An Introduction to Person-Centered Planning

#MHCCChopelives

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Important! Send questions/comments to ‘All Panelists’
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

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
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Introductions and Background

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:
- Directions to our offices

JOIN:
- Recovery Network listserv
  subscribe
- Parachute Factory listserv
  subscribe

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 😊

ARE WE THERE YET?
ARE WE THERE YET?
ARE WE THERE YET?

PERSON CENTRED CARE
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
Partnering does not require that you always AGREE but it **does** require mutual respect and understanding.

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

Person-Centered Care Questionnaire: Tondora & Miller 2009
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/IuNYB9Prnk0](https://youtu.be/IuNYB9Prnk0)  
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
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.
For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

In the last 18 months, Sandra has worked with her 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?
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.”
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!
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.
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.

<table>
<thead>
<tr>
<th>Services &amp; Other Action Steps</th>
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<tbody>
<tr>
<td>Center doc to provide <strong>med management</strong> to reduce irritability &amp; acute manic sx (1X/mos)</td>
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<tr>
<td>Psychologist to provide <strong>family therapy</strong> to discuss Mrs. Gonzalez’s expectations and feelings re: future reunification (every 2 wks)</td>
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<td>Rehab Specialist to provide weekly <strong>Communication and Coping Skills Training</strong> to teach/coach skills that will foster successful visits with wife and children</td>
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<tr>
<td>Wellness Recovery Action Plan (weekly group) with Peer Specialist to promote daily wellness through the use of self-directed strategies</td>
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<tr>
<td>Center chaplain to promote use of faith/daily prayer as a positive coping strategy to manage distress</td>
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</table>
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 it's 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.
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
The plan document is only as good as the PROCESS/RELATIONSHIP it is based on!

What does a person-centered planning meeting look like?

<table>
<thead>
<tr>
<th>TONE AND RELATIONSHIP</th>
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<th>2</th>
<th>N/A</th>
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<tr>
<td>Interactions between providers, person served and others is warm and respectful</td>
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<td>Individual is addressed directly</td>
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<td>Common, understandable language is used – not unnecessary medical or clinical words</td>
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<td>Individual appears to feel comfortable raising concerns</td>
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<table>
<thead>
<tr>
<th>GOALS</th>
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<tbody>
<tr>
<td>Team members developed the recovery plan in partnership with the individual</td>
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<td>Individual determined in what life areas planning would occur</td>
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<td>Stated goals are those of the individual in his/her own words</td>
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<td>Recommended programming (Inpatient) was discussed and purpose explained with individual</td>
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<td>Individual's goals are respected even if they differ from the goals recommended by providers</td>
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<tr>
<td>Goals are about having a meaningful life in the community (home, job, community contribution...)</td>
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Massachusetts Department of Mental Health in Collaboration with The Transformation Center
Sample PCP Plan Audit Tool

### Person-Centered Recovery Planning Indicators: Documentation Quality

<table>
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<tr>
<th>Item #</th>
<th>Documentation Indicator</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>1</td>
<td>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 health, previous treatment experiences, interests/hobbies, abilities and accomplishments, unique individual attributes, recovery resources/assets.</td>
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<td>2</td>
<td>The plan/plan update actively incorporates the person’s identified strengths into the goals, objectives, or interventions.</td>
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</table>
| 3     | The narrative/interpretive summary includes the following required elements:  
   1. Strengths, interests, and current or desired life roles and priorities.  
   2. Any interfering perpetuating factors, e.g., trauma history, co-occurring medical or substance use disorders, etc. These are the barriers that may be in the way of the person achieving their goal on their own.  
   3. Individual’s stages of change/stages of recovery (Stage of readiness for any relevant behavior change that could help them move towards their goal)  
   4. Available natural supports or community resources  
   5. Cultural factors and any impact on treatment  
   6. A clinical hypothesis/understanding/core theme: what drives the individual’s experience of illness and recovery - the “why” question |     |    |
| 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 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 supports, 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 person living with schizophrenia NOT a schizophrenic) 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     | Objectives meet the SMART criteria. They are written as follows: simply (understandable to the person), are measurable (they happened or not, as evidenced by…), are achievable, realistic, and time limited. |     |    |
| 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 30 days.                                                                 |     |    |
| 11    | The plan/plan update describes efforts to help the person to connect with chosen activities in the community rather than relying on social supports coming from behavioral health agencies. (This is usually found in the interventions) |     |    |
| 12    | Interventions meet the criteria of the 5 W’s: what (billable service), when (frequency), where (location), why (purpose and intent) of the service and who is providing the service. Interventions DO NOT reflect ONLY participation (i.e., Jose will attend individual therapy…) |     |    |
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.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
<th>DK</th>
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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 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 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.

<table>
<thead>
<tr>
<th>Person-Centered Planning Indicators: Person In Recovery Perspective</th>
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Tools and Resources

CT Department of Mental Health and Addiction Services

New York Office of Mental Health, PCP Resource Page
- https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/

New York Care Coordination Program

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)

Person-Centered Care Questionnaire: Tondora & Miller 2009


- 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?
Next Recovery-Oriented Practice Webinar

**Date:** Thursday, November 17\(^{th}\), 2016 at 1:00pm to 2:30pm ET

To rewatch or share this webinar visit:
www.mentalhealthcommission.ca/English/recovery
How did we do?

Please fill out the survey that opens after you leave the webinar
Thank you!

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