Person-Centered Planning

A trauma informed best practice

"I feel for the first time that I am in the driver's seat making decisions for my future"

Purpose. This document provides foundational information about Person-Centered Planning (PCP) and its relationship to trauma informed care. It is intended for those who are wanting an overview or are considering using Person-Centered Planning in their programs and organizations.

Where did it come from? Person-Centered Planning grew out of a commitment to inclusion as a social goal and was consciously designed as an inclusive process. In the 1990's, PCP was defined as "a family of approaches to organize and guide community change in partnership with people with developmental disabilities and their families and friends." (O'Brien and O'Brien[2]). PCP has a deep history in multiple countries and has grown and evolved over a period of more than 30 years into a best practice for various populations. PCP is consistent with trauma informed care principles and practices and is used in many social service systems including addictions and mental health. Its goal is to create a living action plan, organized around one person who is accessing services.

What is it? Person-Centered Planning is a process, directed by the person accessing services and supported by their chosen participants, to identify the person's strengths, capacities, and goals, and to look for opportunities and supports that will give the individual the best chance of experiencing what is most important to them. PCP positions each person as an authority in their own work and engages all aspects of the person's voice in each step of the planning process. It is not provider-driven; rather, it moves from a system-driven, medicalized service delivery system to one that is person-directed. Recognition of the prevalence and impact of trauma in all parts of the plan helps to strengthen the person's engagement in and use of services and supports. The PCP process responds to the person's lived experiences of trauma and trauma-based responses and seeks to actively decrease retraumatization.

Principles of Person-Centered Planning	Principles of Trauma Informed Care
Creating a process where	Creating a process where
• The individual is involved in all aspects of the plan to ensure **safety.**	• The person is **physically and emotionally safe.**
• **Transparency** is encouraged with a goal of relationship building focused on **trust.**	• The decisions are **transparent** and have the goal of building and maintaining **trust.**
• **Collaboration** is possible through the team members, **peers,** and the community involved.	• **Peer** support and **collaboration** is in place.
• The person feels they are treated with dignity and **respect** through giving **choices** and creating a plan around **strengths.**	• **Strengths, Choice and Empowerment** are recognized and built-in with new skills being developed.
• The language in the plan is neither prejudicial nor objectifying and addresses **cultural, social and environmental needs of the individual.**	• Recognizes and addresses historical trauma, and **cultural and gender stereotypes and biases.**

Goals.

- **Visioning.** The person and the invited participants are asked to describe their vision for the future in a plan, including how they anticipate life transitions and seek to create a meaningful life in the community. The individual using services defines what is meaningful in their life.
- **Collaboration**. Trusted family members and friends are partners in the planning. The person directs who is invited to the meetings. PCP encourages "growth of community" and facilitates relationship building and collaboration with people in the person's network.
- **Choice**. Choices are available that reflect what is important to the person, their capacities, goals, and dreams. Choice means at least three options. `Meaningful choices keep the person present, in power, and in lead as much as possible.
- **Actions.** Plans are actionable and hold participants accountable to the desired outcomes.
- **Responsiveness.** The plan results in ongoing listening, learning, reassessing, and revising for further action. Continuous review, evaluation, monitoring, and modification of the person's plan to support personal goal attainment are essential.

Benefits.

- **Social Opportunity**. Increases community, social networks, and resources, while gaining new experiences.
- **Skill building.** Life-long learning to develop a life of their choosing.
- **Quality of Life**. Improves their quality of life with personal goals being met. Addresses what is important *to* the person in addition to what is important *for* the person to realize their dreams, goals and safety.
- **Connection**. Strengthens connection to supports, community, and self.
- **Wellbeing.** Through feelings of self-efficacy, accomplishment, making informed decisions, exploration, and accessing strengths and goals, wellbeing and personal outcomes improve.

The person: is involved in setting meetings up; chooses who is at meetings; leads prep and implementation; is key decision maker; agrees with both planning process and final plan.

The Participants: includes natural supports, friends, trusted family and professionals, and peer supports who are committed to the person and the person's goals. A facilitator who is trained in PCP and TIC is not required but helpful.

The Plan: uses person's strengths, abilities, and aspirations; identifies concrete action steps, measurable objectives, and personal goals; identifies supports, activities, and services within the provider agency and in the community that can help create desired changes.

The Process: includes individually tailored services and a written record of agreements between the person and the invited team; identifies a few small but meaningful short-term objectives that build to longer term goals and dreams that the individual and team focus on to reduce barriers or challenges; and agreements on the kinds of services, activities, and supports the individual needs to achieve these changes are reached. It is a fluid plan with scheduled follow-up meetings.

Resources.

Essential Lifestyle Plans: The Learning Community for Person-Centered Practices, http://www.learningcommunity.us/person.html
PATH: A workbook for Planning a Positive Possible Future, http://www.inclusion.com/bkpathworkbook.html
AMP: Achieve My Plan, http://www.pathwaysrtc.pdx.edu/proj-3-amp
MAPS: Making Action Plans: A Person-Centered Arizona, http://pcp.sonoranucedd.fcm.arizona.edu/resources/person-centered-planning-tools/map
A Guide on Person-Directed Planning, http://www.mcss.gov.on.ca/documents/en/mcss/publications/developmental/GuideonPersondirectedPlanningFinal.pdf.

The content in this TIP has been adapted from the following sources:

1. Adams, N., Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. Maryland Heights, Mo: Elsevier.
2. O'Brien, C.L., O'Brien, J. (2000). *The Origins of Person-Centered Planning: A community of Practice Perspective.* Syracuse, NY: Responsive Systems Associates, Inc.
3. Substance Abuse and Mental Health Services Administration (SAMHSA). *Person-Centered Care*. Retrieved from *http://www.samhsa.gov/section-223/care-coordination/person-family-centered*
4. SAMHSA's Concept of Trauma and Guidance for a Trauma Informed Approach, Prepared by SAMHSA's Trauma and Justice Strategic Initiative, Substance Abuse and Mental Health Services Administration (2014).

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