# Person Centered Planning

## An Introduction

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Person Centered Planning (PCP) honors the person's preferences, choices, and abilities while involving family, friends and professionals as the person desires.

**Self determination** is the result of PCP and helps to assure the person has the authority to make meaningful choices and control over their own lives

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# Before we get to PCP……..Let's Talk About Recovery

## What does this mean?

- ***A process of change through which individuals improve their health and wellness, live a self-directed life, and strives to reach their full potential. There are four major dimensions that support a life in recovery:***
- **Health-**Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, **making informed, healthy choices** that support physical and emotional wellbeing.
- **Home-**A stable and safe place to live.
- **Purpose-**Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
- **Community-**Relationships and social networks that provide support, friendship, love, and hope

# Recovery:  According to William Anthony

- Recovery is described as a **deeply personal**, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles.
- It is a way of living a **satisfying, hopeful**, and contributing life even with limitations caused by illness.
- Recovery involves the development of **new meaning and purpose** in one's life as one grows beyond the effects of mental illness.


- Recovery is what people with disabilities do.
- Treatment, case management, and rehabilitation are what helpers do to facilitate recovery.

# Supporting recovery means focusing on the following:

- Hope
- Choice
- Recovery management
- Person centered plan
- Removal of barriers
- Identification of strengths
- Motivation and developing skills
- Locating and accessing resources

# Understanding recovery will…..


- Help you **see beyond the person's diagnosis** and symptoms
- Help you look beyond **medication compliance** as the primary goal for a successful transition
- Help you understand that person centered planning **starts with the needs and desires** of the person you are working with ….not just what may be on an assessment document.
- Help you understand that people **move at their own pace** and they are in control.

# Understanding recovery will…..


- Help you understand the best way to support someone making a change in their life is to **help them discover and develop** their own strengths
- Help them **connect or reconnect** with natural supports while relying less and less on formal supports
- Help them discover why **they may want to make a change in their life**
- Help **you understand** more about your own **personal ideas and feelings** about mental illness and the role of a transition coordinator

# What is Person Centered Planning

The process of **planning for and supporting** the person's transition. PCP builds upon the person's **strengths and capacity** to engage in community activities while honoring their **preferences, choices, and abilities.** This process involves family members, friends, and professionals the person wishes to participate.

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# Guiding Principles- The basic beliefs of Person Centered Planning are …….

- 1. The person's **desired future** will become the framework for all planning.
- 2. **PCP will begin with input from the individual**. Planning will also include information from the people most important to the individual, and as appropriate, information from professionals.
- 3. The PCP begins with what the **individual can do for himself/herself**. Then it adds resources and supports from family, neighbors, friends, and other community resources. Formal supports and services are utilized as last resort.

# Guiding Principles- The basic beliefs of Person Centered Planning are …….

- 4. Planning activities will address issues and concerns which the individual or others have about **health, welfare, and safety.**
- 5. PCP **will change** any time the person's needs, desires, and circumstances change.
- 6. A PCP approach will **seek feedback** from the individual on a regular basis

# Pieces and Parts of a PCP


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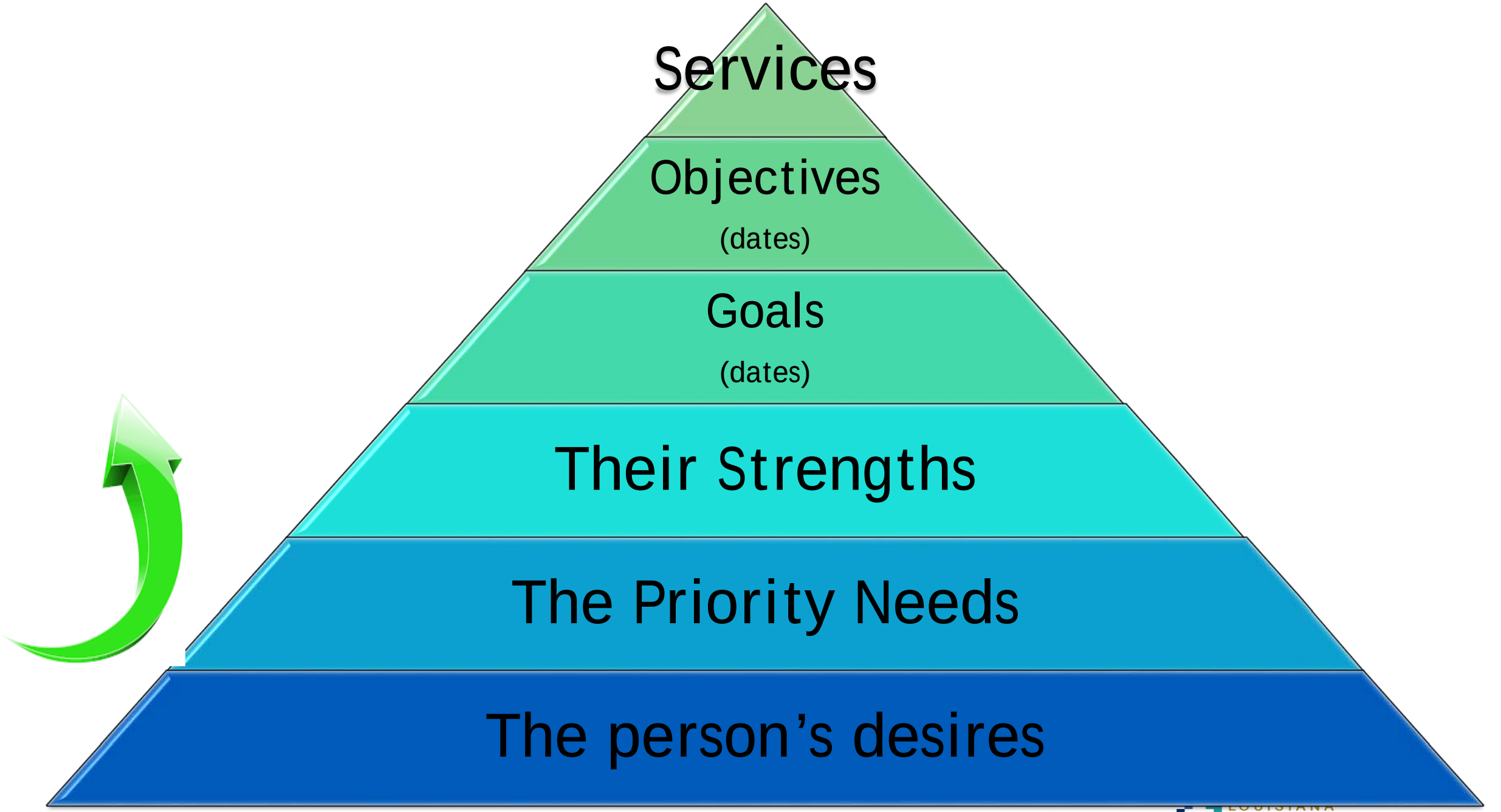
Services
Objectives
(dates)
Goals
(dates)
Their Strengths
The Priority Needs
The person's desires

# Person Centered Planning


Global Outcome- **In their own words, take note of their main desires**. It could be to move out of the nursing home or it could be to improve life while living in the nursing home. It's a snap shot in time of what the person wants at that specific time. It may be very realistic or it may take further discussion to pin point desires within their reach but write down what the person says.

Priority Needs-What are the **most important needs** that must be addressed first? This could be social needs, medical needs, needs related to transitioning out of the nursing home, etc.

Strengths-Begin to identify the person's strengths.

# Discovering Strengths and Needs


- This will come in handy throughout the planning process. Discovering strengths and skills **will take time so keep notes** as you get to know the person.
- People with a history of mental health treatment and who are only used to talking about their illness are **not so great about talking about their strengths and skills**. Ask about work history, hobbies, experiences in school, helping friends, volunteering, etc. to uncover those strengths.
- Regarding needs, ask **what their biggest needs are and be realistic about what can or can not be addressed.** Try to solve at least a small problem if you can. Be realistic and honest about what can be solved and what may take time. Ask the person for their ideas regarding how a problem may be solved and what they can do and what resources they may already have to begin to address their biggest or smallest needs.

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# Goals and Objectives

- Goals define what the person wants, needs, or desires to address a priority need.
- Objectives are the smaller steps needed to accomplish a goal.
- **Goals and Objectives should be S-M-A-R-T**


- **S-**Specific-Focused and not too general
- **M-**Measurable-Developed to measure success
- **A-**Action Oriented-Focus on what the person will do instead of not do
- **R-**Realistic-Developed based on what may reasonably be accomplished
- **T-**Time Limited-Set realistic timeline for both goals and objectives

Desire: To have my own apartment near the downtown bus line

Need: Manage my own money

Strength: I have paid my own bills

Goal: I'll have a checking account in the next 3 months. (August 30, 2018)

Objective: I will save at least $100 next month so I can open a checking account (July 30, 2018)

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# Services/Interventions


Services/Interventions=Supports

- Now that the person has identified their desires, needs, strengths, goals and objectives with target dates, it's time to figure out the next step----

- What supports will the person need to accomplish their goals? Support can be formal or informal.
- **Informal supports** include family, friends, and volunteers.
- **Formal supports** include agencies and individual practitioners.
- For goals and objective(s), identify what supports or services the person will need to accomplish their goals. This includes the interventions, provider(s), and often where the service(s) are expected to be provided.

PCP is a dynamic process. The initial plan will and should change as the needs of the person changes.

It's not just "paper work". Instead, it should be a roadmap to recovery owned and directed by the people you meet.

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