Making Recovery Real...

Person-Centered Planning as a Tool for Crisis Services

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Overview of Session

- Principles and Practices of PCRP
- Documentation of the person-centered recovery plan
- Crisis Services/Regulations
- Examples of Crisis Plans that are person-centered
Texas Person-Centered System of Care

• The State of Texas is embracing a Person-Centered system of behavioral health care

• Integral to this Person-Centered System of Care
  • Person-Centered Assessment
  • Person-Centered Recovery Planning
  • Evidence-Based Practices to effectively address identified needs
Hope Resilience and Recovery for Everyone

Prevention and Early Identification
- Public Awareness of mental health and substance abuse is enhanced and destigmatized
- Training for early identification of risk factors is provided
- Strategies are developed to reduce prescription drug use
- Statewide Suicide Prevention Plan is Developed and Monitored

Timely Access to Care
- No waiting list
- Expand local community beds
- Local crisis services are available and easily accessible
- In-home services are routine
- YES Waiver is expanded

Services Provided Close to Home
- Expand capacity
- Specialized services are available for target populations
- In-home services are routine
- Create long term support in the community for long term residents of the hospitals
- Effective jail diversion strategies are in place at multiple intervention points

Integrate Mental Health and Substance Abuse Services with Primary Healthcare
- All mental health and substance abuse service recipients have access to primary health care
- At risk populations are routinely screened for infectious disease, tobacco use, and obesity
- Healthy lifestyle supports are provided

Modernized Service Delivery System
- Services are purchased based on performance
- Resources are equitably distributed
- Choice of providers is available
- Use technology to enhance service delivery
- Services are trauma informed

Recovery Based Support
- Expand housing supports
- Employment is path to independence and should be routinely addressed
- Use peer providers and natural supports

Data Driven Decision Making
- Provider data is transparent and available to the public
- System wide data is published
- Data is available to everyone’s service system
- Data sharing occurs between providers
- Data is obtainable to enhance services

Implement person centered recovery planning and self-directed care

Cross Cutting Principles
Create strategies to develop an adequate, well trained workforce.
Expand and strengthen partnerships and stakeholder collaborations.
Only Evidenced-based or promising practices are used.
What we hope for THEM...

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

What we value for US...

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

- People with mental health and addictions issues generally want the exact same things in life as ALL people.

- People want to thrive, not just survive...

- PCRP challenges us to move past the “us/them” dynamic and embrace the true pursuit of RECOVERY rather than the maintenance of clinical stability
Person-Centered Care... a fuzzy concept?

- Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what “It” is and what “It” might look in practice.

- Tondora et al., 2005, Implementation of Person-Centered Care and Planning: How Philosophy Can Inform Practice

- The PCRP pilot efforts in Texas have represented a unique opportunity to move from person-centered THEORY to person-centered PRACTICE
Treatment Planning for Person-Centered Care
Shared Decision Making for Whole Health

Neal Adams
Diane M. Grieder
What Exactly is PCRP?

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

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

The PLAN is a window of opportunity to promote CONCRETE recovery-practice change!
The Person-Centered Train: Who’s on Board?
National Perspective
A Person-Centered Approach to Service Planning

• Collaboration and partnership are the hallmarks of creating a good recovery plan.

• The plan prioritizes the consumer’s desires while also including a provider perspective.
PCP is NOT an “Add-On” but an Integrating Framework for Quality in a Changing Healthcare Climate

- Incorporates EBPS, including IMR
- Encourages Peer-Based Services
- Promotes Cultural Responsiveness
- Focuses on Natural Supporters/Community Settings
- Derived from a Comp. Assessment; ANSA/CANS
- Informed by Stages of Change & MI Methods
- Emphasis on the Attainment of Meaningful OUTCOMES
- Maximizes Self-Determination & Choice
- Respects Both Professional & Personal Wellness Strategies
- Consistent w/ Standards of Fiscal & Regulatory Bodies, e.g., CMS, JCAHO, CARF

Emphasis on the Attainment of Meaningful OUTCOMES
Be Mindful of the Power of Language in Recovery Planning

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

### Glass Half Empty... Glass Half Full

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

- Recognize the range of contributors to the planning process (e.g., peers, natural supporters).
- Value community inclusion
- The person is given a copy of their plan
- Demonstrate a commitment to both outcomes and process; high expectations.
- Understand/support rights such as self-determination (e.g., role of advance directives; WRAP, etc.)
Goals of Mobile Crisis

BIG PICTURE
Goals:

• Assessment and Evaluation in the Community
• Stabilization in the least restrictive environment
• Crisis Resolution
• Linkage to appropriate services
• Reduction of inpatient and law enforcement interventions
Benefits of PCRP for Individuals in Crisis

• Building- self-determination, autonomy; individuals becoming the driving directors in their own healing, building trust and connections-by collaborative efforts-opportunities for discovery, recovery is possible)

• Crisis situation as an opportunity to learn/devise/utilize coping strategies to manage symptoms
So you try your best to implement ALL of these “key practices,” but how do we move from the **PROCESS of PCRP** to the **DOCUMENTATION of PCRP**?
...and in a way that balances the spirit of person-centered care with the rigor required in clinical documentation?
“Apparently, Smith’s desk just couldn’t withstand the weight of the paperwork we piled on his desk.”
And not just the territory of traditional treatment plans

• Goal:
  - Maintain psychiatric stability

• Objectives
  1. Compliance with meds
  2. Attend appointments with primary care provider
  3. Attend all psychiatric appointments as scheduled
So, how do all the pieces come together in the written recovery plan?
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”
A Logic Model for Building Person Centered Recovery Plans

Request for services

- Assessment
- Understanding
- Prioritization
- Goals
- Strengths/Barriers
- Objectives
- Services
- Outcomes

Adams & Grieder, 2004
Screening/Crisis Assessment

- Adult-TTAG or CA-TRAG crisis elements
- Evaluation of risk of harm to self or others
- Presence or absence of cognitive signs suggesting delirium
- Need for full crisis assessment
- Need for emergency intervention
- Evaluation of the need for immediate medical screening
Full Crisis Assessment

- Interview with the individual by a physician (preferably a psychiatrist)
- Review of past treatment records
- History from collateral sources
- Contact with current health providers if possible
- Previous treatment and response to that treatment
- Detailed assessment of substance use and abuse
- Identification of social, environmental and cultural factors that may be contributing factors
- An assessment of the person’s willingness to cooperate with treatment
- General medical history that may impact current condition
- Possible trauma, abuse, neglect
Why Strengths?

Critical component of PCRP because focusing **solely** on deficits/barriers ignores the resources a person has on which to build their efforts towards recovery.

Focusing on strengths may help the individual to form a goal.

Provides the practitioner with the WHOLE view of the individual.

Point of engagement with the focus person.
The Role of Strengths-Based Inquiry

• “It’s about what’s STRONG, not just about what’s WRONG! “

• Gina, a former patient at a state psychiatric hospital
Cultural Factors in Assessment

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

NO Stereotyping
Consider the Whole Person

- All of these factors must be viewed in context of the individual’s life/societal role, culture, family and community
Documentation need NOT lose sight of the whole PERSON!

Video clip...The Gestalt Project

http://www.youtube.com/watch?v=QficvVNIxTI&feature=youtu.be
An Example:  
*Why Does Someone Not Use Medication?*

- Person is concerned re: side-effects
- Person does not believe they have an illness/believes meds are “poison”
- Person has religious/cultural objections to taking medications
- Person experiences stigma re: use of psych meds; family/others have advised them not to take it
- Person becomes disorganized/can’t track complex med schedule
A Chance to Put the Pieces Together

- Given the incidence of co-occurring disabilities and/or disorders, effectively addressing co-occurring disorder is critical to successful recovery
  - Medical/physical concerns
  - Substance use
  - Developmental disabilities
- When the assessment identifies co-occurring needs, they are considered in the formulation.
Recovery-Oriented Care

Person-Centered Shared decision-making

Treatment Plans and Shared Understanding
Goals: What Do People Want?

Independence
- I want to control my own money.

Work /education
- I want to finish school

Spiritual issues
- I want to get back to church.

Health/well-being
- I want to lose weight.

Housing
- I want to move out of the group home.

Social activities
- I want to join a bowling league.

Satisfying relationships
- I want to see my kids.

Valued Roles
- I want to volunteer at the Senior Center.

To be part of the life of the community...
Collaboration and Goals

- An essential part of engagement
- Reaching agreement on the goal is essential
  - The provider understands and appreciates the importance of the goal
  - The goal has immediate meaning and relevance for the person/family
  - The goal becomes a shared vision of success
  - Begins to describe/envision an endpoint to services
Barriers/Assessed Needs

- What’s getting in the way?
  - need for skills development
  - Intrusive symptoms
  - lack of resources
  - need for assistance / supports
  - problems in behavior
  - challenges in activities of daily living
  - threats to basic health and safety
  - challenges/needs as a result of a mental/ alcohol and/or drug disorder
Objectives should be SMART

- An objective is a meaningful step (in the eyes of both the person & staff) toward the longer term goal; a concrete change in functioning or behavior
  - Simple or Straightforward
  - Measurable
  - Attainable
  - Realistic
  - Time-framed
Services & Action Steps

- Include those “interventions” provided by clinical & rehab professionals which...
  - Reflect a use of EBPs
  - respect individual choice and preference
  - are tailored to the stage of change/recovery
  - describe medical necessity by clearly describing how services are intended to overcome that individual’s barriers
  - are specific to an objective

- But they also incorporate actions by natural supporters and the person him/herself.
Action Steps by The Person In Recovery & Natural Supporters

• Traditionally, interventions in a plan include only those performed by staff. The recovery model, however, emphasizes the responsibility of a person to participate actively in his or her own care as well as the benefits of seeking contributions of “natural supports” (e.g., family, friends, advocates, & community supporters).

• For each objective, consider specifying:
  
  • “Personal Actions” (this promotes a sense of self-agency and helps to activate people in their recovery) and
  
  • “Natural Support Action” (to help the person build/expand their natural recovery network as a supplement to professional services)
Critical Elements

• Professional services must specify...

  • **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
You can Weave the Golden Thread of Medical Necessity in PCRP

- **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
Individual crisis treatment plan per regulations

• Based on provisional diagnosis
• Based on individual and family preferences
• Should include interventions, outcomes, plans for follow-up and aftercare, and referrals
• For LOC 1 a *recovery* plan is not required, but an individual crisis treatment plan is

Anything missing from the above per PCRP?
Providing Crisis Services

- Reviewing the person’s written plan and updating it to incorporate the crisis
- Introducing the WRAP or Mini-WRAP
- Linkage to services/resources
- Activities: skill building, education, counseling, peer support, relapse prevention, encouraging hope, offering options and alternatives, problem solving, enlisting natural supports, helping them feel like they are not alone, helping them focus on what simple things they might want or that might help immediately.

- The possibilities are endless...
Follow-up in Crisis

• Initial crisis follow-up services should be provided within 24 hours of initial contact
• Contacting the individual’s existing service provider(s) in a timely manner
• Transition to a non crisis LOC
• Receipt of follow-up and relapse prevention by the MCOT or from another community provider for up to 90 days (LOC 5)
• Linkage to evidence based treatments for children and families to prevent out of home placement
Continuity of Care – What’s It Look Like?

• Plan following the person from inpatient to outpatient and vice versa is ideal!
• From practitioner to practitioner – the care provided is continuous and everyone on the team is still working with helping the person achieve their goal(s)
• Having outpatient providers attend the inpatient treatment team meetings
• Each episode of care is not a stand alone event!
Mr. Johnson is having a panic attack. His difficulty breathing & chest pains are so bad, he can barely operate his car on the way to the Emergency Room. He enters & explains to the receptionist that he’s either having a panic attack or heart attack and needs immediate help. A nurse is able to quickly rule out a heart attack and informs Mr. Johnson, “it’s just a panic attack, it won’t kill you.” After 20 minutes of being left alone, he presses the emergency call button, now in tears and feeling hopeless that he’ll get some help, wishing he’d just downed that bottle of vodka like he did when this happened last month. Finally a nurse arrives. Mr. Johnson pleads for some anti-anxiety medication. The nurse leaves the room then returns with a pamphlet on panic attacks, explaining that becoming dependent on anti-anxiety medications will “only lead to more problems in the future.” She encourages him to seek therapy, offers to provide the names of a few local therapists, and encourages him to investigate his insurance coverage and provider network as soon as possible to start getting to the root of his problem. She leaves the room, and Mr. Johnson wonders what he’s supposed to do next, whether anyone will be returning to let him know what’s going on.
Traditional Crisis Treatment Plan

• **Goal**: Stabilize symptoms, rule out danger to self/others

• **Objective**: R/O symptoms of heart attack

• **Interventions**:
  1) EKG test
  2) Provide education & referral for anxiety disorder as needed
Another view

- Mr. Jones is having a panic attack. His difficulty breathing & chest pains are so bad, he can barely operate his car on the way to the Emergency Room. He enters & explains to the receptionist that he’s either having a panic attack or heart attack and needs immediate help. The receptionist says, “Let me get someone to walk you to the back so we can help. Do you need a wheelchair or can you walk on your own?” While waiting for the EKG machine/tech, the nurse says, “My name’s Ed. I’m going to stay with you until we can do an EKG to rule out a heart attack. Is there someone you’d like me to call?” The EKG rules out a heart attack. It’s becoming difficult for Mr. Jones to speak, as his breathing is so rapid and short. Ed asks Mr. Jones if he’d be willing to do some breathing exercises together so that he’ll be able to speak to the doctor when she arrives shortly. Mr. Jones agrees & becomes a little calmer but continues to be very distressed. Mr. Jones is now able to explain that he was on his way to his son’s soccer game, the last game of the season, when this attack came out of nowhere. When Dr. Ramsey arrives, she, Ed and Mr. Jones discuss the best course of action to get him past this panic attack. Ed explains how much distress Mr. Jones is in and how much he’d like to make it to his son’s game this afternoon. They decide that getting him past the current episode is the priority, giving him some anti-anxiety medication. Mr. Jones’ blood pressure will be taken every 5 minutes to monitor effectiveness of the medication in case an additional dose is needed. Ed says, “Hey, I’ve got to step out to take care of some other emergencies, but I’ll let the social worker know you’re in a hurry to get to your son’s game. Maybe she can get your discharge paperwork started and provide some information & referrals on panic attacks so this type of thing doesn’t keep happening. You’ve got important things to do! You mentioned that you like to fish, can I offer you a magazine on fishing while you wait for the meds to becomes effective?”
- Mr. Jones doesn’t make the game but is in & out of the ER in record time & joins the team for celebratory pizza afterward.
A more person-centered plan

• **Goal:** Be able to operate vehicle in order to make my son’s soccer game

• **Objective:** 1. Report anxiety level of 5 out of 10 or lower within 8 hours 2. BP within normal range within 4 hours

• **Interventions:**
1. MD to prescribe Anti-anxiety meds for immediate symptoms
2. Nurse to provide Education/Referrals re: Anxiety D/O once able to process information
3. Social Worker to offer help developing community care plan, including scheduling F/U appointment with provider in network
An Example

• **Immediate Goal** = “I want the voices to stop so I can feel normal again”
• **Long Term Goal** = “I want to get my GED”
• **Barriers**: John is homeless, experiencing extreme emotional distress due to suicidal thoughts, he is not taking his medications, he is smoking pot every day, lack of natural support system, recent release from hospital due to S/I, auditory hallucinations
• **Strengths**: he likes his case manager/rehab specialist, likes to play/listen to music, he is intelligent
• **Objectives**: 1) John will utilize 3 coping strategies every day for 4 days to help make the voices stop within 4 weeks 2) John will begin taking prescribed psychotropic medications again within 2 weeks
• **Interventions**: 1) CS team will meet with John daily to provide and role model coping skills training for better management of voices for 4 weeks 2) John will develop a list of resources to call when he is in distress/overwhelmed by voices within 7 days 3) Psychiatrist/APRN will provide education to John about medication strategies, and explore his symptoms and how medications can alleviate them, on a weekly basis for 2 weeks 4) CM will provide motivational interviewing techniques weekly about drug use for 4 weeks 5) Peer Support Specialist will meet with John every other day for 2 weeks to share his own experiences with medications and using drugs, and help him develop a list of resources to call on 6) John will listen to music on his headset when he starts to feel distress from the voices
A short term example

- **Goal** = I want to stay out of the hospital – just go home”
- **Barriers** = Jennifer is confused, disoriented, anxious, manic, hyper-verbal, stopped taking medications, wandering the streets
- **Strengths** = She lives at home with her supportive husband, she is a loving Mom to her 2 kids, presently in outpatient treatment
Example continued....

- **Objective** = 1) Within 6 hours, Jennifer will be more organized in her thinking as evidenced by being able to verbalize a need to return to outpatient treatment and take her medications as prescribed

- **Interventions** = 1) MD to administer emergency meds today to help her become more organized/less anxious
2) MCOT will contact outpatient provider within 24 hours and establish an appointment for the next day to re-engage her in services
3) MCOT will contact her husband within 3 days and enlist his support to better understand why she discontinued her meds and understand the family situation/stressors.
In Conclusion...

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

- *We just need to stop accepting what is and start creating what should be...*  Dale DiLeo
  - How will YOU be a part of change moving forward?
Closing Q & A...
Your Thoughts and ideas...
What is one thing you can do, something new that you are not already doing, that can further a recovery oriented, person-centered approach to crisis intervention?
For more information:

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