American Psychological Association

Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment

5. Person Centered Planning

August 2014
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Overview
In this module of the course we will discuss the concepts and methods involved in person centered planning.

Learning Objectives
At the end of this module you will be able to:

• Discuss at least four concepts of person centered planning and its relation to the recovery philosophy
• Identify and describe at least five cultural factors that must be taken into account in any planning and service delivery enterprise
• Describe at least three barriers to implementing person centered planning and discuss the reasons why these must be overcome prior to implementing the process
• Identify the five steps that make up the person centered process and discuss the essential components of each
• Describe at least three practices to facilitate true person centered planning

Resources

• Lecture Notes
• Required Readings
• Lecture Notes Citations
• Sample Learning Activity
• Sample Evaluation Questions
• Additional Resources

Required Readings


Activities

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

The concept and process of person centered planning are integral to the philosophy of recovery and essential for a mental health system to be truly a recovery oriented system of care. Person centered planning embodies the recovery movement as it places the individual with serious mental illness at the heart of everything that is undertaken to facilitate the person’s recovery. The right to make choices for oneself is a fundamental human right that is not contingent on freedom from symptoms. Every person has the right to be involved in, and make decisions about services received, how and where to live, with whom to associate, etc. Person centered planning is the operationalization of respect for a person’s right to make these choices.

Recent research has demonstrated the value of person centered planning for people who receive services (Holburn, Jacobson, Schwartz, et al., 2004; Robertson, Emerson, Hatton, Elliott, et al., 2005; 2007; Sanderson, Thompson & Kilbane, 2006), and it has been found that person centered planning does not lead to a significant increase in costs (Robertson, Emerson, Hatton, Elliott, et al., 2007).

As we will see later in this module carrying out person centered planning is not easy to do. There are many barriers and it is much more difficult to actually carry out this work than might be imagined because, like other aspects of the recovery paradigm, doing so requires a shift in thinking and a departure from the way that most were trained.

So, what exactly is person centered planning? At its most rudimentary, person centered planning means that the person with the illness is the fulcrum around which all discussions, planning, interventions, evaluations, etc., occur, and it means that the person is in charge of defining future directions for his or her life. This means that nothing is planned or undertaken without the person’s active input and approval. As will be seen, the steps in the process require much more than simply having the person present or asking the person to agree with, or “sign off” on assessments, goals, interventions, and evaluations. All of these must emanate from the person him or herself. This may be easier said than done, especially when done correctly. Another important aspect is that person centered planning often requires that community agencies be involved in order to ensure that the person is fully integrated into his or her community. As such, the process differs considerably from traditional service planning approaches where each agency typically provides only those services within its mandate and does not concern itself with service deficits outside its own mandate. The table below provides a graphical depiction of the
differences between traditional approaches to planning and service delivery and one that is person centered, sometimes referred to as personal strategic planning.

**Traditional versus Person Directed Approach**

<table>
<thead>
<tr>
<th>Traditional Approaches</th>
<th>Person-Directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-determination comes <em>after</em> individuals have successfully used treatment and achieved clinical stability</td>
<td>Self-determination and community inclusion are fundamental human rights of all people</td>
</tr>
<tr>
<td>Compliance is valued</td>
<td>Active participation and empowerment is vital</td>
</tr>
<tr>
<td>Only professionals have access to information (e.g., plans, assessments, records, etc.)</td>
<td>All parties have full access to the same information – often referred to as “transparency”</td>
</tr>
<tr>
<td>Disabilities and deficits drive treatment; Focus is on illness</td>
<td>Abilities/choices define supports; Wellness/health focus</td>
</tr>
<tr>
<td>Low expectations</td>
<td>High expectations</td>
</tr>
<tr>
<td>Clinical stability or managing illness</td>
<td>Quality of life and promotion of recovery</td>
</tr>
<tr>
<td>Linear progress and movement through an established continuum of services</td>
<td>Person’s chooses from a flexible array of supports and/or creates new support options with team</td>
</tr>
<tr>
<td>Professional services only</td>
<td>Diverse supports (professional services, non-traditional services, and natural supports)</td>
</tr>
<tr>
<td>Facility-based settings and professional supporters</td>
<td>Integrated settings and natural supporters are also valued</td>
</tr>
<tr>
<td>Avoidance of risk; protection of person and community</td>
<td>Responsible risk-taking and growth</td>
</tr>
</tbody>
</table>

*Source: Tondora, 2011*

**Historical Origins**

The concept of person centered planning originated in the developmental disabilities field and came about in the 1960s because of the recognition that planning for, and delivery of services should include individuals themselves and their families, and should be built on the strengths of the individual and the goals he or she has for his or her life. Disability rights advocates argued for inclusion of individuals and their families in the planning and service delivery process and argued that people with disabilities should be considered full members of their community and the larger society. It was at this time that the Principle of
Normalization was developed (Nirje, 1969; Wolfensberger, 1972). The Normalization Principle espouses the belief that all people should have access to the rights, roles, and responsibilities that are part of everyday life and that those with any disability or impairment should be treated with respect, provided functional supports only as they need and want them, and treated in the same way that people without a disability or impairment are treated. This would include making informed decisions and the idea was quite discordant with the way people with disabilities were viewed and ultimately paved the way for many of the changes that came about in later years.

Following this, the Self Determination movement was initiated. The Self Determination movement espoused the notion that professionals alone should not determine the services received, but rather that individuals should be involved in all decisions related to medications and the services they would receive. The Self Determination movement also proposed that individuals should be fully integrated into the community in which they live (O’Brien, 1989).

Following these initial efforts, several others began outlining the concepts and processes involved in a system that recognizes the importance of putting the person at the middle of the planning and service delivery process. In the mental health field, these developments led to the evolution of the recovery movement where persons with serious mental illness and some professionals recognized that recovery and living a satisfying life in the community are possible. The person centered planning process is now central to provision of services that are recovery oriented.

The Importance of Culture in Planning and Service Delivery

Prior to beginning a discussion about the process and steps involved in person centered planning, a discussion about the importance of cultural factors is in order. The influence of a person’s culture, background, religious beliefs, and or upbringing are important considerations that are often overlooked. This is becoming more evident as the population becomes increasingly heterogeneous. Cultural factors, including religion, beliefs about mental illness, its etiology, and its acceptability, views regarding a person’s right to make choices as opposed to having those choices made for him or herself, to name just a few, can substantially impact on the planning process, services received, and recovery process. Language barriers can also have a profound effect on ability to communicate the many important facets of a person’s life and background – all these impact on the planning process. A few examples follow.

In some cultures, the concept of mental illness is virtually non-existent as behaviors are considered to be under the control of spirits or other forces that can be controlled by indigenous healers or faith based providers (Constantine, Myers, Kindaichi & Moore, 2004; Malarney, 2002). Another factor is that in many cultures, mental illness and attendant behaviors are highly stigmatized making help seeking extremely difficult if not impossible.
There are also many cultures in which young people do not ordinarily make decisions or choices for themselves but defer to the wishes of their elders (Ellis, Lincoln, Charney, Ford-Paz, et al., 2010; McKay, Hibbert, Hoagwood, Rodriguez, et al., 2004). Similarly, some cultures do not afford women the opportunity to express opinions or make decisions, reserving these for male members of the family (Said-Foqahaa, 2011). In such cultures, it could be very difficult for the person with the illness to participate actively in the planning process and take part in determining the future direction for his or her life. This may be especially important if talking about sexual health issues is not permitted. Issues such as sexually transmitted diseases and contraception have the potential to impact on physical well being and one’s future life, making these important to discuss.

Another cultural issue that is not often discussed involves trauma resulting from family perpetrated physical or sexual abuse. Although this occurs in some cultures, it is not officially sanctioned. However, in some cultures women and sometimes children are seen as property to be used as desired (Chaudhuri, 2005; Said-Foqahaa, 2011), and these practices may be overlooked or unofficially sanctioned. This is rarely discussed but leads to tremendous trauma for the victim and sometimes for the perpetrator as well.

Although the above examples may appear to be irrelevant to many, there are remnants of the same beliefs and practices in the U.S. There are also many recent immigrants from societies where the above examples are prevalent. Sensitivity to individuals from backgrounds that differ from what might be considered the mainstream is essential if steps toward person centered planning and services are to be taken. In such cases, greater attention to family beliefs and preferences should be considered primary while attempting to involve the individual to the greatest extent possible and facilitate planning, service delivery, and ultimately recovery on the person’s and family’s terms. In all cases, the person’s wishes about culturally influenced choices must be respected.

**The Process and Steps Involved in Person Centered Planning**

Prior to beginning the discussion of the steps involved, two important components should have occurred or be in place. First, the individual him or herself should want to receive services from the mental health system and should have asked for assistance. Secondly, the mental health system should be one that actively promotes and supports a recovery orientation and person centered planning. Without such commitment, mental health practitioners will find it difficult to undertake person centered planning and to follow through with agreements made with the people receiving services (Walker, Koroloff, Schutte, & Bruns, 2004).

The definition below of a patient centered intervention indicates very concisely what is involved in developing a set of interventions that are truly person centered:

Psychologists are especially well trained to work with individuals from a person centered and recovery perspective because of the training and emphasis on strengths and helping individuals overcome diversity to lead fulfilling lives. Psychological interventions such as CBT and the strengths based approaches of Positive Psychology are two examples of the unique intervention modalities that are to be called upon in all phases of the person centered approach to working with individuals with serious mental illnesses.

**Initial Meeting**

During the initial meeting, the approach of person centered planning would be discussed with the individual and he or she would be asked to think about, and for future meetings, to involve as many individuals that he or she trusts and wants to ask to be part of the process. The identified individual(s) should be asked to take part in the process with the person, not to speak for him or her, but to provide support and fill in detail, as requested.

Following the initial meeting, one or more additional meetings will be necessary to carry out an assessment, design a plan that will assist the person to achieve the goals she or he sets, evaluate progress, and potentially develop additional or revised goals, and make transition plans.

**Assessment**

For psychologists, an assessment carried out as part of a person centered planning process is very different than one that would be undertaken for diagnostic or other clinical reasons. Clinical assessments are typically done to label someone’s illness, usually because some part of the system requires such a label. Reasons for requiring a diagnostic label could include insurance reimbursement requirements, a medically oriented system where
practitioners feel more comfortable if the illness has a diagnostic category, judicial review requirements, etc. An assessment that is undertaken as part of person centered planning is done to find out what the individual wishes to achieve and to identify the assets available and challenges to be overcome in order for the person to reach the goal(s). A person centered assessment is one in which the person identifies his or her goals, strengths, and challenges, in as much detail as possible, and conveys these to the service provider. Strengths and challenges are not limited to those intrinsic to the person but include those available or desirable in the person’s support system and wider community.

Prior to beginning the formal assessment process, it is important to explore with the person his or her interest in the planning process. All too often, service plans are written assuming that individuals are ready to take action, when people may not actually be ready to do this. The result can be that the person does not participate in the planning process and the person is labeled non-compliant or resistant. In order to avoid this, exploring with the individual thoughts about his or her readiness for the process, and reaching out to the person with a focus on engagement and building trust, would be the first course of action (Adams & Grieder, 2005; Osher, Osher & Blau, 2005).

Once the person is ready to begin, the assessment process can begin. Some components of a person centered assessment include – each identified by the individual and explored in detail:

- Personal strengths viewed as an important personal asset
- Areas for improvement:
  - Employment – what kind
  - Education – in what areas
  - Socialization – what kind, how frequently, with whom
  - Leisure – what kind, how frequently including interests not explored
- Community/environmental resources and assets that can be accessed
- Problems/issues:
  - Financial, legal, safety, medical, interpersonal relationships
- Living situation:
  - Preferred, realized, including location and with whom
- Mental health:
  - Current status, i.e., doing ok, receiving services, having problems, etc.
- Issues not identified or discussed such as trauma, abuse, medication, etc.
- Desired outcome of services – where would the person like the process to end up?
Once all components of the assessment have been completed and reviewed, an integrated summary should be written that pulls together all of the information into an integrated whole that paints a coherent picture of the person and his or her world. All aspects of the assessment and summary are shared with the person and others according to the person’s wishes. The Assessment module of this curriculum contains greater detail about conducting a strengths based assessment.

Creating the Plan

Once the assessment and integrated summary are completed and all are agreed that these present a comprehensive vision of the person’s strengths, challenges, and overall goals, a plan for building on those strengths, making strides to overcome the challenges, and work toward goals can be developed.

As with the assessment and summary, the plan should be developed together with the individual and any others that he or she wishes to involve, and all should receive copies of it.

The plan will have three overarching components: goal(s), objectives, and interventions. Each of these is discussed below.

Goal(s)

The goal or goals are accomplishments that the individual wishes to achieve. They can be long term as the person may have some goals that will take a while to achieve, but ideally goals should be ones that can be accomplished within a year. Additional goals can be added as the person achieves earlier ones, or as the person determines that initial goals should no longer be included. Goals can be written fairly broadly such as return to school, live independently, etc. Goals should build on the person’s strengths and be written with the person’s culture and values in mind. The number of goals should be manageable and realistic so that to the greatest extent possible, they can be accomplished. However, practitioners must be careful that their own view of what is realistic does not supersede the wishes of the person. Goals that are truly unrealistic such as “I want to be the first person to land on the moon”, can be listed and discussed openly and non-judgmentally without imposing the provider’s will on the person. All goals that the person expresses should be considered and discussed in a non-judgmental perspective.

Objectives

Objectives can be seen as the steps needed to reach each particular goal. Objectives should be based on the strengths and abilities of the person and usually involve the steps needed to overcome a challenge or barrier that was identified during the assessment or that is identified as the process moves forward. Objectives are developed with and by the person and should be achievable and realistic in that person’s eyes. A helpful mnemonic that has been adopted for use in person centered planning (Tondora, 2011) and that can be used to prompt the writing of good objectives is that objectives should be SMART:
Interventions

Interventions can be thought of as assists that will be provided to help an individual as he or she works through the objectives on his or her way toward one or more goals. Like objectives, interventions should also be written in specific terms identifying what the intervention will consist of, who will provide it, how often it will be provided and for how long it will be provided. While interventions are often thought of as the purview of professionals, they may also be activities that are carried out by family members, supporting individuals, or from resources available in the community.

Strength-based approaches are not limited to adults and are ideal for children and young people as well. Interventions that draw on strengths should be implemented across the age span at the individual child and family team level, with adults, and with older adults at both the individual level and at the community level as well (McCammon, 2012). Competency-building and promoting mental wellness are complementary approaches that should be used in conjunction with treatment interventions (Miles, Espiritu, Horen, Sebian & Waetzig, 2010). As with objectives, the plan should provide specific information about interventions, including:

- What the intervention consists of
- How frequently it will be provided
- Its duration, or for how long it will be continued
- Who will provide the intervention
- Its intended impact (Tondora, 2011)

Evaluating Progress and Making Revisions as Needed

Reviewing progress and updating the plan on a regular basis is important to ensure that it remains focused on helping the person achieve his or her recovery goals. Reviews should take place when milestones are achieved or when problems arise that may interfere with progress. Otherwise, quarterly reviews provide a good opportunity to “check in” to see how things are moving along. Progress reviews can be a good time for assessing what has gone well, what has become a stumbling block, and what has been learned about all aspects of the plan and about the participants in the process. It should never be considered that failures have occurred; rather evaluating progress should be seen as a learning opportunity for personal growth.
During the review process, the person can describe progress, thoughts about the plan, and discuss his or her satisfaction with its components, and those involved in helping with it and providing interventions. Any adjustments that need to be made to any aspect of the plan can be made during the review meeting.

It is important to note that goals may not always be achieved. There are many reasons why a goal might not be reached and these can range from simple ones such as it was no longer important to the person, or the resources needed to reach the goal are no longer available. The planning team, led by the person served, can evaluate what has impeded accomplishment of the goal and the plan can be re-written to focus on something that may now be more important or more attainable. Plan changes should not be seen as failures – all of us encounter setbacks that require changes to even the best plans. Alterations should be viewed as learning opportunities where all can benefit from the knowledge gained about new or continuing strengths and challenges, both at the person or provider level and at the system or community level.

Making Transitions

There are several points when transitions will occur and planning for these is important. Some of these include times when the person is satisfied that goals have been achieved, requested services have been received, the person indicates a readiness to move on, or other life changes require transitioning to a different planning process with the person. If the person is to remain connected to the service system, a new planning process may need to be initiated for the next phase of services. Planning can occur as often as the person wishes; it does not need to be an annual event or occur only when transitions are on the horizon.

Challenges

Person centered planning means working in a truly participatory environment by ensuring that the person is the driving force in every aspect of the process, building on the person’s strengths and capabilities, and continually revisiting the plan and its outcomes with the entire team. While the concept seems simple enough, there are many challenges or barriers to true implementation of such a process.

One potential barrier that should be explored at the very beginning is working with the person to determine that he or she is truly ready to begin the process. If not, it may be necessary to reach out to the individual to engage him or her in the recovery process. Even small steps that the person chooses to work on can go a long way toward averting failures due to the provider’s enthusiasm to get the process off the ground, when the person may not be ready to do so.

Another important challenge is that most mental health systems and the practitioners who work in them, have considerable difficulty dispensing with the traditional view of persons requesting services as people to be directed to whatever the provider deems best. In all cases, the individual must be the driving force who directs the process.
System administrators and practitioners (like most everyone) find changing the way things are done to be anxiety provoking and often very difficult to deal with. Excuses for resisting change range from the perception that costs will increase due to the need to train staff and create new infrastructures, to beliefs that consumers are not capable of real participation or will be dissatisfied with the services they receive.

Another challenge is ensuring that person centered planning is implemented properly. There may be poor or partial implementation attempts leading to less than desired results with the concept of person centered planning taking the blame for the failed attempt. Peer specialists can play a vital and cost effective role here.

Like the recovery process itself, of which person centered planning is a part, undertaking a participatory process with the people receiving services requires a paradigm shift on the part of decision makers and practitioners alike. This can be challenging to accomplish.

Summary

Person centered planning is a collaborative and interdisciplinary process and is an essential component of the recovery paradigm because at its most basic level, it means that the individual is the decision maker for all aspects of the process from the point of requesting services, to choosing helpful family or friends to participate, to working through the assessment process, to deciding upon goals, objectives, and interventions to meet the goals and objectives, and to evaluating progress and satisfaction throughout the entire process.

Although it may sound quite simplistic, implementing person centered planning requires a dramatic shift in thinking both on the part of service delivery systems and professionals in those systems because it puts the individual to be served in the driver’s seat and equalizes the level and status of the system and its professionals. This is quite a radical departure from the way most systems are organized and the way most professionals are trained to think about themselves and the people they work with.

Person centered planning cannot be carried out by one or two professionals within a system. The organization must be committed to the process and to following through with commitments made with the people who will be the recipients of services. This requires a true paradigm shift. The full process involves several steps beginning with a request for services from the individual, to assessment, goal(s) identification, defining objectives to meet the goal(s), deciding upon interventions to overcome any challenges that might hinder meeting the objectives, evaluation of the process and interventions, revising the plan as needed, and transition planning. All steps and points in the process require the involvement of the person, who is the reason for undertaking the work and is at the heart of the process.
Sample Learning Activity

First, explain to the group that this exercise will be an opportunity to look more closely at issues and policies that affect the lives of people with serious mental illnesses. The purpose of the exercise is to discuss the ways that people with serious mental illnesses are affected by stigma and decisions that are made for them instead of with them. This includes policies that service systems have about who makes decisions – typically the service provider. System policies have profound impacts on: access to health care, child care, employment, vulnerability to violence and abuse, abuse from law enforcement, to name just a few.

With the group, generate a list of topics that the group would like to address and have the group choose their top 3 – 4 topics. Example of topics that can be considered include (different/additional topics can be used):

Health Care – access and decision making
Education – decisions are made about who can access higher education
Work – in paid or volunteer employment
Housing – decisions are made about who can live in what kind of housing

Divide the large group into 3 – 4 small groups; each small group will consider one of the topics decided by the large group. Participants can choose which group they join.

Distribute the small group discussion questions below and review the questions with the large group. The small group discussion questions are:

1. When planning for services, how do policies made by the service system affect people with serious mental illnesses and how can person centered planning help to overcome the negative impact on people’s lives?
2. What is the impact of this issue on your community?
3. What are some ways that mental health service providers and those affected by serious mental illnesses can address this issue?

Small groups then discuss the questions and prepare a presentation for the large group. If the group doesn’t know the answers to a question, don’t guess. Instead, think about what additional information could help to answer the questions. One person from each small group is designated as the rapporteur. When finished, the rapporteur will present the small group’s discussion to the large group. Only one answer to each question will be presented.

Reconvene the large group and have each small group present their discussion by presenting one answer to each question. If time permits, the large group can discuss. The main point of this exercise is to expose participants to using a serious mental illness perspective and to see how that perspective can influence our approach to clinical services, including ways to change policies and practices that discourage people most affected from making decisions about their goals and services that will help them achieve those goals.
## Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A diagnosis is essential to understanding the person with serious mental illness and is a crucial first step in the assessment process</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The individual with serious mental illness should be present at any meeting where he or she is discussed and the person should receive a copy of any documents that are prepared relative to him or her</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. A discussion of strengths should be a central focus of every assessment, plan, evaluation process, and summary prepared</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Person-directed planning means the person should make his/her own decisions without input from people who are natural supports to the individual, such as family members and/or trusted friends</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. A goal of person-centered planning is to encourage and work toward greater community inclusion for people with serious mental illnesses</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Lecture Notes Citations


### Additional Resources

American Psychological Association Recovery to Practice Initiative.  


Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
Recovery to Practice initiative at the American Psychological Association, [www.apa.org/pi/rtp](http://www.apa.org/pi/rtp)

or

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