Person Centered Planning and Natural Supports

2023

Person-Centered Planning Values and Principles

- Person-Centered Planning is a highly individualized process designed to the needs and desires of the individual.
- It recognizes the person's strengths and his or her ability to express preferences and make choices.
- Choice and preferences are always honored and considered but may not always be granted.
- Recognize that everyone has gifts and contributions to offer the community.
- Person-Centered Planning should maximize independence, create community connections, and work toward the person's dreams, goals and desires.
- The person should choose how supports, services and treatment may help the person utilize his or her gifts and make contributions to community life.
- We will always recognize a person's cultural background and value this during the decision-making process.

Family-Centered Planning Values and Principles

- A family can include birth, step, extended, tribe, adoptive, foster families, or any constellation of members defined by the family itself.
- Family-Centered Planning supports and builds family resilience and strengths.
- Family-Centered Planning promotes safety, permanency and well-being for children.
- Family-Centered Planning is about respecting families and working in a collaborative relationship to support positive outcomes for children.
- The family plays the lead role in making change happen.
- Family-Centered planning is inclusive and while the family plays the lead role in making change happen, agencies, service providers, relatives, kith and kin and community members as determined by the family are part of the planning process.
- The family will always be the center of attention.
- Families will be engaged in every part of service delivery.
- Families will be linked to comprehensive, culturally relevant, and community-based supports for services, both formal and informal.

Person-Centered Planning/Family Centered-Planning Essentials

- To be effective, the care plan requires objective communication.
- Pre-planning meetings must occur and deep, meaningful discussions are held about what the person or family wants for their life is critical.
- Engagement is essential and success is based on a group of thoughtful, committed people working together to craft ideas that create a life of meaning, family permanency, and a life of community contribution.
- The case holder must demonstrate through language and actions, that he or she is invested in working with the person or family to achieve meaningful outcomes.

Collaborative Relationships

Engaging and building a collaborative relationship with a person or a family requires the case holder to have effective communication skills.

- **Be honest and genuine when interacting with the person and family:**
  - Help the person or family understand the role of the case manager/supports coordinator/therapist
  - Provide full disclosure about confidentiality and reporting requirements
  - Talk about safety issues
  - Talk about barriers to services and supports that could impact how others interact with the person and family
  - Be transparent
- **Listen and remain interested by:**
  - Asking the person or family to tell their story
  - Meet the person or family where they are
  - Pay attention to worries about their situation
  - Appreciate what the person/family is going through
  - Acknowledge what the person/family has already done
  - Learn about the person's/family's culture and community
  - Ask about the person's experiences
- **Recognize the person's and family's strengths:**
  - Point out what they have done well
  - Look for talents and skills
- **Discover the person or family's supports and resources:**
  - Learn who the person or family turns to for help and advice
  - Link to providers that meet the person's or family's comfort level
  - Include the person or family's faith-based and spiritual community resources if desired
  - Look at the person and family's informal and formal supports
  - Identify every possible protective factor
  - Take a holistic view of the person or family including culturally relevant information
- **Focus on talking about recovery and resilience:**
  - Listen to the person or family's problems to learn about their needs, hopes, dreams and goals
  - Explore what has worked in the past and ask what they have tried
  - Remember that this is just a moment in the family's or person's life. How can we help them get to where they want to be after we are no longer in their life?
- **Find common ground:**
  - Consider the person's, parent(s)' and children's point of view
  - Nurture collaboration while finding agreement
  - Focus on the person's/children's needs to help build an alliance
- **Don't take behaviors personally:**
  - Realize some people have reason not to trust
  - Acknowledge trust is earned and earn trust through communication and honesty
- **Use coping questions to reveal the person's, parent(s)' and youth's skills and abilities and show the efforts they have made to overcome problems:**
  - "You have been through so much, yet you keep going. How do you do that?"

- “I am sure there have been times when you feel like quitting. What stopped you?”
    - “You had a really tough week and still stayed in school. What helped you?”
- **Transparency:**
    - Acknowledge why you are working with the person
    - Talk about safety and well-being
    - At the pre-planning meeting, list who the person/family wants to invite to the planning meeting and who they do not want at the planning meeting. Also list anything that the person/family does not want discussed. This does not mean it won’t be addressed in the plan, it just means that it will not be openly discussed at the planning meeting
    - Allow the person or family to choose who will facilitate the planning meeting including the use of an independent facilitator
    - Provide the person and parents with a copy of the person-centered plan within 15 business days
    - Make the person or family true members of the treatment team

Strength-Based Planning

Person-Centered Plans are created from deep conversations between the case manager/supports coordinator and the person, parent(s), child/children, and other partners.

- **Was the person or family encouraged to discuss what they wanted to have happen?**
    - Use active listening and open-ended questions
    - Ensure that the person or family is a full member of the team
    - Ensure that the time and location of meetings accommodate the person or family and any others that the person may want to attend to support the person.
    - Ensure that the person or each family member has the opportunity to talk, uninterrupted
    - Have a meeting agenda to share with the person or family
    - Give the person or family the option of using an independent facilitator
- **Include any legal, community, school, or other social services concerns:**
    - Use reflective questions to elicit ideas to address concerns
    - Negotiate by listing the person’s concerns and concerns from others and choosing one concern from each list
    - Spell out non-negotiable elements of the plan in a way that everyone understands the goal and the steps that are going to be used to reach the goal in measurable terms
- **Use the family’s or person’s language/terms in the goal statements:**
    - Goals are to be jargon free and written in a way that the person or family knows what the goal will look like when it has been achieved (How will I know when I have met this goal?)
    - How was the voice of the family included in the plan?
- **Prioritize:**
    - Ask the person or family which goals should have priority
    - Ensure that if a non-negotiable item is a high priority, the expectation is clearly written
- **Make sure the goals are manageable:**
    - Ask the person or family what a good first step would be
    - Evaluate whether the goals build on the person or family’s strengths
    - Include the family’s or person’s natural supports as part of the plan to ensure the plan will work and the person or family have ownership of the plan

Supporting People and Families

- Have consistent contact with the person or family. Contact with other service providers *is not* a substitute for face-to-face contact with the person or family in the person's or family's home.
- The plan should document the frequency of the visits as requested by the person or family based on the person's acute or chronic condition or illness.
- **When visiting adults and children in their home, assess and document:**
    - Safety including injuries, illness, health concerns, incidents, risks of harm to self/others and physical environment
    - Service plan goals and progress
    - Review that the plan continues to meet the person or family's needs
    - Barriers to meeting goals
    - Well-being needs of the family or person
        - Confirming that everyone is receiving regular medical care, including any specialists
        - Confirming that the children are attending school
        - Reviewing need for any other services
        - Confirming that the person or family is meeting their basic needs including but not limited to adequate and safe housing, home is pest and vermin free; the home is in relatively good repair nutritious food, safe drinking water, working toilet, working sinks, bath or shower; adequate beds with sheets and blankets; Supporting Relationships and Connections to Culture and the Community.
- Does the person or the children have relationships with relatives, friends, neighbors, and other community members and how can those be fostered?
- Review the plan of service and ensure that it includes both formal and informal supports that offer the family, children, or person connections to culture and tribe/community members.
- Use the person's or family's preferred language whenever possible.
- Understand and respect the family or person's family structure and cultural traditions.

Support Plans

- Person-Centered Plans are the formal record of the agreed-upon action plan that guides the person or family toward their goals.
- Once the initial plan is developed, it must be reviewed and updated to reflect new information and any changes in circumstances.
- When something significant changes in the lives of a person or family *a new plan must be written not an addendum.* This could include hospitalization, movement from one level to care to a higher or lower level of care.
- Person-Centered Planning is an ongoing process, and the plan is a living document. The plan can be revised at any time and the consumer can choose to change goals or priority of goals.
- Start at the point where the person or the family will be successful then build on strengths and capabilities.

Questions? We welcome you to contact the Continuing Education Supervisor at aschabel@sccmha.org or call 989-797-3451 and your question will be directed to the Supervisor or Director who can answer your question best.