

READING ROOM

You might also like to read the following:



[Person Centred Planning and Care Management](#)

'What' and 'how': understanding professional involvement in person centred planning styles and approaches

Jackie Kilbane and Helen Sanderson

Introduction

This article is third in the series exploring person centred planning. The second article focussed on exploring person centred planning and the challenges and opportunities it may present to professionals. The purpose of this article is to identify a range of person centred planning styles and approaches and highlight different contributions to plans from professionals. We begin with stories about planning, describing the planning styles that are used and the contributions that professionals made to them. Dimensions of potential involvement from professionals are explored in more depth and key implications for practice are identified.

People and their plans

Using person centred approaches

Joseph is a solicitor who has worked for himself for two years. Joseph was approached by a prestigious solicitors firm to join them as a Partner. He was flattered and torn– should he forget about his practice and join the firm, or stay put? Joseph knew Louise, a person centred planning facilitator and he asked her to help. Louise looked at what good work days and bad work days were like for Joseph and then they explored which of the two jobs would give Joseph more good days at work. Joseph decided to stay and develop his own practice. That was three years ago, and he says it was one of the best decisions that he has ever made.

"I would not describe myself as an indecisive person, but Louise helped me to think about my work in a new way that helped me make an important decision"

Louise did not do a full person centred plan, she used a person centred approach to explore Joseph's good and bad work days. This gave Joseph the information that he needed. There are many different person centred approaches that are practical tools, which professionals can integrate within their practice as well as good and bad days. Examples include 'Learning Logs', where people record what is working and not working about activities, 'Communication Charts' which simply record our

understanding about someone's non verbal communication, and 'History Maps', where we can graphically record someone's story or history. MAP's as a tool also helps us do this.

MAPs

Sharon is 36, people who know and care about her describe her as warm, funny and steadfast. She does not use words to communicate and her physical disabilities mean that she relies upon her parents (whom she lives with) and paid carers to support her. Planning became important when Sharon's Care Manager (Louise) was finding it difficult to find and keep carers who knew Sharon. Terry (Sharon's advocate) was worried that Sharon's routines and daily life were becoming mostly about staying at home, getting clean and having regular meals.

Louise and Terry met and shared their ideas on how best to respond to these issues and in discussion with Sharon's mum, Terry and Louise initiated a MAP meeting. The people who were invited (and came to) the MAP gathering included Sharon's family, community nurse, sessional worker from a day centre, paid carers and a physiotherapist that Sharon had known a while back. Terry knew a nurse who had been trained in PATH & MAP facilitation and asked her to facilitate.

The MAP gathering brought people together over a day, with lots of breaks. One of the actions from the MAP was for health professionals who spent time regularly with Sharon to begin using learning logs to help shape an understanding of what was enjoyable in Sharon's life. Another was to develop a shared understanding of the ways that Sharon communicates; they chose to use the communication approach used within Essential Lifestyle Planning. The Care Manager used the plan to inform paid carer recruitment and support, part of the reason for initiating the plan.

Maps have a section at the beginning of the process for going over the history of an individual. For Sharon, this part of the process shifted how health professionals understood Sharon and her families' experiences and priorities. MAPs also asks the question 'who is the person?' and 'what are their gifts?' Sharon's MAP harnessed the energy of the people who were supporting her, to work collectively to help her move towards a life she wanted. The MAP process allows people to express both their hopes for the future, in the dreaming section, and their fears about the future, in the nightmares section. The action plan is about working towards the dream and away from the nightmare.

Essential lifestyle planning

In the past **Peter** lived at home with his mother and younger siblings. When he left school he moved into a shared house with three other men he did not know (and over time realised he had little in common with), with 24 hour support provided by an agency. Peter said that it was hard to live with these men, "one shouted a lot".



After 6 months of trying to find somewhere, Peter now lives in a new flat and support is available nearby. He said, "I love living on my own. I have my own place, my own money and help when I need it. Now I want a job!"

Peter was part of the local People First Group. They were running a course called "Listen to Me". The course was to help people to think about their lives and how they are supported and to plan for the future. Peter went on the course because he thought it was a way of getting his own place.

On the course Peter was supported to fill out the "Listen to Me" workbook which asked questions about what is important to Peter, such as family, friends, important possessions, important routines, his likes and dislikes, and his dreams for his future.

Peter chose a student nurse that he knew to support him with his plan. Peter decided to meet in a pub about the plan and invited the manager of the service, his social worker, key worker, other support workers from where he lived, and Suzanne from People First.

At the meeting everyone had a drink and a meal, then Peter shared his workbook. He told people that he wanted his own place. The student nurse and Suzanne helped Peter to speak up. Everyone said they could see how important it was for Peter to have his own place and it was agreed to help Peter to find somewhere. Regular meetings were held to check how things were going and to find out if a place had been found.

After 6 months of trying to find somewhere, Peter now lives in a new flat and support is available nearby. He said, "I love living on my own. I have my own place, my own money and help when I need it. Now I want a job!"

Essential Lifestyle Planning (Smull & Harrison 1992) was developed to enable people to move from long-stay institutions. It is a way to learn who and what is important to people in their everyday lives and how to support people to have the lifestyle that they want while staying reasonably healthy and safe. This information is recorded in a clear, simple but powerful way in the person's Essential Lifestyle Plan. Essential Lifestyle Planning specifies the way that support is to be provided on a day to day basis, and this is helpful when different members of staff need to work consistently or when the person or the family is not able to give such detailed direction.

Essential lifestyle planning and PATH

Martin is thirteen years old and has been described as having severe, complex learning and speech difficulties and epilepsy. **Margaret** is Martin's mum.

Margaret used the Families Leading Planning pack to develop an Essential Lifestyle Plan for Martin. One of the things that emerged was that Martin wanted to spend more time with his peer group and go to a mainstream school. Margaret took Martin's essential lifestyle plan and a five-minute video clip of him with her when she visited the school. This enabled the head teacher to see who Martin really is, not masked by labels and reports. The teacher said, "had we only read the usual review



documents which describes a person by their difficulties first, we would never have considered him coming to our school." Martin now attends his local mainstream school part time.

The essential lifestyle plan helped Margaret to prioritise Martin's support needs, understand what is important to him, and recognise opportunities for Martin that he may enjoy.

Margaret also wanted to think and plan for the future with Martin. She asked a person centred planning co-ordinator to facilitate a Path with Martin and their family.

The Path took place on a Sunday morning. Martin contributed his own graphics. It was a powerful and emotional process for the family. The actions focussed on Martin becoming more involved in the community, having support with Martins behaviour and the family enjoying time together.

Margaret invited health professionals from the community team to work with her family to achieve some of these actions.

PATH (Pearpoint, Forest & O'Brien 1993) can be used as a planning style with individuals and with organisations. It helps people with a basic commitment to the person to sharpen their sense of a desirable future and to plan how to make progress. It assumes that those present know and care about the individual and are committed enough to support the person towards a desirable future. PATH is not a way of gathering information about a person, but a way of planning direct and immediate action.

'PATH is there when a situation is complex and will require concerted action, engaging other people and resources, over a longish period in order to make an important vision real.' (O'Brien & Pearpoint 2003)

Personal futures planning

Two years ago, **Joyce** moved from a hostel to a semi-detached house in the city with Ruth. In the last two years she has had three key workers supported by three managers. Consequently, little was remembered about Joyce's views, what is important to her, or her past.

June, Joyce's current keyworker talked to Joyce about having a plan. Joyce wanted to collect the information about her life herself with some help from her brother and Karen, a planning facilitator. For two months, Joyce and Karen spent an afternoon each week together working on a personal profile. When they had finished, Joyce shared it with her brother. Next they discussed where and when Joyce wanted the meeting to take place and who would be invited. Joyce decided that she wanted her physiotherapist to send a report about the specific work that she had been doing with Joyce's posture, as she did not want the meeting to be very big.



Karen and Joyce talked about how she wanted the information from the profile shared with others and they decided to transfer the information from the profile onto posters Joyce and Karen could talk through at the meeting. At the meeting Joyce gave people coffee and some cakes that she had baked.

Joyce was asked what she wanted to change. On her relationship map there were two people that Joyce did not see anymore and that the staff did not know about. Joyce wanted to meet up with them both again. Joyce also wanted a telephone and answering machine in her bedroom, a doorbell that worked and a carriage clock like her mother's. Joyce wanted to try new activities and visit new places.

The group worked with Joyce to turn each of these into actions. Her brother agreed to help her buy the carriage clock and bought her an answering machine for her birthday. June and Joyce planned how to get in touch with the 2 friends again and try new things.

Joyce said: 'I liked doing the plan - it brought back memories. I liked looking at the things that I wanted to do and putting down my dreams - I didn't think I could have my dreams. It was a good meeting... I could say what I wanted and I enjoyed being in charge.'

Personal Futures Planning (Mount 1987) is a planning process that involves getting to know the person and what life is like now, developing ideas about what s/he would like in the future and taking action to move towards this. It involves exploring possibilities within the community and looking at what needs to change within services. The process is colorfully recorded in words and pictures using different 'maps'. Joyce used Personal Futures Planning to take stock of her life and think about her future.

'The personal futures planning process suggests a series of tasks and provides a set of tools to help us begin the process with people to uncover their capacities, to discover opportunities in the local community, and to invent new service responses that help more than get in the way.' (Mount 1987)

Person centred planning and professional involvement

Although different, each planning style is based on the same principles: all start with who the person is and end with specific actions to be taken. They differ in the way in which information is gathered and whether emphasis is on the detail of day-to-day life, or on dreaming and longer term plans. Joseph's story reflects that planning happens for everyone at different times in our lives and illustrates how useful person centred

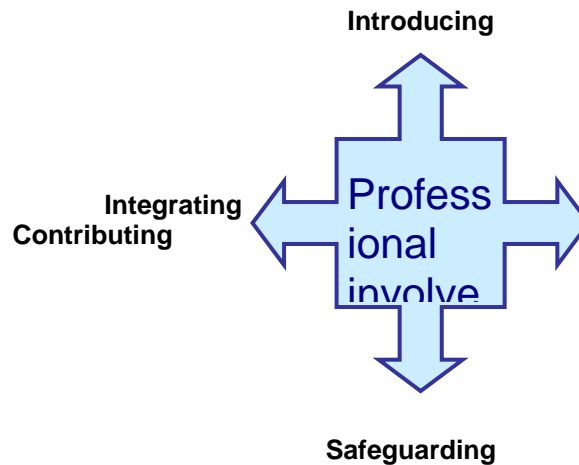


approaches have been to people who do not have a learning disability. The health professionals in Sharon, Peter, Joyce and Margaret's lives had different degrees of involvement, and consequently made different contributions, summarised below.

Person	Professional Involvement	Person Centred Approach or Style
Joseph	<ul style="list-style-type: none"> None 	Approach; good day/bad day exercise
Sharon	<ul style="list-style-type: none"> Health professional suggested a plan might be useful for Sharon Health professionals invited by Sharon to contribute to the process, including the MAP gathering. A Nurse trained in MAP facilitation, facilitated the MAP. Completing learning logs Contributing to communication section The Care Manager used information from the MAP when recruiting staff to support Sharon 	MAP Approaches; (learning logs and communication chart) provide additional learning about what works for Sharon
Margaret	<ul style="list-style-type: none"> Once the PATH was completed, Margaret invited various health professionals to work with her in completing actions developed from the plan. 	Family led ELP Family Path
Peter	<ul style="list-style-type: none"> Peter invited a student nurse to support him in recording his information to develop his plan. The student nurse contributed to the planning meeting and making the actions happen for Peter. 	ELP
Joyce	<ul style="list-style-type: none"> A health professional was invited to contribute information to the planning meeting. 	Personal Futures Planning

Many professionals are connected with people with a learning disability as friends outside of any formal role. In these instances, professionals may be invited to contribute to a plan in the same way as any friend would. The key interface between person centred planning and professional practice was described in a model presented in the second article of this series (Kilbane & Thompson 2004), placing emphasis on professional intervention following the development of any person centred plan and part of ongoing learning about a person. Building upon this, we offer 4 ways in which professionals may contribute to person centred planning:





Introducing

Where a person does not have a person centred plan, then a professional may introduce the idea of person centred planning with them (or their representative). If the person does want a plan, enable them to consider whether they want to gather the information themselves, as Peter and Joyce did, whether the family want to lead the plan, as Margaret did with the ELP, or with a facilitator as Margaret did for the family Path, and Sharon did for her MAP.

To be able to introduce person centred planning and approaches to an individual or family, health professionals need to:

- ⊙ Have a clear understanding of what person centred planning is
- ⊙ Know what the different styles of planning are and what their relative contributions are
- ⊙ Know that in some styles of planning the information gathering can be lead by the person or family (ELP and Personal Futures Planning), and what resources are available for people to use (manuals: Listen to Me (ELP), and Capacity Works (Personal Futures Planning) Families Leading Planning pack (ELP)
- ⊙ Know whether there are courses being run for people to lead their own plans (e.g. Listen to Me and Families Leading Planning courses)
- ⊙ Know who to contact within the implementation group if families want support that the professional is not able to provide

Contributing

Professionals may make different contributions to a plan:

1. Facilitate the plan once they have training and experience in this.
2. Member of planning meeting/process, as in Peter's story
3. Contribute to plan but not part of the meeting as in Joyce's story
4. Contributing to actions that result from plan as in Margaret's story
5. Supporting the person or the family to lead his or her own plan as the student nurse did in Peter's story

To be able to contribute to a person centred plan, professionals need to:



- ⊙ Be invited to contribute by the focus person
- ⊙ Have an association with the focus person that enables them to make a contribution
- ⊙ Be trained or training in a style(s) of person centred planning, practice this and stay up to date
- ⊙ Know about resources such as Our Plan for Planning – written by people with learning disabilities about the support they want to stay in control of their meetings
- ⊙ Have a clear understanding of what the focus person has asked them to contribute and in what way
- ⊙ Have a commitment to completing actions where this is agreed
- ⊙ Be flexible with their working hours and be prepared to attend meetings in evenings and at weekends

Safeguarding

Professionals have an important role in safeguarding the quality of plans and planning. Where a professional has knowledge, experience and understanding of person centred styles and approaches, they may:

- ⊙ Identify where a plan is of low quality and does not mirror the key features of person centred planning.
- ⊙ Spot gaps in people's plans and help people think about what they might do about them.
- ⊙ Link learning about how to make plans happen to local implementation groups.

To be involved in safeguarding person centred planning, health professionals should

- ⊙ Understand the five key features of person centred planning described in the implementation guidance and how these are applied to plan development and implementation.
- ⊙ Know the key elements of the different planning styles, and where there are quality criteria (e.g. in ELP) know what these are – in essence, can spot a 'cheap imitation'
- ⊙ Be familiar with the quality process being used by the local implementation group in relation to person centred planning
- ⊙ Keep up to date with developments in person centred planning and share these with colleagues

Integrating

Integration of person centred planning into professional practice happens at 3 levels:

- ⊙ Plan by plan between the focus person, the professionals and their supporters.
- ⊙ Local learning about person centred planning is fed back into implementation groups, local quality measures and knowledge management frameworks.
- ⊙ Embedding learning and person centred professional practice systemically. For example, including person centred planning



interface with professional practice in curriculum development for professional courses.

To be involved in integrating person centred planning, health professionals should

- ⊙ Be experienced in introducing, contributing to and safeguarding person centred planning and approaches
- ⊙ Agree ways of including relevant information from your professional intervention in the plan with the focus person.
- ⊙ Use local mechanisms for feedback and integration. For example, a local implementation group or professional fora.
- ⊙ Find ways of sharing learning, which enables others to learn from your experience and offers opportunities for support and challenge. For example, initiate a person centred planning action learning set in your area
- ⊙ Understand where you may influence the interface between your profession and person centred planning. For example, curriculum development.

Key practice implications

- ⊙ The professional spends time with the focus person and their supporters reading the plan and increasing their understanding of the person through the plan and this forms part of any pre-intervention work.
- ⊙ Any professional intervention applies person centred approaches. Examples of this range from arranging meetings or activities with the person in the mornings if their plan indicates this is a good time, to using approaches like learning logs.
- ⊙ Outcomes, new learning and actions from the course of any professional intervention need to be recorded and integrated into the person centred plan.

References

Kilbane J & Thompson J (2004) Never Ceasing Our Exploration: Understanding Person Centred Planning Learning Disability Practice Vol 7 No.3

Mount B (1987) Personal futures planning: finding directions for change. Unpublished PhD University of Georgia.

O'Brien J & Pearpoint J (2003) Person Centred Planning with MAPs and PATH: a workbook for facilitators, Inclusion press

Pearpoint J Forest M & O'Brien J (1993; 2nd Edition) PATH: A workbook for Planning Positive Possible Futures, Inclusion Press



Smull MW and Harrison SB (1992) Supporting people with severe reputations in the Community. Alexandria, VA, National Association of State Mental Retardation Program Directors.

