

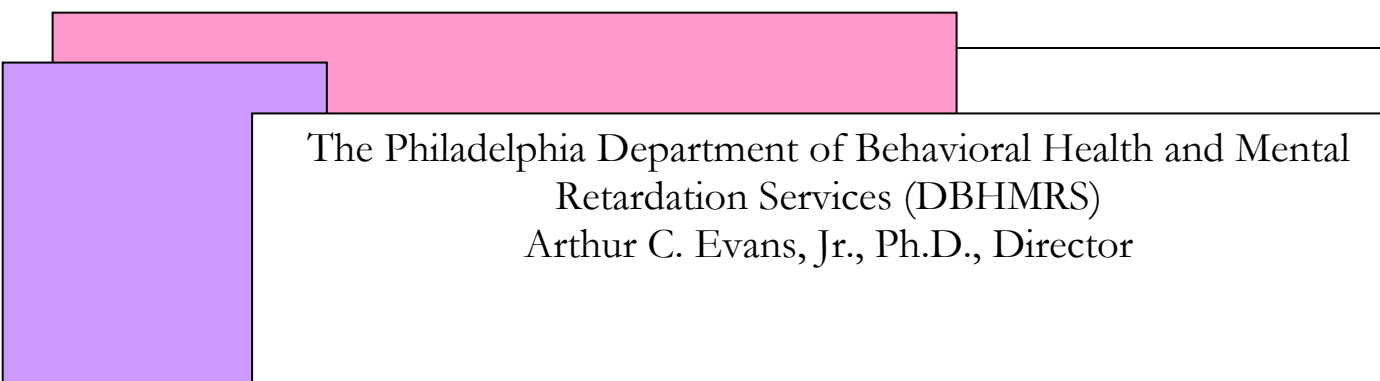
The Philadelphia Department of Behavioral Health
and Mental Retardation Services (DBHMRS)

Tools for Transformation Series: Person First Assessment and Person Directed Planning



Recovery is the process of pursuing a contributing and fulfilling life regardless of the difficulties one has faced. It involves not only the restoration, but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one's community. It is facilitated by relationships and environments that promote hope, empowerment, choices and opportunities that promote people in reaching their full potential as individuals and community members.

Philadelphia Department of Behavioral Health/Mental Retardation Services (DBHMRS, 2006)



The Philadelphia Department of Behavioral Health and Mental
Retardation Services (DBHMRS)
Arthur C. Evans, Jr., Ph.D., Director

**Tools for Transformation Series: Person First
Assessment and Person Directed Planning-*Authorship*
*page***

This packet was authored by: Sade Ali, MA; Joan Kenerson King R.N., M.S.N., CS; Seble Menkir M.A.

Important guidance, input and review time was provided by: Marageret Minehart M.D., Mary Harper, B.A., Jeff Shair and Ellen Faynberg, Psy.D.

Table of Contents

Section	Page Number
Introduction	4-5
Chapter 1: Person-First Assessment	6-19
Chapter 2: Person-Directed Planning	20-33
Person-First Assessment Definition Person Directed Planning Definition	34
Provider Checklist	35-37
Person in Recovery Working with Provider Checklist	38-40
Person in Recovery Assessing One's Own Daily Activities	41
DBH/MRS Checklist	42-43
Resource List	44-46

Introduction

Creating a recovery-oriented system of care is a top priority of the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS). A recovery-oriented system is committed to supporting people in moving beyond their problems and challenges to develop a full and meaningful life in the community. This process involves discovering the hopes and dreams of people who have experienced behavioral health issues, and using the assets of these individuals, their families and the community to achieve these hopes and dreams. It is grounded in the evidence that people impacted by such behavioral health issues can successfully achieve long-term recovery. In a recovery-oriented system of care, the thoughts and ideas of individuals and family members in recovery are taken seriously; service providers assertively include people in recovery and their families (as defined by the person) in making decisions. Each individual is treated as a whole person (body, mind and spirit) and in the context of his/her culture.

This document is one of a series of resource packets produced by the DBH/MRS to provide tools and a greater understanding of key recovery concepts for persons in recovery, family members, service providers and DBH/MRS staff as part of the Philadelphia DBH/MRS Recovery Transformation.

Each packet in the Tools for Transformation series focuses on a system transformation priority area that has been identified as important by numerous stakeholders in the system. During the next 12 months, these priority areas will be the focus of our recovery transformation. Other resource packet topics include:

- family inclusion and leadership,
- holistic care,
- partnership,
- quality of care.

Each packet has:

- Information for persons in recovery, providers, and DBHMRS staff about the priority area;
- A self assessment checklist for providers that lets them evaluate their own practice in the topic area;
- A similar checklist for people in recovery to think about ways their provider is supporting them in this area and to develop ideas about other ways that support could be given;
- A checklist for people in recovery to explore how they are doing in the area and to get some new ideas for ways they could take more steps in their own recovery;
- A checklist for DBH/MRS staff that lets them evaluate their practices in a priority area; and

- A resource list with information that can be obtained through websites, books and articles.

This latest entry in the Tools for Transformation series departs from the standard format in length and depth. The topics of person first assessment and person directed planning are presented here in one comprehensive packet for several reasons. The concepts of assessment and planning have been artificially separated by behavioral health systems. Assessment has often been seen as something that was conducted at the beginning of treatment, led to a diagnosis and clinical formulation and then was finished. In the traditional system, treatment planning was based on this assessment process, directed by medical diagnosis, completed by the professional staff with “input” from the person in recovery (PIR) and then signed by the person.

In a transformed behavioral health system, the process of building relationships is seen as central to the recovery process. Relationships between professional staff and PIRs, between PIRs and key supporters and between everyone and the community take time to build and so the assessment process (chapter one) is seen as beginning with the first contact, proceeding and deepening throughout the relationship and continuously informing the planning process.

The planning process (chapter two) is seen as an alive and on-going process, based in the person’s hopes and dreams, informed by the clinical expertise of the provider in relationship to the PIR and changing on a regular basis (rather than at predetermined review times) as the person progresses through the steps to achieve their recovery goals. Because assessment and planning are an interlocking process they are presented here together.



HOW DO PERSON-FIRST ASSESSMENT AND PERSON DIRECTED PLANNING RELATE TO RECOVERY?

As we move forward in the transformation of the behavioral health system to one that is focused on the goal of recovery for every person all aspects of the way we deliver care are impacted. The process of assessment and planning is profoundly changed in a transformed system. In a recovery oriented system of care this process of assessment moves from one mostly focused on identifying deficits and pathology to one focused on identifying the person's strengths and abilities and the challenges that interfere with their lives, hopes and dreams. In a person-first assessment process the identification of challenges extends beyond symptoms to barriers that interfere with the person achieving the life in the community that they desire. It does not ignore the role of illness in creating challenges but puts it in the larger context of the person's experience of those challenges.

The Person-directed Planning (PDP) process allows systems to move away from an illness-based model of diagnosis and treatment towards a strengths-based approach of growth and achievement where every person involved has an important role to play. Inherent in this process is also recognition that building on individual resilience factors, supporting self determination and moving into the community to develop recovery capital are part of this movement. In order for Person- Directed Planning and assessment to be fully implemented, all aspects of the system (program, organizations and government) must be fully committed to the transformation.

Person-directed Planning must be embedded in a system that is committed to changing not only what staff and PIRs *do* (e.g., in the practice of PDP) but also how they *think and feel* about recovery, resilience and self determination. Person-directed Planning represents a window of opportunity to move from concept to practice, to apply the concepts and values of a transformed system in real life practice. It provides for a different conversation between professionals and people in recovery that opens up new ways of relating, growing, learning and changing for all participants in the process.

CHAPTER ONE: PERSON-FIRST ASSESSMENT

Preparing for the Journey- A Person-First Assessment

If we perceive behavioral health recovery as a journey of transformation, then it is safe to assume that the goal of this transformation is to enable individuals and families impacted by behavioral health challenges to live meaningful lives in their chosen communities while striving to achieve their full potential. If recovery is analogous to going on a journey, several things are necessary to ensure that the journey is successful. When beginning a trip, we create an itinerary that identifies the destination, how we will travel, and the times we will travel. We will also need to plan what we want to see as we travel. In addition, we might consider if others might want to travel with us. What shall we pack? Do we have the necessary items like identification, medications, toiletries and other items we use in our everyday life?

Planning for the trip (person-first assessment) is almost as important as going on the trip. The same is true about preparing for developing the person directed plan. The recovery traveler has much to consider. Are there family and friends that might want to participate in order to offer their support to us on the journey? Have we decided what areas of our life we want to work on first? What will we need to have in place as we travel? As we travel, what signs will we see that will tell us that we're on the right road? What strengths are we bringing to this journey, what has been our experience with the road in the past? When preparing to develop a PDP/recovery plan there needs to be sufficient attention given to who might be included in the planning process in order to increase the probability of long-term success and satisfaction. Attention also needs to be paid to the journey itself. What is the quality of life of the person day to day? Are immediate changes in basic needs needed?

Everyone involved in the person-first assessment process needs to apply old skills (i.e. listening, reflecting, questioning, planning) in new ways or to develop new sets of skills. There is a learning process here for everyone. The PIR need to be assured that their perspective and ideas are important, and in fact at the center of the assessment process. Families/key supporters need to be invited to communicate what is important and why it is important.

Supporters need to be responsive to the expressed needs of the individual and approach assessment and eventually planning from a broad based perspective that is strength-based in its affirmation of the individual's skills and capabilities. People in recovery, their families, advocates and supporters need to insist on an assessment that considers the

pursuit of their hopes and dreams as well as their concerns. Supporters must communicate respect for and value of those hopes and dreams, and be able to discern what the individual is communicating. Supporters must have interviewing skills to discern where an individual might be at any given juncture in order to suggest activities to facilitate the individual's continued progress. Person-first assessment and person-directed planning must begin where the individual/family is, as "no matter how person-directed a practice is in theory, it ceases to be person-directed if it does not respect the individual's preferences as well as his/her existing capacities and resources" (Tondora, et.al., 2005).

In some service organizations, this way of collaborating will be a natural extension of their current assessment planning processes. For many, it may represent a significant departure from their typical approach and practices. No matter what one's experience with person-first assessment and person-directed planning, nearly all programs and service settings and individuals can benefit from certain preparatory activities that can be conducted prior to the planning meeting itself. Doing so will increase the likelihood that the plan will be a positive and productive component of the person's efforts toward recovery and his/her team's efforts to support him/her in that process.

People in recovery who have had long histories of experience in the behavioral health system have learned how to be passive participants in their assessment and planning processes. The shift to an active assessment and planning process that is directed toward their hopes of achieving a life in the community like everyone else (rather than only on symptom stabilization or behavior management) may come as a surprise to them. Rather than being told what is best they will now be included in the conversation and their ideas, thoughts and opinions will be more actively sought. This is a major transition for many people. In Philadelphia to date we have learned that it is important that people in recovery and their supporters receive education about the shift to person-first assessment and person-directed planning so that they know what to expect and what are now their roles and responsibilities. Staff will need similar training and support. Two key areas where staff will need training and supervision in the expansion of existing skills and or development of new skills are conducting a comprehensive, strengths-based assessment and understanding cultural concerns and preferences.

A Person-First Assessment is a Strengths-based Assessment

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to advance in his or her recovery. Therefore, an essential component of person-first or family-first assessment is the focus on

strengths and capabilities. People in recovery and their families have demonstrated incredible resilience and coping to overcome the obstacles in their path thus far to be where they are at this moment. Often our assessments have not explored these unseen strengths. Strength-based assessment (which leads to strengths-based planning) is based on the “Strengths Model” developed by Charles Rapp (1993) of the University of Kansas.

Using the Key Ideas in the Strength-Based Model means:

- Recognizing that people who are successful in living, use their strengths to attain their aspirations and goals
- Exploring and respecting the individual/family’s abilities, beliefs, values, support systems, goals, achievements, and resources
- Identifying, using, building upon and reinforcing inherent strengths of the individual/family. All key supporters who are willing can be brought into this process.
- Limiting the impact of societal problems, family dysfunction and individual disease by using the individual/family’s strengths to build new coping skills, new interests, community involvement, etc. (recovery capital, protective resilience factors)
- Puts the service user at the center and focuses interventions not just for the individual but also about how to improve availability, access and adaptation of resources in the community.

Within the strengths-based model, those providing support help the individual or family identify the strengths they already have (assessment) and learn how to set goals and plan activities (planning) based on those strengths. While doing a strengths-based assessment is something professionals have talked about doing for many years, the actual implementation of this approach presents challenges for even the most seasoned clinician. Moving from identifying problems (which most professionals were trained to do) to identifying the sometimes hidden strengths in a person is a difficult but rewarding transition. For PIRs and families this is also difficult. All of us are more likely to focus on what is *wrong*, rather than what is *right*, to focus on when and how we failed rather than when and how we succeeded. It is not uncommon for individuals to have difficulty identifying their “strengths” as this has not historically been the focus of behavioral health services and assessments. It’s just not what gets services Individuals may have also lost sight of their gifts and talents through years of struggles with their illness and recovery. As a result, simply asking the question, “What are your strengths?” is often not enough to solicit information regarding resources and capabilities that can be built upon in the

planning process. Guiding principles and sample questions to be used in strengths-based assessment are provided below.

Guiding principles of strengths-based assessment (Adapted from Tondora and Davidson, 2006)

- Consider the following: A discussion of strengths is a central focus of every assessment, care plan, and case summary. Strength based assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.
- The strengths-based assessment is conducted as a collaborative/partnership process and all assessments in written form are shared with the individual.
- Initial assessments recognize the impact of simple, yet powerful, questions such as “What happened? And what do you think would be helpful? And what are your goals in life?” Self-assessment tools rating level of satisfaction in various life domains can be useful ways to identify diverse goal areas around which supports can then be designed.
- Practitioners attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may automatically be perceived as “non-compliant,” “lacking insight,” or “requiring monitoring to take meds as prescribed.” This same individual, however, could also be seen as “making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications” or could be acknowledged for “working collaboratively to develop a contingency plan for when medications are to be used on an ‘as-needed’ basis.”
- While strengths of the individual are a focus of the assessment procedure, thoughtful consideration also is given to potential strengths and resources within the individual’s family, natural support network, service system, and community at large. This is consistent with the view that recovery is not a solitary process but rather a journey toward interdependence within one’s community of choice.
- The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected. Saleebey (2001), for example, recommended conceptualizing strengths broadly to include the following dimensions:

- o skills (e.g., gardening, caring for children, speaking Spanish, doing budgets);
 - o talents (e.g., playing the bagpipes, cooking);
 - o personal virtues and traits (e.g., insight, patience, sense of humor, self-discipline);
 - o interpersonal skills (e.g., comforting others, giving advice, mediating conflicts);
 - o interpersonal and environmental resources (e.g., extended family, good neighbors);
 - o cultural knowledge and lore (e.g., healing ceremonies and rituals, stories of cultural perseverance);
 - o family stories and narratives (e.g., migration and settlement, falls from grace and then redemption,);
 - o knowledge gained from struggling with adversity (e.g., how one came to survive past events, how one maintains hope and faith);
 - o knowledge gained from occupational or parental roles (e.g., caring for others, planning events);
 - o spirituality and faith (e.g., a system of meaning to rely on, a declaration of purpose beyond self); and hopes and dreams (e.g., personal goals and vision, positive expectations about a better future) .
- In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered “strengths,” e.g., the individual’s most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.
 - Assessment explores the whole of people’s lives while ensuring emphasis is given to the individual’s expressed and pressing priorities. For example, people experiencing problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, or relationships. For this reason, it is beneficial to explore in detail each individuals’ needs and resources in these areas.
 - Strengths-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been prescribed for them by others.

- Guidance for completing a strengths-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches to treatment. For example, DeJong and Miller (1995) recommend the following types of inquiry:
 - exploring for exceptions (occasions when the problem could have occurred but did not),
 - imagining a future when the problem has been solved and exploring, in detail, how life would then be different;
 - assessing coping strategies, i.e., asking how an individual is able to cope despite the presence of such problems;
 - and using scaling questions (where the individual rates his or her current experience of the problem) to elucidate what might be subtle signs of progress .
- Self-management strategies for coping with symptoms and daily wellness approaches such as WRAP (Wellness Recovery Action Plan) are respected as highly effective, person-directed recovery tools and are fully explored in the strengths-based assessment process.
- Cause-and-effect explanations are offered with caution in strengths-based assessment as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice (Cowger, 1994). For example, to conclude that an individual did not pay his or her rent as a direct consequence of his or her "non-compliance" with medications could lead to an intervention to control the individual's finances or medication. Strengths-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).
- Strengths-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual's family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strengths-based assessment is an on-going process that occurs over time. At the

time of initial contact the assessment can be started to meet regulatory requirements but can be continuously expanded on as the relationship grows and possibilities and opportunities expand.

- Efforts are made to record the individual's responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-directed. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of "dysfunction, disorder."
- Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric diagnoses, addictions, and their loved ones. Language is used that is empowering and avoids the eliciting pity or sympathy, as this can cast people with disabilities in a passive, "victim" role and reinforce negative stereotypes. For example, just as we have learned to refer to "people who use wheelchairs" as opposed to "the wheelchair bound" we should refer to "individuals who use medication as a recovery tool" as opposed to people who are "dependent on medication for clinical stability." In particular, words such as "hope" and "recovery" are used frequently in documentation and delivery of services.
- Practitioners avoid using diagnostic labels as "catch-all" means of describing an individual (e.g., "she's a borderline"), as such labels yield minimal information regarding the person's actual experience or manifestation of their illness or addiction. Alternatively, a person's needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles may be required for other purposes (e.g., decisions regarding medication, justification of level of care), asset-based assessment places limited value on diagnosis per se. In addition, acknowledging limitations and areas of need are not viewed as accepting one's fate as a mentally ill person or an addict. Rather, identifying and accepting one's current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of disability.
- Language used is neither stigmatizing nor objectifying. At all times "person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict." Employing person-first language does not mean that a person's disability is hidden or seen as

irrelevant; however, it also is not to be the sole focus of any description about that person. To make it the sole focus is depersonalizing, and is no longer considered an acceptable practice.

- Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one's powerlessness over a substance and acknowledging how one's life has become unmanageable. It is also common for such individuals to introduce themselves as: "My name is X and I am an alcoholic." This preference is respected as a part of the person's unique recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as "a person with alcoholism" in the name of person-first language or principles. Use of person-first language is in the service of the person's recovery; it is not a super-ordinate principle to which the person must conform. While the majority of people with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers.

The table below gives additional examples of the contrasts between deficit and strength based language:

The Contrast Between Deficit-Based and Strength-Based Language	
Deficit-based Language	Strengths-based, Recovery-oriented Alternative
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following...
An addict/junkie	A person diagnosed with an addiction who experiences the following...
Clinical Case Manager	Recovery Coach/Recovery Guide (<i>"I'm not a case, and you're not my manager"</i> !)
Front-line staff/in the trenches	Direct care/support staff providing compassionate care
Substance abuse/abuser	Person with an addiction to substances; substance use interferes with person's life
Suffering from	Working to recover from; experiencing; living with

Treatment Team	Recovery Team, Recovery Support System
High-functioning vs. Low Functioning	Person's symptoms interfere with their relationship (work habits, etc.) in the following way...
Acting-out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups/mutual aid groups
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis; does not agree that they have a mental illness, pre-contemplative stage of recovery
Resistant	Not open to... Chooses not to...Has own ideas...
Weaknesses	Barriers to change; needs
Unmotivated	Person is not interested in what the system has to offer; interests and motivating incentives unclear
Clinical decompensation, relapse, failure	Person is re-experiencing symptoms of illness/addiction; an opportunity to develop and/or apply coping skills and to draw meaning from managing an adverse event: Re-occurrence
Maintaining clinical stability/abstinence	Promoting and sustaining recovery
Untreated alcoholics	People not yet in recovery; pre-contemplative/contemplative stage of recovery
Puts self/recovery at risk	Takes chances to grow and experience new things
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; beginning to think for oneself
Minimize risk	Maximize growth
Consumer /Patient	Person in recovery, person working on recovery, person receiving services, person
Treatment works	Person uses treatment to support his/her recovery
Discharged to aftercare	Connected to long-term recovery management
Enable	Empower the individual through empathy, emotional authenticity, and encouragement
Frequent Flyer	Takes advantage of services and supports as necessary
Dangerous	Specify behavior
Manipulative	Resourceful; really trying to get help

Entitled	Aware of one's rights
DTO/DTS/GD (danger to others/danger to self,/general danger)	Describe behaviors that render one danger to self/others, etc.
Baseline	What a person looks like when they are doing well
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
User of the system	Resourceful; good self-advocate
Content of table derived from the following sources: Tondora and Davidson, 2006; White, 2001; and Meta Services, 2005.	

Areas to Explore in Strengths-based, Person-first Assessment

- **Personal Strengths:** *e.g., What are you most proud of in your life? What is one thing you would not change about yourself?*
- **Interests and Activities:** *e.g., If you could plan the "perfect day," what would it look like?*
- **Living Environment:** *e.g., What are the most important things to you when deciding where to live?*
- **Employment:** *e.g., What would be your ideal job?*
- **Learning:** *e.g., What kinds of things have you liked learning about in the past?*
- **Trauma:** *e.g., Have there been people in your life who have hurt you in some way in the past (physically, emotionally, sexually)? In relationships with other previous or current therapist(s) and/or doctor(s), have you ever been treated inappropriately or in ways that were harmful to you (e.g., poor boundaries, sexual inappropriateness, physical abuse, etc.)?*
- **Safety and Legal Issues:** *e.g., Do you have any legal issues that are causing you problems?*
- **Financial:** *e.g., Would you like to be more independent with managing your finances? If so, how do you think you could do that?*
- **Lifestyle and Health:** *e.g., Do you have any concerns about your overall health? What are those concerns? Tell me a bit about your behavioral health: What does a good day look like? A bad day?*
- **Choice-Making:** *e.g., What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?*
- **Transportation:** *e.g., How do you currently get around from place to place? What would help?*
- **Faith and Spirituality:** *e.g., What type of spiritual or faith activities do you participate in?*
- **Relationships and Important People:** *e.g., Who is the person in your life that believes in you? In what ways does this person convey this belief in you?*
- **Hopes and Dreams:** *e.g., Tell me a bit about your hopes or dreams for the future. (Tondora, 2005)*

Cultural Concerns and Preferences

As in all of healthcare today, the ability to respond to the changing demographics and diversity of American society is essential if systems are to serve people equitably. It is critically important that

direct service providers embrace and fully understand the principles of cultural competence and its integration into all aspects of the workflow and clinical processes within the service delivery system.

Key Definitions

Culture: *Includes but is not limited to, the shared values, norms, traditions, customs, art, history, folklore, religious and healing practices and institutions of a racial, ethnic, religious or social group that are generally transmitted to succeeding generations* <http://www.britannica.com>

Cultural Competence: *A set of congruent practice, skills, attitudes, policies, and structures which come together in a system, agency, or among professionals and enable that system, or those professionals to work effectively in cross cultural situations (Cross, Brazron, Dennis, & Issacs, 1989)*

Basic tenets of culturally-competent assessment and planning:

- *Working with individuals is inevitably a cross-cultural enterprise.*
- *Becoming culturally competent is a process, not an endpoint.*
- *A central part of working effectively across cultures is becoming aware of our own personal cultural filters.*
- *“How to” and “cookbook” approaches to cultural competency training promote stereotyping.*
- *Stereotyping is a natural part of the human perception process, but one that needs to be examined and challenged.*

The Need for Culturally Appropriate Assessment and Formulation

Although often overlooked, the DSM-IV provides a simple but useful outline of what should be included in considering cultural factors and how they influence both assessment and PDP. (APA, 2000).

- **Cultural Identity:** cultural reference groups; language (s); cultural factors in development; involvement with culture of origin; involvement with host culture
- **Cultural explanations of illness:** idioms of distress; meaning and severity of symptoms in relation to cultural norms; perceived causes; help-seeking experience and plans
- **Cultural factors related to psychosocial environment and levels of functioning:** social stressors; social supports; level of functioning and disability
- **Cultural elements of the clinician-patient relationship:** clinician’s ethno-cultural background; language; knowledge of patient’s culture

Below are some sample questions that might be included in a culturally appropriate “Bio-cultural Psychosocial Assessment” (Ali, 2005) to enhance cultural competence within practice consistent with the DSM-IV Cultural Formulation.

- **What do you call your problem? What caused it?** The answer has everything to do with the cultural filters of the person in recovery and can provide you with rich information and possible avenues for discussion of recovery support networks.
- **Who do you include as family? Who do you trust?** This is where the guy at Dunkin Donuts may come in and these are the folks who may form the person’s recovery support network.
- **Have you ever been a member of a faith community?** This is important because many people believe that God has turned his/her back on them when they become ill or develop chemical dependency problems and they cease involvement with church, synagogue, mosque or other religious communities.
- **Are you a member of a faith community now? If so, would you like the Rabbi, Priest, Pastor, Imam, etc. involved in your support network?** It’s a rare clergy member who will not participate as best he/she can when called.
- **Are you now going, or have you ever gone, to an Indigenous Healer for help with your problem? Would you like that person involved as part of your recovery support network?** This question is especially relevant for Native people, Latinos and folks of African origin. The Healers include Priests in African Traditional Religions, Curanderos and Curanderas, Espiritistas, Medicine Men or Women, Pipe Carriers, Lodge Keepers.
- **With whom do you have intimate relations and relationships?** Clinicians (and persons from LGBTQ communities) report that this way of asking about sexual orientation is a bit more sensitive than asking a person’s sexual orientation outright.
- **Do you identify with the gender (male or female) with which you were born?** This question would be relevant only to those who are transgender (male to female or female to male) and would have no relevance to others. Transgender individuals may be at any stage in their transitions for this question to be important.
- **Have you ever experienced racism, police brutality, discrimination and/or other forms of oppression?** Expect to get a wealth of clinical information from this one. Be mindful that you might not get that type of information at the outset but as the trust deepens, the information will flow.
- **How do you identify culturally/racially/ethnically?** We tend to make assumptions about people based on their outward appearances and often, those assumptions are incorrect. Always ask. Most folks know to ask what language the person feels most comfortable speaking, even if we cannot provide the linguistic services.
- **What do you know about your culture? What holidays do you observe? Are they related to your culture?** We find that if an individual knows even a little about his or her ethnicity, the

opportunity for him or her to become a giver of information regarding it is often a pleasant experience for both the clinician and the person.

- ***Has your family always lived in this area?*** This question gets at histories of emigration and immigration, as well as issues such as sharecropping in families of African origin, migrant workers, etc.
- ***What were the messages about your culture that you received while growing up? What were the messages you received about the cultures of others?*** Again, this can be rich clinical information. Issues such as self-hate, white privilege, reverse and internalized racism, etc. surface with this question.

As was previously mentioned, no assessment process is ever complete. It begins with the first contact with a person and doesn't end until the relationship ends. The relationship between participants and staff is central to the process. Person first assessment, inherently strengths-based and culturally competent, will be done in the context of this relationship and is truly preparing for the process of person-directed planning.

CHAPTER TWO: PERSON DIRECTED PLANNING (PDP)

Person-Directed Planning: What It Means and Why It is Important?

In a transformed health system, a diagnosis of a serious mental illness... will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care. ...The plan of care will be at the core of the recovery-oriented mental health system. The plan will include treatment, supports, and other assistance to enable consumers to better integrate into their communities and to allow consumers to realize improved mental health and quality of life. (New Freedom Commission Report on Mental Health, 2003)

For people in recovery, person-directed care means they have choices in the services they receive. It means they can select their own recovery support team and invite family members and other natural supporters to be involved. It means realizing – or being helped to realize – that they have the power to change their lives and can partner with their recovery team in doing so.

For providers and clinicians, it means assisting people in recovery (not directing them) to achieve goals that are personally meaningful to them even when such goals extend beyond those areas traditionally addressed by clinical behavioral health services.

Where did the idea of PDP come from?

People in recovery have long been speaking out against assumptions that “to be mentally ill means to have lost the capacity for sound reasoning” or the capacity to take responsibility for their treatment and other major life decisions (Deegan, 1992).

Person-directed planning is, in part, a response to such assumptions. PDP as presented in this guide is informed by many sources, particularly the experiences of individuals who have overcome the limitations of traditional models of care to call for radical change toward more person-directed planning models. In addition, the vision of PDP in the behavioral health field is informed by similar efforts in other disability fields. For example, some of the earliest and most prominent “person-centered planning” models were developed in the 1980’s by professionals and advocates in the developmental disabilities field. While each of these approaches is unique they share the following principles which guide all person-centered planning approaches:

- The primary direction in the planning process comes from the individual or his/her designated other. The involvement of significant others and a reliance on personal

relationships as the primary source of support is recognized as positive and is a key component of this planning approach.

- A focus on capacities and assets rather than on limitations and deficits.
- An emphasis on promoting access to inclusive community settings.
- An acceptance of uncertainty, setbacks and disagreements as natural elements in the path to self-determination (*Tondora et.al., 2005*).

Is this Really Any Different? Traditional Approaches to Planning

Traditional models of planning differ across setting and service provider but can generally have these characteristics:

- are disease-focused
- result in a system of care that centers on an illness or symptom paradigm
- emphasize caring for or managing illness rather than specifically promoting recovery
- focus on the assessment and treatment of the deficits, aberrations, and symptoms—the things that are “wrong” with people
- can lead supporters to overlook all that remains “right” with people which includes, amongst other things, their health, assets, strengths, and competencies (Davidson & Strauss, 1995)

Some of the limitations of traditional models of care may include the following:

- Power is allocated largely (or only) to the care-giver to determine diagnosis and to develop treatment strategy
- People receiving services are not commonly encouraged to take an active or self-directed role and therefore are not involved in learning during the planning process

- Service agencies focus on systemically defined outcomes (e.g., hospitalization rates) and are held less accountable for other outcomes that hold real value for those they serve (e.g., employment, relationships, community activities)
- Success is most often determined by the provider and is gauged on narrowly defined goals such as treatment compliance or symptom reduction
- Services are typically fragmented and disconnected from other important parts of a person's life. For example, behavioral health services are typically provided separate and apart from general healthcare. Another example of service fragmentation is the lack of connection between the behavioral health system and a spiritual or faith community.

Treatment planning delivered within more traditional medical models is heavily influenced by these limitations:

- Traditional treatment planning is usually accomplished by providers and clinicians in the presence (hopefully) of the person receiving the services but with minimal input from the individual.
- The participation of the person receiving services is generally limited and often simply involves the signing of the plan to acknowledge that they "participated" in the process
- Participants are generally limited to professional service providers with less attention paid to the involvement of natural supporters such as family and friends.
- Treatment goals are often based on the person demonstrating an expected level of engagement in treatment, e.g., medication compliance or regular attendance at group. Failure to meet such goals is often attributed to the person's lack of "motivation" rather than the system's failure to deliver person-centered services.

- The table below provides additional contrasts between traditional and person-directed planning approaches:

How Recovery-oriented (Person-Directed) Planning Differs from Traditional Approaches (Tondora and Davidson, 2005)	
Traditional Approaches	Person Directed
Self-determination comes <i>after</i> individuals have successfully used treatment and achieved clinical stability	Self-determination and community inclusion are fundamental human rights of all people
Compliance is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have full access to the same information – often referred to as “transparency.”
Disabilities and deficits drive treatment; Focus is on illness	Abilities/choices define supports; Wellness/health focus
Low expectations	High expectations
Clinical stability or managing illness	Quality of life and promotion of recovery
Linear progress and movement through an established continuum of services	Person chooses from a flexible array of supports and/or creates new support options with team
Professional services only	Diverse supports (professional services, non-traditional services, and natural supports)
Facility-based settings and professional supporters, “one size fits all” regardless of cultural memberships	Culturally-appropriate, integrated settings and natural supporters are also valued
Avoidance of risk; protection of person and community	Responsible risk-taking and growth

The New Direction: Fundamental Principles of PDP

In the section which follows, each of the areas noted in the checklist above will be briefly described. These areas represent fundamental principles that must be respected in the process of implementing person-directed planning in behavioral health systems and which direct the practice of implementing person directed planning.

Self-determination and community inclusion are fundamental human rights of all people.

The question of planning ownership—or “who owns the plan?”—in person-directed planning is undeniably central. Yet, as we consider this key question, it may be more enlightening to ask ourselves instead, “who owns the person’s life? (Jonikas, Cook, Fudge, Hlebechuk, and Fricks, 2005).

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his [/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law. -- U.S. Supreme Court, (Union Pacific Railway Co. v. Botsford, 1891).

These quotes highlight the fact that person-directed planning is fundamentally based on a civil rights model of psychiatric disability. This views self-determination and participation in community life as basic rights of people with behavioral health issues rather than as privileges that have to be earned either through compliance with treatments or through the acquisition of a variety of social, cognitive, or behavioral skills.

Simply—yet importantly—stated, recovery is built on the principle that *people with behavioral health challenges do not have to be cured of their illness in order to participate fully in community life*. This approach has profound implications for the structure of behavioral health care in America because achievements such as meaningful jobs, intimate relationships, and a home to call one’s own are not things that come after a person has recovered. In a system focused on recovery, person-directed planning becomes the vehicle to drive to the achievement of those hopes and dreams. Underlying the entire process is a basic assumption of the individual’s right, and ability, to self-determine, and this assumption is not nullified by labels, compliance, or perceived stages of recovery.

Practice example: As the person engages in their recovery planning process the provider keeps an eye on the community at large. The provider and the person in recovery engage in a collaborative process of obtaining information about and participating in various community integration activities that are of interest to the person receiving services.

What are the person's desires for greater connection in the community? The goals are directed toward this end and the services delivered support those goals for greater community involvement, for example supporting the development of volunteer roles. If this is the goal the PIR and provider together break down the steps toward the goal into small actions that can be implemented in a short time frame (i.e. looking on line for agencies that might need volunteers, walking around the neighborhood to see where those agencies are located, placing calls, etc.) and that build on each other. These short term steps build skills, confidence and lead not just to the goal of volunteering but to increasing resources for sustaining a long term recovery process.

Active participation and empowerment is vital.

Ownership of one's life isn't a tangible thing that comes with a guarantee or warranty. It is a physical, mental, spiritual, and responsible connection/reconnection to life for an individual who seeks his/her own destiny. (Nancy Fudge As quoted in Jonikas et al., 2005, p.1).

Self-determination requires that individuals have the right to control the direction of their lives and treatment free from undue external influence. This includes the right to exercise choice in the planning of services and supports. In PDP, there is an emphasis on personal empowerment and maximizing ones ability to make life-defining decisions involving key areas of life such as one's living situation, relationships, vocation, and education.

All participants in the planning process must understand, and respect, that the recovery journey belongs to the person receiving services (and their family or supporters of choice). Service providers may metaphorically provide the person with a car, but it is their trip and their recovery plan! Sometimes providers are asked to ride along in the car and other times to drive for short periods of time but it is the person who sets the direction and is the owner of the car. Active participation and empowerment of the person is vital. Participation that is limited to passive compliance is seen as potentially damaging and can reinforce a sense of hopelessness and interferes with the growth necessary for people to advance in their recovery.

Particular attention must be paid to the fact that the underlying concepts of person-directed planning (e.g. self determination, autonomy and independence) may conflict with an individual's cultural values. Family and peer-centered processes are often more central to goal-setting and decision-making in these cultures. Therefore, one must modify the person centered planning process in a way that legitimizes a more collective decision-making approach when this is

necessary due to cultural preference. For example, when an expressed cultural preference indicates a desire to defer to a parent or a community elder, a concerted effort must be made to encourage that person's participation and to support him or her in taking an important and active role in the process, whether this be exercising leadership directly or offering input into the decision-making. In order to ensure this active participation, in some cases it may be necessary to offer the identified elder or parent information regarding the purpose and function of the person-centered planning process and the range of his or her possible roles in and contributions to it. If the individual expresses such a cultural preference or value the facilitator should manage the planning process in a way that legitimizes a more collective decision-making approach (Marrone, 1997).

Practice example: An individual identifies wanting to move out of the residential placement that they are in. Rather than the provider saying that the goal is unrealistic or the person is not ready, the provider explores what would need to happen for the person to be able to move into their own apartment and how the process can begin. The plan involves concrete action steps toward this larger goal (i.e. taking a cooking class, applying for a section 8 voucher, learning to take their own medications, attending training to learn the skills of being a renter etc.). Each small accomplishment is noted and celebrated.

All parties have full access to the same information.

Transparency means plans are written, to the extent possible, using the person's own words and all parties have access to the same information in order to embrace and effectively carry out responsibilities associated with the recovery plan and process (Osher & Osher, 2001).

In a person-directed planning process, the person (and family as relevant) is provided with support and information before the planning meeting so that they can be prepared and participate as equals (e.g., Osher & Keenan, 2001). Equal access to information, often referred to as "transparency," is essential to level the playing field and to allow all parties involved to participate as valued members of the team and planning process.

Transparency means that the person is always able to see his or her own records; they are always offered a copy of their recovery (treatment) plan; they have the right to write in their record to express alternative views or to augment what has already been written. In addition, prior records should be readily available when new situations arise so the person and his/her team can learn from past experiences.

Practice example: In the week before a team meeting with the person/key supporters a copy of the most recent plan is reviewed with the person and their primary contact person. At this time the PIR is invited to think about and identify what their achievements are, what their concerns are and what they would like to get out of their team meeting. All team members recognize that moving to this way of doing planning is

a developmental process, the system has trained people to be passive participants and assuming an active role in one's own planning and life takes time and education for staff, PIRS and supporters alike.

Abilities and choices define supports.

Rather than subsuming the entirety of the person, a psychiatric label is but one aspect of a person who otherwise has assets, interests, aspirations, and the desire and ability to continue to be in control of his or her own life. (Tondora & Davidson, 2006 and Jacobsen & Greenley, 2001).

Person-directed care values and builds on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The strengths and needs of the person are stated from the person's own perspective; and planning makes use of and expands what they already know works in their own life. This may include things that may not necessarily be appreciated in the mainstream or dominant culture. For example, someone may see their spirituality as a strength whereas their time spent pursuing this might make it difficult to obtain employment.

PDP respects the fact that behavioral health challenges are only one aspect of a multi-dimensional person. Every person, including someone with a behavioral health issue has gifts, talents, interests, and dreams. In a person-directed planning process, everyone (including the person), needs to recognize that the diagnosis is not as important as the person's individuality and humanity. The use of person-first language (as was discussed earlier) reinforces the humanity and potential of the person. This principle does not mean that a diagnosis is hidden or seen as irrelevant, but it is not the sole focus of the plan. To make it the sole focus is depersonalizing and derogatory.

Practice example: Diverse supports can consist of a variety of activities, people and other resources. One young woman who lives with Asperger's autism had a difficult time adjusting while attending a four-year college. During her senior year she found that volunteering in the school's laboratory, working with lab rats, was therapeutic and a helpful support in her recovery journey. The responsibility of working with the rats in the laboratory helped her through some challenging times. Also an accomplished artist, she was later commissioned to create a piece for one of the professors in the psychology department. She is currently associated with Rat Chick Rat Rescue and is actively working on promoting her art work.(Interview with Phoebe, 2008).

Addition on a person's recovery plan of things they do or have done in the past that bring them peace, pride, satisfaction and tranquility identifies these things as important.

Inquiry about things they feel are their talents sends the message that he or she is seen as more than a diagnosis to be treated.

High expectations for recovery are the norm.

The vision of person centered planning and self-determination is, and should remain, the pursuit of an ambitious ideal but one that is, ironically, based simply on the attainment of goals that are universal to typical human experiences – goals which appreciate our common humanity, our common aspirations and dreams, and our common sense of responsibility to become contributing members of society. Setting the bar high means focusing on choice and control; valued and enduring relationships; freedom, health, and safety and decent places to live; economic security; opportunities for community membership and contribution; and support by nurturing and caring human service professionals. (Nerney, 2005).

Outcomes for people with behavioral health challenges need to include the expectations and aspirations shared by all humans, not just outcomes commonly valued in the human service system (e.g., stability, compliance, and satisfaction with services). High expectations should be the norm for all people and not reserved only for those who are judged by professionals to have reached a certain stage or phase of recovery.

Practice example: Positive expectations can be communicated by the way questions are asked in the assessment and planning process. Asking for the person's hopes and dreams communicates that you know they, like all human beings carry them. Asking for when they have been successful at something carries the implication that they have been.

Quality of life and promotion of recovery are the focus of care and planning.

The plan itself is not the goal, even if it is multifaceted, culturally relevant, and directed by the person or family. Rather, the plan is simply one pathway to a life complete with respect from others, meaningful opportunities and choices, personal responsibility, community/school presence and participation, and self-chosen supports (Jonikas et al., 2005).

Currently, it is common for planning efforts to focus largely, or exclusively, on the reduction of symptoms through the provision of professional clinical services. While these interventions will continue to be an important part of overall service planning, PDP also focuses on the attainment of broad-based recovery goals that the individual decides

are important to him/her. Focusing on these goals, what the person considers important, helps the person move toward a life in the community (in other words a higher quality of life) like everyone else. All aspects of a person's life are explored including physical health, family and social relationships, employment, education, spirituality, housing, recreation, and community service and civic participation unless they are designated by the person as not-of-interest. A person-directed plan always has an eye to flexible and natural supports. Whether the person's goal is to advance in the workplace or to audition for the lead in a theatre production, they should receive treatment and supports that promote the achievement of their personal goals.

In a system which provides clinical care (treatment) clinical interventions are parts of the overall recovery plan but are now tied directly to the attainment of recovery goals in a way that is clear to the individual. Symptoms are addressed to the degree that they are distressing to the person and stand in the way of achieving their recovery goals. A provider's expertise has to be applied toward what is important to the person or it will not be as helpful or as effective as it should be. For example, a psychiatrist or therapist needs to understand the individual's goals and to help him/her to make an informed choice about what can help to reach those goals (rather than making the decision for the person). This often requires a response that goes well beyond simply writing a prescription.

If employment and/or education are critical components of what the PIR defines as a quality life then modifications to medication schedules to promote maximum energy and cognitive functioning at certain times during the day may be needed. The team may need to discuss with the person how symptoms and or medication side-effects impact work performance and to brainstorm personal management strategies. If desired by the individual, the team can also contribute critical expertise in offering consultation to the employer regarding reasonable accommodations that will enhance the individual's performance and potential for success. This example reflects how PDP stresses using medication to promote maximum functioning and increased quality of life as opposed to using medication solely for the purpose of symptom reduction. Combined with other flexible supports, each of these interventions can be an important component of the on-going person-directed planning process.

Practice example: In settings where recovery planning is being carried out, psychiatrists report a decrease in the need for medication as people become increasingly involved in their lives (Fisher and Ahern, 1999). They report being asked for a medication regimen that will make the person less sleepy because they have many involvements. In these situations a full understanding of the person's plan is critical for being an active participant in the support team.

Person chooses from a flexible array of supports and/or creates new support options with team.

When he asked me, "So how can I best be of help!" I thought, "Oh great, I've really got a green one. You are supposed to be the professional—you tell me!" But I get it now. I need to decide what I need to move ahead in my recovery. And I needed to know it was OK to ask people for that. That was the key (Tondora and Davidson, 2006).

A focus on clinical symptoms to the exclusion of broad-based recovery goals often leads systems to establish a continuum of services that individuals are expected to progress through in a linear fashion whether or not starting at "point A" and moving to "point B" fits with their unique recovery process. For example, it is common for referral to vocational rehabilitation programs to be controlled by a clinical provider who will only sign off on the referral once the person has proven "ready" for employment through compliance with clinical treatment and is deemed "stable." There is a large body of literature which has shown that these types of screening procedures and criteria have limited predictive validity regarding success in the workplace. Requiring people to move through services in this manner also neglects the fact that activities such as working are often the path through which people become clinically stable in the first place. In person-directed systems, individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment. A pre-established continuum of services is replaced by a flexible array of supports that individuals can choose from based on their unique needs and preferences and how these might shift over time.

Practice example: When someone identifies employment as a goal and then is able to secure competitive employment (perhaps even on their own), the focus of the support team becomes discussing with the person what supports will help increase the likelihood of their being successful on the job. These supports may include professionals but may also include having friends who are willing to be "on call" to talk after a bad day at work or services directed toward increasing communication and conflict management strategies on the job.

Diverse supports, including self-management, peer support, holistic medicine, and natural supports are valued along with professional services.

It made such a huge difference to have my pastor there with me at my planning meeting. He may not be my father, but he is the closest thing I've got. He knows me better than anyone else in the world and he had some great ideas for me. (Tondora and Davidson, 2006).

In an effort to support broad-based recovery goals and to offer people a flexible array of supports, the PDP process values a wide range of diverse supports including self-management, peer support, holistic medicine, cultural healers, etc. These types of non-traditional supports should be made available for the people in the manner that best assists them in their recovery. It is particularly useful to note strategies which have been helpful to others with similar struggles. Information about medications and other treatments should be combined with information about self-help, peer-support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, supported community activities, homeopathic and naturopathic remedies, and more. In some cases, this may require creativity on the part of team members.

If it is the person's preference, it can be particularly useful to include "natural supporters" in the team as they often have critical input and support to offer. Natural supporters are people such as family members, friends, acquaintances, co-workers, fellow members of spiritual communities, and others who are not paid to be in the person's life but who choose to be because of their personal connection to the individual or family. Just as no one ever thought of hand controls for people without the use of their legs in driving a car until one person had a vision, so too do we need to creatively develop recovery supports when what is currently available is insufficient. In summary, treatment should complement, not interfere with, what people are already doing to keep themselves well, and this includes drawing strengths from diverse wellness resources as well as diverse natural support networks. These should be equally valued in the planning process along with the expertise of professional services and providers.

Practice Example: The Wellness Recovery Action Plan is a tool which can be used by anyone facing challenging situations. There are five key concepts in a WRAP: hope, personal responsibility, education, and self-advocacy and support (Mead and Copeland, 2000). People use these concepts daily to maintain their recovery and to get through difficult times. One person, who has had a WRAP for two years, used it to manage his recovery during an episode of homelessness and hospitalization. He applied the concepts of hope and personal responsibility to identify his triggers and put supports in place. He uses the WRAP in his daily maintenance routine to become stronger and enhance his wellness. He also currently serves as a WRAP facilitator (interview with Darryl, 2008).

Ideally, the person's recovery support team should outnumber the professionals at the table when it is time to conduct a planning meeting. Never should the provider define "family." This definition should always be determined by the person coming for services.

Planning meetings should never interfere with other recovery supporting activities (i.e. work, school, volunteering, etc.).

Access to inclusive community settings is emphasized.

Traditional mental health systems have been described as tending to “surround people with serious mental health problems with a sea of professionally delivered services . . . which stigmatize them and set them apart from the community” (Nelson, Ochocka, Griffin & Lord, 1998, p. 881).

Achieving interdependence with natural community supports is a valued goal for many people in recovery who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members (Reidy, 1992).

Person-directed planning supports access to inclusive community settings while seeking to reduce, or eliminate altogether, time spent in segregated settings designed solely to support people labeled with a mental illness and/or substance use disorder. While specialized service settings can play a pivotal role in an individual’s recovery, over prolonged periods of time they tend to perpetuate a sense of chronic alienation (or “patient-hood”) while also perpetuating discriminatory and unethical practices on the part of community members. For example, it has been common in behavioral health systems to offer sheltered workshops rather than real jobs for real pay or to offer movie nights at the behavioral health center rather than passes to the local theatre. Just as meaningful community life is not what comes AFTER recovery, it is also not something that service systems can, or should, create FOR people in artificial microcosms.

Practice example: PDP goals reflect this knowledge that the community is the setting where life takes place. The assessment asks about naturally occurring community connections (faith communities, mutual self help groups, friendship groups etc.) and the planning process explores other connections that the person would like to develop and supports development of these through planning, skill building and community exploration strategies. People go to work or school or into other recovery-supporting activities when *they* say they are ready, not when the *provider* determines that they are ready.

Responsible risk-taking and growth are valued as part of recovery.

All human beings need the opportunity and freedom to learn from their own mistakes. Therefore, in circumstances that do not pose serious and imminent risks to the person or to others, direct supporters accordingly afford individuals “the dignity of risk” and “the right to failure” (Deegan, 1996, p. 97).

In person-directed planning, individuals are presumed competent and entitled to make their own decisions. Prior to imposing power or restrictions, providers try multiple ways of engaging the individual. They support the dignity of risk and sit with their own discomfort as the person tries new experiences that are necessary for growth and recovery, working with the person to outline the range of options and their potential consequences (and fruits).

Practice implication: PDP in no way implies a laissez-faire approach to clinical care. Rather it shifts the relationship from one based in hierarchy to a partnership where one aspect of the relationship involves discussing costs and benefits of potentially risky choices (non life-threatening) in a respectful, mutually transparent way. The provider recognizes that growth for all humans happens through taking calculated risks and that the “protective at all costs” approach of the system in the past has limited people’s potential and learning.

Definitions

Person–First Assessment

A Person-First Assessment is a strength-based process that fully embraces the principles of cultural appropriateness and relevance. It fosters an end to health disparities. It is integrated into all aspects of the service relationship with the person who comes for services, their family and their supporters. This is an ongoing and dynamic process.

Person-Directed Planning

Person-Directed Planning flows from the Person-First Assessment. The primary direction in the planning process comes from the individual and/or his/her designated other(s), a focus on capacities/assets, with an emphasis on promoting access to inclusive community settings, an acceptance of uncertainty and setbacks on a path to self-determination.

Provider Checklist- Please think about your own practices and see how many of these activities support Person-First Assessment and Person-Directed Planning.

Statement	Yes	No	Notes
I understand that all people are entitled to choice, no matter where they are in their recovery process.			
I do not make people wait until I think they are “ready” before working with them to connect with their community of choice.			
It is possible for someone to be working on their recovery process even if they aren’t doing what I want them to do or think they should be doing.			
I express my thoughts and concerns clearly even when I disagree with someone’s choices but stay connected to them.			
People who receive services from me have easy access to all records, evaluations, and any kind of written material about them.			
As much as possible all documentation is done in the person’s words.			
My focus is on what people can do, what strengths they bring to the table.			

Provider Checklist continued on the next page

Statement	Yes	No	Notes
I see whatever behavioral health issue the person is facing as a challenge to be met, not as the defining issue in the person's life.			
I believe in the possibility of recovery for everyone, that everyone can have a better life tomorrow than today.			
I support the people who receive services from me in their recovery process.			
I see medication as one tool that can be used to support the recovery process. It must be adjusted to fit the person's goals. Managing all symptoms at the cost of being able to work or relate to others may not be the person's goal. I explore this with them.			
I listen to what people tell me about what makes life worth living to them and recognize that may be different than what I think.			
I actively ask about who is important in the person's life and reach out to them to engage them in planning meetings.			
If there are broken relationships in the person's life that are important to them I work with them to try to find ways to heal the breach.			

Provider Checklist continued on the next page

Statement	Yes	No	Notes
I recognize the important role spiritual communities play in many people's lives and actively ask about them and actively include members of those communities in planning meetings if the person chooses.			
I ask about alternative healing strategies that the person uses.			
I recognize that the goal of all services is to help the person develop a life in the community "like everyone else".			
I recognize that all people grow and learn through stretching beyond their comfort zone.			
When someone tries to do something I might not agree with and it doesn't work I see it as an opportunity for learning together.			
I educate myself about local community activities including recreational, vocational, housing, volunteer and educational opportunities.			
I share community resources with providers and people receiving services.			
I invite people in recovery receiving services to educate me about community activities that are available to them.			

End of Provider Checklist

Person in Recovery Working with Provider Checklist I- Persons in Recovery can assess whether the provider is promoting person-first assessment and person-directed planning by determining whether they are engaged in the following activities (this is a non-exhaustive list):

Statement	Yes	No	Notes
My provider understands that I am entitled to make my own choices, even when I am not doing well.			
My provider listens to the ways I want to connect with the community and doesn't tell me that I am not ready.			
Even when I disagree with my provider's recommendations he/she still keeps working with me and is willing to keep helping me work on decisions.			
My provider lets me know in a respectful way when he/she disagrees with my choices and why. This helps me think about my decisions.			
I can see my records at any time and am not made to feel bad for asking to see them.			

Person in Recovery Checklist I continued on the next page

Statement	Yes	No	Notes
What I read in the records is often written in my words and is about things I know about, things providers have talked to me about. I am able to write in my own chart.			
My provider helps me see things at which I am good and to identify strengths I might not have known I had.			
My provider treats me as a person, not a diagnosis.			
My providers hold hope for my recovery even when I might not believe it for myself.			
My provider supports me in my recovery process.			
My provider helps me get my medication adjusted in a way that supports my ability to live my life (for example to help me get the schedule adjusted so I can be alert for work or to take care of my children).			
My provider listens when I tell him/her what is important to me, helps me think about new alternatives but finally respects my interests.			

Person in Recovery Checklist I continued on the next page

Statement	Yes	No	Notes
The people who are important to me are welcomed into meetings where planning with me is done.			
My provider helps me think about ways to mend the broken relationships in my life, gives me ideas for strategies and is willing to meet with people who are important to me to help me if I so choose.			
My spirituality and spiritual communities are respected. Leaders and members of my communities are included in planning meetings if I so choose.			
Alternative healing strategies that I use are asked about in a respectful way.			
My provider helps me to keep working at developing a life in the community “like everyone else”.			
My provider encourages me to stretch myself, to take risks and to try new things.			
When I try something new, even if it was something my provider didn’t agree with, we work through whatever happens together.			

End of Person in Recovery Checklist I

Person in Recovery-Assessing One's Own Daily Activities
Checklist II- Persons in recovery can do some of the following things to become an active collaborator in their person-first assessment and person-directed planning.

Statement	Yes	No	Notes
I am willing to think about trying new things and listen to the ideas of others.			
I work on the things in my recovery plan.			
I think about what else I might want to change in my life so that I can bring that information to my planning meeting.			
I look for chances to learn new things (i.e. attending system wide trainings on storytelling, person first training, etc.)			
When other people identify strengths in me I listen to them even if it is hard to hear good things.			
I find out about community activities such as work, housing, education, volunteerism and I share this information with my provider and other people at the agency.			
I work on developing a positive, collaborative relationship with my therapist, psychiatrist, case manager.			

End of Person in Recovery checklist II

DBH/MRS Staff Checklist-Use this checklist to increase the utilization of person-first assessment and person-directed planning in your own work and daily activities.

Statement	Yes	No	Notes
I have taken training in Person-First Assessment.			
I have encouraged people receiving and providing services to take the Person First Assessment Training.			
I have encouraged people receiving and providing services to take the Person-Directed planning training.			
I have taken training in Person-Directed Planning			
I encourage open, transparent communication between the person providing and the person receiving services.			
I have a good understanding of Person-First Assessment and Person-Directed Planning , and encourage providers to use them at their agency.			

DBHMRS checklist continued on the next page

Statement	Yes	No	Notes
I discuss the benefits of Person-First Assessment and Person-Directed Planning with people receiving and providing services.			
I believe that all people are entitled to choice no matter where they are in their recovery process. I share this belief with my co-workers, providers and people receiving services.			
I express my thoughts and concerns clearly even when I disagree with someone's choices.			
I continue to stay connected to people even if I disagree with their choices.			
My focus with people receiving services, people providing services, my colleagues is on what people can do and what strengths they bring to the table.			
I discuss person-first assessments and person-directed concepts in supervision.			
As a supervisor, my focus is on what people can do and what strengths they bring to the table.			

End of DBHMRS checklist

Resource List

Supporting References and Additional Resources

Ali, S. (2005) – *Developing a Bio-cultural Psychosocial Assessment*

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision). . Washington, D.C.:

Callicott, K. (2003). Culturally-sensitive collaboration within person-centered planning. *Focus on Autism and Other Developmental Disabilities*, 18 (1), 60-69.

Chinman, M. J., Allende, M., Weingarten, R., Steiner, J., Tworkowski, S., & Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan*. Oakland, CA: New Harbinger Publications.

Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work* 39(3), 262-268.

Davidson, L. (1999). On the road to collaborative treatment planning: Consumer and supporter perspectives. *Journal of Behavioral Health Services & Research*, 26(2), 211-218.

Deegan, P. E. (1992). The independent living movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal*, 15(3), 3-19.

Deegan, P.E. (1996). Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal*, 19, 91-97.

DeJong, G. and Miller, S. (1995). How to interview for client strengths, *Social Work*, (40), 729-736.

Fisher, D. and Ahern, L. (1999). Personal Assistance in Community Existence. National Empowerment Center. Downloaded from:
http://www.cmhanipissing.on.ca/data/1/rec_docs/766_pace_manual.pdf

Forest, M. & Pearpoint, J. (1990). Common Sense Tools: Maps and Circles for Inclusive Education. The Inclusion Network. Inclusion.com.

Jacobson, N. and Greenley, D (2001). What is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, 52, 482-485.

Jonikas, Cook, Fudge, Hlebechuk, and Fricks (2005). Charting a Meaningful Life: Planning Ownership in Person/Family-Centered Planning. Paper presented at SAMHSA's National Consensus Initiative on Person/Family Center Planning Meeting on December, 8th 2005, Washington, D.C.

- Mead, S. & Copeland, M.E. (2000). What Recovery Means to Us: Consumers' Perspectives. *Community Mental Health Journal*, 36(3),
- META Services, (2005). Self-directed Recovery Plan: A Guide to Your Individual Service Plan. Recovery Education Center, Phoenix, AZ.
- Nelson, G., Ochocka, J., Griffin, K., and Lord, J. (1998). " Nothing about Me, Without Me": Participatory Action Research with Self-Help/Mutual Aid Organizations for Psychiatric Consumer/Survivors. *American Journal of Community Psychology* 26(6), 881-912.
- Nerney, T. (2005) Quality issues in consumer/family direction. Downloaded from <http://www.mentalhealth.samhsa.gov/publications/allpubs/NMH05-0194/default.asp> [July 13, 2005].
- O'Brien J. & O'Brien, C. (Eds.). (2002) Implementing person-centered planning: The voices of experience. Toronto: Inclusion Press.
- Osher, D. & Keenan, S. (2001), From Professional Bureaucracy to Partner With Families, *Reaching Today's Youth*, 5:3, 9–15.
- Osher, T. W., & Osher, D. (2001). The Paradigm Shift to True Collaboration With Families. *Journal of Child and Family Studies*, 11:1, 47-60.
- Ralph, R.O. & Recovery Advisory Group (1999). *The Recovery Advisory Group recovery model*. Paper presented at the Joint National Conference on Mental Health Systems Block Grant and Mental Health Statistics, Washington, DC.
- Rapp, C.A. (1993). Theory, principles, and methods of the strengths model of case management. In M. Harris, (Ed) & H. C. Bergman, (Ed) (Eds.), *Case management for mentally ill patients: Theory and practice*. (pp. 143-164): Harwood Academic Publishers/Gordon & Breach Science Publishers, Langhorne, PA, US.
- Reidy , D. (1992). Shattering illusions of difference. *Resources*, 4(2), 3-6.
- Saleebey, D. (2001). The diagnostics strengths manual. *Social Work*, 46, (2), 183-187.
- The President's New Freedom Commission on Mental Health, July, 2003
Retrieved 4/1/09 from
<http://www.mentalhealthcommission.gov/reports/FinalReport>
- Tondora, J. & Davidson, L., (2006). Practice guidelines for recovery-oriented behavioral health care. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.

Tondora, J., Sangster, S., Miller, R., Piczko, M. (2005). Preparing for Your Person Centered Recovery Planning Meeting: What You Need to Know. New Haven, CT: Yale Program for Recovery and Community Health.

Union Pacific Railway Co. v. Botsford, 141 U.S. 250 (1891) Union Pacific Railway Company v. Botsford No. 1375 Submitted January 6, 1891 , Decided May 25, 1891 , 141 U.S. 250 ERROR TO THE CIRCUIT COURT OF THE UNITED STATES FOR THE DISTRICT OF INDIANA

White, W. L. (2001). The rhetoric of recovery advocacy: An essay on the power of language. Retrieved from <http://www.friendsofrecoveryvt.org/articles/rhetoric.pdf>