

Doing With, Not Doing For

What it Takes to Facilitate Person-Centered Planning

Q&A and Resources

Questions

Q: How do you help implement PCP with individuals who have very limited communication skills?

Darien: The way to implement PCP To someone with limited communication skills is too have someone Record the information about the person centered planning.

Carol: It would be important to have people at the planning meeting who work closely with the person and who understand his/her verbal and non-verbal communication. It could also help to provide the questions to him/her beforehand, in plain language, perhaps in yes/no questions, and be sure any assistive technology needed is available. A communication chart can help those who aren't as familiar with the person: <http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/communication-chart/>

Q: In the context of “Making sure the plan is being implemented according to a person’s wishes” Amy talked about the connections that were essential before she moved out of hospitalization. 1) Does this mean that the facilitator is expected to follow the person along through their service journey and not just be there for planning events? 2) Tips on how to work with Guardians/ parents that are barriers to actually following through on planning/activities to assist members with achieving their goals?

Janis: 1) In order to achieve the full potential of person-centered planning, the primary “facilitator” of the PCP process should ideally have a responsibility for being a “shepherd” of the person’s vision of a good life for themselves – and help to carry, and advocate for, that vision across all involved stakeholders and service providers AND across all levels of care. In many program models around the country, independent PCP facilitators do not currently have the breadth of responsibility or scope of authority to perform these functions. Systems-level interventions would be necessary to address the variability seen in PCP facilitator roles and job descriptions.

2) When invited into the PCP process by an individual, family members and guardians should be educated about person-centered planning practices and understand their rights and responsibilities in advance of the meeting. Their contributions to the planning process can include providing the team with a strengths-based view of the individual, corroborating data that the individual may not be able to express themselves, supporting the individual, and committing (and following through on) specific tasks to help further the person’s attainment of their goals. There should be open discussion about what might be helpful, versus not-so-helpful, ways of contributing! For example, while we should encourage a family /guardian to share their concerns so that the team can collectively brainstorm some strategies and solutions, family members/guardians may also need to be re-directed if they approach PCP meetings as an opportunity to align with professionals and to apply undue pressure on the person around key

service and life decisions out of a desire to protect the person. Oftentimes, the most important question a family member/guardian can ask is “How can I support you in a way that would be most helpful to you?” to allow each and every individual to express their own unique preferences around their involvement.

Q: Part of being person centered is understanding that one person cannot know everything. Is there any guidance or best practices on how to recognize when a mistake is made and how to acknowledge that?

Darien: I haven't personally experienced a time when someone has made a mistake on a person centered planning but if there has been a mistake made on someone's person centered planning you should go to the person that helped him build that person centered plan and say something to make needed changes.

Carol: I authored a curriculum for the National Alliance for Direct Support Professionals on Supporting Informed Decision Making that can be useful.

<https://nadsp.org/informed-decision-making/>

In embracing a person-centered approach and supporting self-direction, people receiving supports need to be empowered to make their own choices. These ideals and practices of informed decision making are embedded into the NADSP Code of Ethics. Whether it involves relationships, privacy, sexuality, well-being, or other areas people should be supported in making informed decisions, while understanding the associated risks and responsibilities that are tied to those decisions.

Q: Do you have any useful strategies to help "concretize" the process when guiding individuals to reflect & articulate their vision for future - Hopes and Dreams and long term goals? *Some students have difficulty with abstract, open ended process/dialogue of creating a "PATH"

Janis [answered in chat]: Melanie Sipko, great question! If you check out the Appendix page of the Core Competency Document, there is a table that maps on several concrete tools for use in support of each competency domain - and the richest set of resources is actually in that "visioning/hopes/dreams" area you refer to. Some great nuts-and-bolts tools - check it out :)

Q: How do we take strengths based approach to planning while giving an accurate view of the individual's needs?

Carol: A balanced view of the person's strengths and support needs is essential. Needs should not be overlooked in the interest of appearing more strengths based. Strengths should not be overlooked to focus only on deficits. A one-page profile can help summarize both:

<http://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/>

Janis: In PCP in behavioral health, this question of adequately documenting and addressing needs/problems most often comes up in the context of requirements around medical necessity and justification for certain levels of care or service packages... We address this tension in our Top Ten Concerns paper if helpful: <https://www.viahope.org/wp-content/uploads/2018/01/Top-Ten-Concerns.pdf>

In addition, while person-centered planning strives to capitalize on the person's strengths, it is also true that the “roadblocks” which interfere with goal attainment often take the shape of disability-related limitations, experiences, or symptoms. These too, have a place in the comprehensive person-centered plan. Barriers should be acknowledged alongside assets and strengths as this is essential not only for the purpose of justifying care and the “medical necessity” of the professional supports we provide, but also because a clear understanding of what is getting in the way informs the various professional interventions and natural supports

which might then be offered to the individual in the service of their unique vision of a good life. The difference in a person-centered plan is that the barrier does not become the exclusive and dominant focus of the plan and it only takes on meaning to the extent that it is interfering with the attainment of larger life goal such as getting a job, finishing school, being a better parent, pursuing a hobby, etc.

Q: What are your thoughts on self-advocacy, influence and power when the person is a ward (perhaps with reduced cognitive function from Dementia) and the issues are around being heard and having one's wishes listened to?

Carol: Decision making tools such as a profile about how a person makes a decision and an agreement about how to support a person in a specific situation can help people have more causal agency in their lives regardless of guardianship status:

<https://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/decision-making-profile/>

Q: The teams I'm involved with always seem to struggle with "marrying" person centered planning and ensuring plan requirements are addressed. any suggestions on how to do this better?

Janis: This is similar in some way to the strengths-barriers tension noted above... Parallel tension is the choice and autonomy versus professional/clinical due diligence. Our Top Ten Concerns paper noted in the comments above gets at these tensions.

Another useful resource might be a publicly available 90-minute overview webinar I did for the MHTTC last summer.. Here is the link and description from the MHTTC website:

<https://mhttcnetwork.org/centers/new-england-mhttc/product/person-centered-recovery-planning-live-webinar>

Janis Tondora lead this webinar which reviewed key indicators of PCRCP from both a process and a documentation perspective. Particular emphasis was placed on strategies for maintaining a strengths-based recovery orientation in collaborative care planning while simultaneously meeting rigorous documentation standards associated with fiscal and regulatory requirements.

Resources

Five Competency Domains for Staff Who Facilitate Person Centered Planning:

https://ncapps.acl.gov/docs/NCAPPS_StaffCompetencyDomains_201028_final.pdf

Plain language version:

https://ncapps.acl.gov/docs/NCAPPS_StaffCompetencyDomains_PlainLanguage_Final.pdf

Martha Barbone's "Applying Peer Support to the Top 10 Concerns About Person-Centered Planning in Mental Health Systems -

https://ncapps.acl.gov/docs/Webinars/2020/NCAPPS_PeerSupportAndConcernsOfMHPProviders_Handout_200817_508.pdf

International Association of Peer Supporters: <https://www.inaops.org/>

Student-Directed IEP: Bringing Person-Centered Practices to Schools and Beyond [NCAPPS webinar from October 27 2020]: <https://www.youtube.com/watch?v=DKgocrdryNg&t=2s>