - describes end point of helping relationship

Goals *continued*

- Person-centered
 - Ideally expressed in person served's / family's words
 - Easily understandable in preferred language
 - Appropriate to the person's culture
 - reflect values, life-styles, etc.
 - Consistent with desire for self-determination and self-sufficiency
 - may be influenced by culture and tradition



Goals *continued*



- Essential features
 - attainable
 - one observable outcome per goal
 - realistic
 - written in positive terms
 - **built upon abilities / strengths, preferences and needs**
 - embody hope/alternative to current circumstances

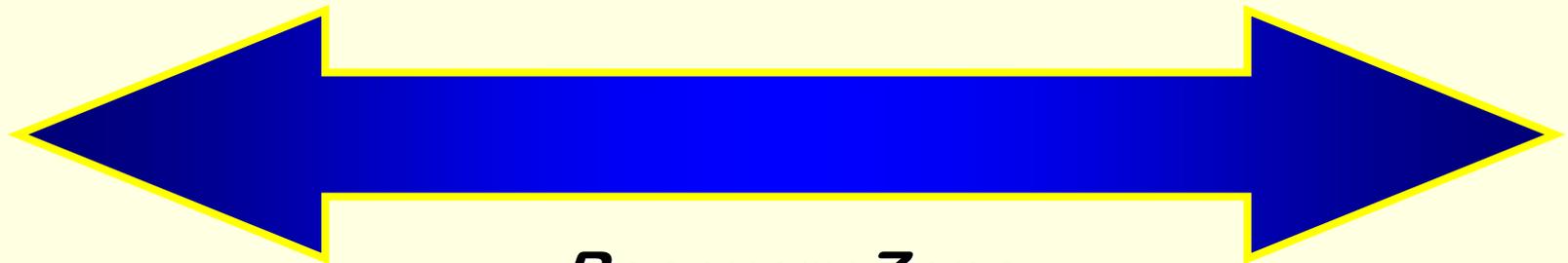
Goals *continued*

- For dually diagnosed:
 - Small but readily attainable goals
 - Abstinence may not be an immediate goal
- There might be three types of goals:
 - life goals
 - treatment goals
 - quality of life / enhancement goals

The Right Balance

Let client do what
he/she wants

Get client to do
what I want



Recovery Zone

Neglect

Control

Common Ground

- **Clients should have the dignity of risk and right of failure**
- **Providers are advocates of client choice**
- **Clients are not abandoned to suffer “the natural consequences” of their choices**
- **Provider or client not a failure if choice results in failure**
- **Use reinforcers to support client choice**
- **Assure true choice over a wide range of options**
 - **Pat Deegan**

Carmen Pre-contemplation

Now assume that...

Carmen believes that her condition is utterly hopeless, that her “sins” are unforgivable, that she has irrevocably shamed her family, and that she is doomed to a life of suffering.

Carmen's' Plan: Pre-contemplation

- Goal
 - “I don't have any goals for my future”

Carmen

Contemplation / Preparation

Now assume that...

Carmen now understands that it is fairly normal for teens in this culture to experiment with relationships and sex, that people make mistakes in their lives, and that it is possible for things to change and improve. She feels less negative and hopeless about the possibility of going to college but can't imagine what else she might do or how she can back on track.

Carmen's Plan: Contemplation / Preparation Stage

- Goal
 - “I need to know what my future will be”

Carmen Action

- Now assume that...

Carmen has realized that she needs to be doing something different with her life in order to feel better and achieve the shared value she has with her parents- to graduate from high school and go on to college.

Carmen's Plan/Action

- **Goal**

- "I want to graduate from high school"

Carmen's Plan: Maintenance Stage

- Goal (***same goal as active stage***)
 - “I want to graduate from high school”

Strengths

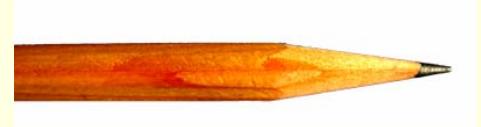
- Environmental factors that will increase the likelihood of success: community supports, family/relationship support/involvement, work
- Identifying the person's best qualities
- Strategies already utilized to help
- Competencies/accomplishments
- Interests and activities, i.e. sports, art
- Identified by the consumer and/or the provider

Barriers



- What is keeping the person from their goals?
 - need for skills development
 - intrusive or burdensome 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

Objectives



- Work to remove barriers
- Culture of persons served shapes setting objectives
 - address culture bound barriers
- Expected near-term changes to meet long-term goals
 - divide larger goals into manageable tasks
 - provide time frames for assessing progress
 - maximum of two or three per goal recommended

Objectives

- Build on strengths and resources
- Essential features
 - behavioral
 - achievable
 - measurable
 - time framed
 - understandable for the person served
- *Services are not an objective*



Objectives

- Appropriate to the setting / level of care
- Responsive to the person's individual disability, challenges and recovery
- Appropriate for the person's age, development and culture
- *"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

Carmen's' Plan: Pre-contemplation

- Goal

- “I don’t have any goals for my future”

- Objective

- Within 6 weeks Carmen will share her daily mood journal with her therapist.

Carmen's Plan: Contemplation / Preparation Stage

- Goal
 - “I need to know what my future will be”

Objective

- Within one month Carmen will have a plan for high school and college education

Carmen's Plan/Action

- **Goal**

- "I want to graduate from high school"

- **Objective**

- Carmen will return to class attendance for 5 consecutive full days within a month as reported by Carmen / or support worker

Carmen's Plan/Relapse Prevention

- Objective
 - Carmen will develop the cognitive and behavioral skills to remain free of depressive symptoms as measured by her receiving her diploma in June 2007

Interventions

- *Actions* by staff, family, peers, natural supports
- Specific to an objective
- Respect consumer choice and preference
- Specific to the stage of change/recovery
- Availability and accessibility of services may be impacted by cultural factors
- Describes medical necessity



Six Critical Elements



- Interventions must specify
 - provider and clinical discipline
 - staff member's name
 - **modality**
 - frequency /intensity / duration
 - **purpose / intent / impact**
- Clarifies who does what
- Include a task for the family, or other component of natural support system to accomplish

Carmen's' Plan: Pre-contemplation

- Intervention

- Olinda Garcia, LCSW, will provide Carmen with supportive psychotherapy 1 hour/ week for 6 weeks in order to build a safe and trusting relationship that can help her to overcome her fears and avoidance of treatment

Carmen's Plan:

Contemplation / Preparation Stage

■ Interventions

- Susan Williams, Case Manager, will meet with Carmen 2x per week for 1 month in order to help her access home-schooling supports so that she can graduate without returning to class
- Beth Angeles, peer specialist, will meet with Carmen one time per week for one month to provide support and encouragement

Carmen's Plan: Action Stage

■ Interventions

- Psychiatrist to provide weekly to **monthly pharmacotherapy** management visits for 3 months to relieve acute symptoms of anxiety and depression
- Social worker to provide one hour of **cognitive-behavioral psychotherapy** twice a week for 4 weeks to help Carmen resolve feelings of guilt and loss
- Support worker to meet with Carmen up to 3 hours / week for 4 weeks as required to **coordinate / facilitate** return to school with school counselors and mental health team
- Carmen and family to attend weekly sessions with the parish priest to bring about forgiveness and family reconciliation.

Carmen's Plan: Maintenance/Relapse Prevention Stage

■ Interventions

- Continue with monthly pharmacotherapy with Dr. Hall to prevent recurrence of symptoms for 6 months
- Stacey Hahnemann, M.Ed, will provide CBT every other week for 6 months to learn affect management and conflict resolution skills
- Continue to attend teen support group for 6 months at least one time per month for ongoing support with acculturation issues

Workshop Summary

Topics that were covered during this day:

- The business case for treatment planning
- Introduction to a comprehensive assessment
- Interpretive summary writing practice
- Incorporating assessment findings into treatment plans
- Components of a person-centered treatment plan
- Putting it all together exercise
- Lessons learned and applications

Common Mistakes

■ **Assessment**

- Do not use all available information resources
- Not culturally appropriate / sensitive
- Not sufficiently comprehensive
- Lack adequate integration / understanding of the person



Common Mistakes

■ **Goals**

- Not global
- Not directed towards recovery
- Not responsive to need
- Not strengths based
- Too many



Common Mistakes

■ Objectives

- Don't support the goal
- Not measurable or behavioral
- Interventions become objectives
- Not time framed
- Too many simultaneous objectives



Common Mistakes

■ Interventions

- Purpose not included
- Frequency, intensity, and duration not documented
- Too few
- Don't reflect multidisciplinary activity



Pre-Contemplation

Goals and Objectives for this Stage:

- Earning trust & overcoming sense of demoralization
- Raising awareness of ability to change/consequences of not changing
- Setting the stage for change by meeting basic needs/immediate goals
- Increasing access to resources/supports
- Inspiring thinking about the possibility of change

Recommended Strategies and Interventions:

- Outreach and engagement
- Risk assessment & management
- Assistance with basic needs: Housing, food, childcare, legal aid, medical care, employment/education, and income support
- In-home or facility-based acute care when needed for safety and/or containment

Contemplation

Goals and Objectives:

Resolving ambivalence by...

- Encouraging self-appraisal & providing personalized feedback
- Raising awareness of discrepancies between goals & present behavior/circumstances
- Increasing confidence in ability to make changes
- Increasing sense of importance & immediacy to change
- Enhancing supports conducive to change

Recommended Strategies and Intervention:

- MI & harm reduction approaches to care
- Identification & engagement of natural systems of support
- Individual & family psycho-education
- Medication education & assessment

Action

Goals and Objectives:

- Collaboratively designing a person-centered plan for change
- Enhancing discrete strategies/skills to make lasting changes
- Strengthening helping relationships
- Planning for challenges

Recommended Strategies and Intervention:

- Cognitive-behavioral treatment strategies
- Supported community living
- Monitoring medication use and effectiveness
- Peer & mutual support groups

Relapse Prevention

Goals and Objectives:

- Encouraging a long-term perspective on achieving stable changes
- Placing setbacks in context of the process of recovery
- Exploring gains/successes
- Reviewing stumbling blocks and revising plans accordingly

Recommended Strategies and Intervention:

- Relapse prevention approaches
- Recruitment for peer facilitation/mentorship
- Sustained independent employment, housing, socialization, recreation
- Treatment Plan review

Sustained Recovery

Goals and Objectives:

- Maintaining gains
- Developing and working toward new goals
- Maximizing natural support networks & minimizing reliance on formal supports

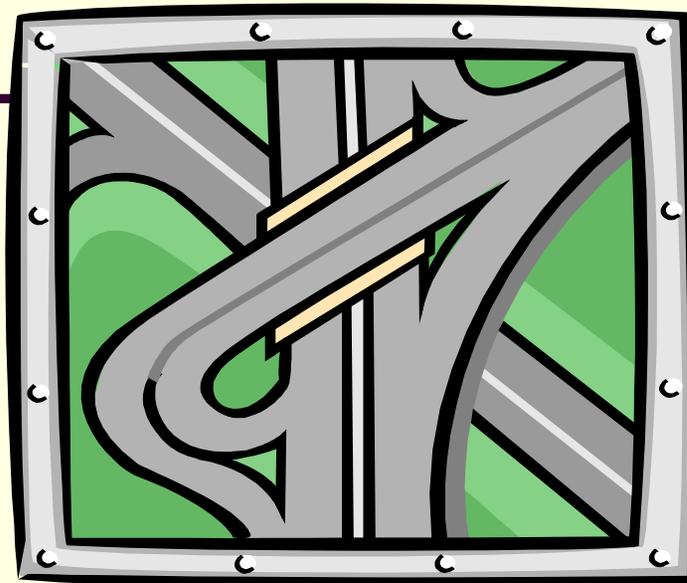
Recommended Strategies and Intervention:

- Advocacy/sponsorship/role model activities
- Supporting or subsidizing personal enrichment pursuits
- Medication management and annual recovery check-ups

Creating the solution

- The treatment / recovery management plan can be the bridge between the system as it exists now and where we need to go in the future





“If you don’t know where you are going,
you will probably end up somewhere
else.”