CHAPTER 1

Introduction: Planning the Trip

When you’re finished changing—you’re finished.
Benjamin Franklin

I. STATING THE CASE

What does it mean to be person-centered? What are recovery and resiliency? What is the role of the individual plan? These are critical questions challenging all health care providers at the dawn of the 21st century, and they are especially important for both providers and individuals seeking mental health and addictive disorders services. There is a growing consensus that current service delivery systems are failing to meet the needs of society as well as of individuals and families. Changing current practices in service planning can be a powerful strategy for effecting overall systems change. Ensuring that individuals and families are at the center of the process and directing their own plans and care should be an essential component of transformation in health care delivery. The challenges of daily work and the experience of providers in mental health and addictions stand in contrast to those concepts. Across all of the disciplines, providers frequently complain about feeling overwhelmed by a host of demands that keep them from their primary task of providing services. Consistently, the task of developing individual service plans is identified as the most clinically irrelevant, meaningless, frustrating, and mandatory administrative burden providers face. Training in this necessary task is often minimal and skill levels are low. Most direct care providers would likely groan in protest at the
mention of attending training on individual planning, or the necessity of having up-to-par clinical documentation.

How can the individual plan simultaneously be viewed as a key element of systems transformation and be so disdained by providers? Why was reform of current planning practice identified as a major goal in the President’s New Freedom Commission on Mental Health report? Is there any evidence that person-centered planning really improves the individual and family experience of care, promotes effectiveness, and enhances outcomes?

The History

The requirements and expectations for individual planning are long-standing and well established in regulation, payer requirements, and clinical standards. Despite this, auditors for licensure and certification, accreditation surveyors, and quality improvement staff consistently find that individual planning practices fall short of expectations. For example, CARF... The Rehabilitation Accreditation Commission, a leading standards-setting organization in the mental health and addictive disorders fields, has found that accreditation standards related to assessment and individual planning are cited in over 40% of accreditation surveys. Frequently identified problems include the lack of adequate assessment data, limited analysis or integration of information, uncertainty about goals and objectives, confusion about the differences between objectives and services, and inconsistent participation by the individual and the family receiving services.

While there is a general lack of study and evidence on the impact and value of individual planning, the practice may be so well accepted and expected simply because it has compelling face validity. In many sectors of our society, planning is a routine activity and a prerequisite for action. The quality of outcomes is often understood as a reflection of the integrity of the planning process and the quality of the plan itself. In general, the greater the complexity of a task that is undertaken, the greater the attention that is applied to the planning process.

Architecture is an example of a profession in which planning activities are essential to the practice, and the central role of the client is understood. Although the client may lack the professional and technical ability to design and construct a building, the architect understands that it is his or her role to make sure that the client’s needs, wishes, and dreams are included in the planning process. It is a given that the client’s expectations will be clearly visible in the final outcome.
It is not clear why the culture of the mental health and addictive disorders field has evolved so differently, but we can easily speculate. The tradition of psychiatry and mental health treatment derives from psychoanalytic practice, in which the emphasis was chiefly on process rather than outcome. As planning implies movement to an identified end point or goal, a process-driven approach did not necessitate nor lend itself well to planning. However, as systems of care became more organized, and as payers and oversight organizations began to demand more accountability for services and outcomes, there were increased expectations for coherent and visible planning. Yet some of the implicit values and expectations of the field and the traditions of practice were antithetical to the idea of planning. Moreover, the skill and motivation to teach and practice a planned approach to services did not exist.

In the addictive disorders field, the emphasis has been on personal and peer experience as a primary therapeutic tool and on sobriety as an outcome. The focus on proscribed group treatment and organized programs is not easily adapted to unique individual needs or concerns, and it diminishes the relevance of individual plans. Why emphasize individual planning when the goals and interventions have been effectively predetermined?

There is some limited research evidence that suggests that person-centered approaches to individual planning can make a difference. In a recent Arkansas study, the outcomes of a demonstration program involving Medicaid recipients with a range of disabilities were examined. The evaluation revealed that individuals receiving “consumer-directed” services reported higher levels of satisfaction and reported that an increased number of needs were fulfilled. These data are quite promising and strongly support the value and importance of actively involving individuals and families in decisions about services.

Although there is no strong evidence base demonstrating the value of a person-centered approach to individual planning, there is some “practice-based evidence” supporting the idea that planning is more than just a burdensome requirement. Liberman et al., for example, have put forward the notion that individual planning is the essential ingredient of care:

A key element in achieving favorable outcomes is the active involvement of clients, together with their families and other natural supporters, in the process of treatment planning, intervention, and evaluation of progress. To motivate clients to engage in treatment and adhere to comprehensive treatment regimens, the multidisciplinary team must help them identify personally meaningful goals
and demonstrate that collaborating with treatment providers can help them attain their goals. Because treatment and rehabilitation must be individualized, evidence-based interventions cannot be taken directly from controlled clinical trials and applied to all clients in the same way. Standardized treatments, both psychosocial and pharmacological, not only must be tailored to the individual client but also must be integrated with other services into a coherent package that changes as necessary with the phase of the disorder and the client’s goals as treatment proceeds.

In spite of this, experience shows that providers continue to see creation and utilization of an individual plan as an administrative and clinical burden, an unnecessary paperwork demand that takes time away from their “real work”—responding to the needs of individuals seeking services. The commonly held view is that there is little value in planning. In day-to-day practice, it is not uncommon to find that the plan is, in fact, not used to guide services. As a result, there is little evidence that an individual plan does, in fact, lead to better outcomes rather than simply waste time and paper.

Evidence-Based Practice

Evidence-based practice (EBP) is quickly becoming the de facto standard of care throughout all of health care. At the same time, there are special concerns about its application and use in the mental health and addictive disorders services field. Drake et al. have identified three principles of EBP as it applies to mental health and addictive disorders services. They suggest that EBP involves the following:

1. using the best available scientific evidence
2. individualizing the evidence for the unique needs and preferences of each person
3. a commitment to the ongoing expansion of evidence and clinical expertise

However, Drake et al. go on to say that “the movement toward fully informing patients and families about the evidence, engaging them in a process of informed, shared decision-making, and protecting their rights to self-determination has generally lagged in mental health and addictive disorders treatment. Accurate information regarding illness, treatment options, effectiveness, and risks is rarely offered; patients are often considered incompetent to make such decisions and subjected to involuntary treatments; and providers operate from an outmoded paternalistic model.”
The gap between the Liberman et al. and Drake et al. insights, experience, and common practice in the field today is nothing short of troubling. Why does it seem necessary to convince providers—individual practitioners or large organizations—that planning can be an efficient, useful, and beneficial, if not essential, part of the service delivery process?

It is worthwhile to note that many of the values and principles now invoked in general health care, as well as the mental health and addictive disorders field, have their roots in the tradition of rehabilitation sciences and practice. For example, the developmental disabilities field has been undergoing a quiet revolution over the past 10 to 15 years in which the role of the individual receiving services—along with the roles of the provider and family—has been radically transformed. Similar changes have also occurred in the provision of services to children with severe emotional disturbances (SED) and their families. Long ago it was understood that focusing on strengths, fostering independence, and promoting self-determination could help people to realize their hopes and dreams even in the face of substantial challenges. The critical change occurred with a shift in the relationship between the individual and the provider from a provider-driven focus on services to a person-centered emphasis on recovery, wellness, resilience, and community integration.

The Future

Regardless of how we might try to understand the past, the vision for the future is clear. The 2003 President’s New Freedom Commission on Mental Health report stated the following:

*Nearly every consumer of mental health services . . . expressed the need to fully participate in his or her plan for recovery.*

Although not stated explicitly, the report strongly implied that this has not always been the case in service delivery systems. Instead, “consumers” have often suffered the results of fragmented and complex systems that have not provided hope or the opportunity for recovery and control of their own lives. Yet self-determination is vitally important to mental health and well-being. The need for improvement in the development of individual plans as a key element in system reform points to the shortcomings of current practice. Success in creating person-centered individual plans is essential if we are to succeed in creating the service-delivery systems that people want and deserve for mental health and addictive disorders.
The President’s Commission created a new vision of the experience of receiving services. The roles of the individual and family must be made explicit: an individual plan should describe the services and supports an individual and family need in order to enhance resilience and achieve recovery.

Consumers’ needs and preferences should drive the type and mix of services provided, and should take into account the development, gender, and linguistic or cultural aspects of providing and receiving services. Providers should develop these customized plans in full partnership with consumers, while understanding changes in individual needs across the lifespan and the obligation to review treatment plans regularly.

Always a dynamic endeavor, the mental health and addictive disorders field is moving into a new era; there is growing awareness of the paradigm shift impacting all of health care. Interest in—if not demand for—quality and accountability, and the expectation that services are person-centered and based upon the current best evidence of effectiveness, continues to increase. At the same time, the language of recovery, and a new hopefulness about the value and effectiveness of services, is spreading among both providers and individuals receiving services. The importance of ensuring that services are customized and responsive to the unique needs and attributes of each individual and family is more critical than ever. This is consistent with the crucial need to be culturally competent in all phases of assessment and service provision. The development of individual plans creates an opportunity to group these sometimes competing demands and expectations. A well-crafted plan is the key to success in providing services.

The psychoanalytic/psychodynamic tradition of mental health practice placed an emphasis on issues of transference and power differentials in the relationship between the individual and the provider. The new emerging model for the mental health and addictions field clearly calls for re-examination and re-alignment of the treatment relationship; a cooperative partnership and effective alliance between the person served and the provider must prevail. Individuals and families present their unique strengths and resources, while the provider serves as a consultant who offers expertise with full respect for the dignity of the individual and family and recognition of the importance of their choices and preferences. The emphasis is not on exploration of the subterranean unconscious or on covert fault-finding, but rather on the clear articulation of the individual’s hopes and dreams coupled with an understanding of the challenges and barriers that must be overcome. The provider is transformed from a dominant and
controlling figure to a coach and facilitator helping people to develop skills and grow. This must be reflected in all phases of the process, especially in assessment and planning.

**Person-Centeredness**

Past practice can be understood, in part, as a result of basic assumptions or rules that structure the relationship between providers and individuals receiving services. Individual planning has typically followed a medical model or tradition with an emphasis on the problems and deficits of the individual. Treatment goals and objectives have been driven mostly by provider attitudes and assumptions. The focus has been on symptom reduction and the management of disability instead of life success. While there has been, at least in theory, some acknowledgment of the importance of input from the individual receiving services, development of individual plans, for the most part, have not been truly person-centered. Rather, the tendency has been to emphasize problems or diagnoses and to use prescribed responses in lieu of individualized goals, objectives, and service interventions.

The Institute of Medicine (IOM)’s 2001 landmark report, *Crossing the Quality Chasm: A New Health Care System for the 21st Century*, cited person-centeredness as one of the six primary aims of a transformed quality health care delivery system. Not only does the report identify core goals or domains, it also identifies 10 rules or principles that should guide and shape provider behavior. The report also contrasts the implicit and explicit rules that have guided and governed current practice with a proposed new set of guidelines. With its emphasis on person-centered care, the IOM provides a framework to support quality improvement strategies that help shift theory and policy into practice.

Sadly, good examples of person-centered approaches to individual planning in everyday mental health and addictive disorders practice are difficult to find. Many providers are at a loss as to how to achieve this vision. Given that individual planning is often viewed as an administrative requirement of limited clinical value, there is little appreciation of individual planning as an acquired skill, if not a clinical art. Although individual planning should be viewed as an essential clinical activity that is given high regard and supported with the necessary resources, all too frequently it is not. In some settings it is frankly devalued, and the connection between individual planning and outcomes has been lost. Frequently, the time allotted to assessment and plan
development is too limited. Merely filling in the blanks on an individual plan form does not satisfy the requirements for proper individual planning. Rather, an accurate understanding of the individual’s needs, strengths, and goals, as discovered through the relationship with the provider, should shape and form both the process and the product. The plan format should support rather than define the process. The development of the plan must be a learning experience for the individual as well as the provider and must act as the basic foundation of an effective helping relationship. In this notion of planning, creation of the plan is in itself a meaningful and valuable (and billable) service provided, not just another bureaucratic hurdle to be cleared.

**Education and Training**

A review of the literature on individual planning reveals, for the most part, a gap between emerging concepts of best practice and the training and education of the workforce: there seems to be little, if any, emphasis or focus on person-centered approaches. Individual planning is not often taught in either pre-degree education or professional training programs. Moreover, it is not at all uncommon for non-degree paraprofessionals to be given primary responsibility for the creation of individual plans. Typically, on-the-job training is limited at best. To the extent to which planning is taught, the emphasis is on didactic review of the formal elements of a plan. There is little if any focus on actually developing and practicing the skills in service settings. Feedback is provided only on rare occasions. This is not only a reflection of how individual planning is undervalued, it is also an explanation as to why practice is so slow to change.

This is but one example of many ways in which today’s education and training programs fail to adequately prepare the workforce for the real demands of providing services. Training and skill development must keep pace with changing expectations and demands. Resources to support these changes are clearly needed. If the vision of a recovery-oriented system is to be realized, individual planning needs to assume its rightful place in the curriculum and training experience for providers in the mental health and addictive disorders field.

**II. CREATING THE SOLUTION**

The relationship and interactions between individuals and providers must change if the aim of person-centered care is to be achieved. Without such
changes, the substantial gap between theory and practice, the difference between what should be and what is, will continue to grow. The solution lies in a commitment at all levels of the mental health and addiction service systems to assure that individual planning succeeds. Individual planning needs to become an essential, valued, and meaningful clinical activity, rather than an administrative requirement.

A New Framework

A new framework and perspective are needed to understand the importance of the individual plan. A person-centered approach offers an exciting, dynamic, and fresh response to the challenges of individual planning for mental health and addictive disorders services; the recipient of services must be the driving force in the development of a plan that articulates a vision of recovery and wellness for each individual and family. Ideally, individual planning should be the following:

- an opportunity for creative thinking
- a successful strategy for managing complexity
- an opportunity to build an alliance with the individual receiving services
- a mechanism for acknowledging the hopes and dreams as well as the strengths and resources of each individual and family
- a means for assuring the provision of person-centered effective (and, whenever possible, evidence-based) services
- a process for creating a guide for the journey to recovery of each individual and family

Such a framework creates a positive alternative to current practice that is about more than just changing procedures, forms, or requirements. Ultimately, it is about changing the very model by which we understand the needs of persons seeking help and the response of providers. Individual planning must be a manageable task for providers, a meaningful process for individuals receiving services, and a resource tool to ensure optimal outcomes, while satisfying the expectations and requirements for payers and oversight authorities.

According to the 2003 President’s Commission report,¹ individual plans are viewed as

...a genuine opportunity to construct and maintain meaningful, productive, and healing partnerships. The goals of these partnerships include:
improving service coordination
making informed choices that will lead to improved individual outcomes
ultimately achieving and sustaining recovery

The Map

An individual plan has been compared to a road map that displays the path or direction of the journey for each individual and family. Using this metaphor, the goal of services can be considered the destination consistent with their vision of recovery. But, as with most journeys, there are many possible routes, barriers, and obstacles that must be overcome or avoided, unanticipated detours and side trips to distract or deter, and mid-course corrections to be made. In a long journey, we often make stops along the way. The longer the journey, the more likely the route to be indirect and filled with detours and midpoints.

All too often the journey is initiated without a clear destination or route. This is similar to stating that we need to get there without ever really saying where there is. We frequently get behind the wheel simply because it seems important to get going but without knowing what direction to head in or the next point along the way. Providing mental health and addictive disorders service is not as simple as going to the convenience store around the corner—a trip that is routine and admittedly needs little planning. Rather it is created anew for each individual and family based upon their unique needs and preferences. It is surprising how often services are initiated without this kind of understanding or plan.

Like a road map, a plan displays the course. Figure 1.1 provides a simple yet effective image of this idea. Sometimes the final destination seems to be remote and unattainable. By division into a plan or itinerary with a series of intermediate destinations, a potentially overwhelming journey is broken into manageable steps. This is helpful for the traveler—the individual receiving services—and for the provider serving as “coachman” or pilot.

![FIGURE 1.1](image-url)
In this diagram, \( A \) is the starting point—derived from the assessment and based upon an understanding of the individual’s needs; \( E \) is the end point—the goal of the person in seeking services, the end of the journey. The important question to ask and understand is this: why is the individual not able to simply move directly from \( A \) to \( E \)? Those reasons are oftentimes identified as barriers or challenges and become the focus of service interventions. In an individual plan, points \( B, C, \) and \( D \) are the equivalent of objectives that work to remove or resolve the barriers. The arrows from \( A \) to \( B \) to \( C \) and so on represent the services and activities that help the individual move along in his or her journey.

This diagram should not be taken too literally—it does not mean to imply that the process is always sequential and linear. Sometimes several objectives may be addressed simultaneously; at other times there is doubling back; and there are occasions when a change in plans or route will require mid-course corrections. But this kind of map makes the process of recovery and meeting goals very clear to all those involved. Instead of being a mysterious and obscure process, it will be one that is apparent and clear to the provider as well as the individual and family seeking services.

Developing the skill and discipline to create these kinds of maps—either figuratively or literally—can do a tremendous amount to change current practice, the experience of individuals, and the outcome when applied to the needs of individuals and families. This is a very practical and easy way to approach individual planning. With a shared understanding and clarity, both the planning process and recovery itself proceed more rapidly and with greater efficacy.

III. MAKING IT HAPPEN

A simple, straightforward, and practical approach to translating the concepts of person-centered care and individual planning into routine practice is clearly needed. This approach should apply to all providers responsible for planning and providing services, ranging from solo practitioners to multi-disciplinary teams. It involves a learnable set of skills and techniques that can substantially change both the experience of care and the outcome when applied to the needs of individuals and families. This book is intended to help providers gain the knowledge and skills required to make necessary changes in their practice. It is also intended to inform policymakers and administrators of systems changes that should occur to support providers in their efforts.
Systems Change

The importance of changing the world one individual and one provider at a time cannot be underestimated. As demonstrated by Gladwell in *The Tipping Point,* small changes can often have large effects. System transformation can, and oftentimes does, occur in small ways—the whole can become greater than the sum of its parts. Ensuring that providers have the necessary knowledge, skills, and abilities to succeed in a person-centered approach is crucial to changing service-delivery systems, changing the experience of individuals and families, and making a vision of recovery and resilience real. Each reader, each student, and each provider has the potential to change practice. This is reflective of the hope, promise, and power that a person-centered model provides for individuals. Changes in treatment models, assessment practices, and the relationships between providers and individuals and families seeking services *will* make a difference.

Attention must also be paid to the larger practice environment. It would be disingenuous not to acknowledge that the changes required to truly succeed in person-centered planning often go far beyond clinical routines and individual care. Changes in systems of care are ultimately part of changing the individual planning process. It is not about merely changing administrative requirements, creating new forms, or successfully passing an audit or survey; it is about the clear articulation of values and fundamental changes in practice and the experience of providers, individuals, and families.

The burden of service systems change is often disproportionately borne by direct-care staff. However, to truly succeed, change strategies require endorsement and support from all levels of a service organization—especially administration and leadership, who need to ensure that the resources and time necessary to affect a changeover are, in fact, available.

Moving Forward

As a practical step, all those involved in providing services should conduct a fearless inventory of current practices, clinical as well as administrative. Being honest about current practice is an essential first step in identifying needs and strategies for change. It is an often-observed irony that a field dedicated to helping others make change so often finds itself bound by the past and unable to move forward.
A useful approach can be a SWOT analysis—a careful evaluation of

- Strengths
- Weaknesses
- Opportunities
- Threats

Strengths should include recognition of current practices that should be preserved. Weaknesses should identify those elements of current practice that keep planning and services from being person-centered. Opportunities are those circumstances that allow for and foster necessary change. Threats are the resistances and barriers—both internal and external—that must be overcome.

Ultimately, we are left with a series of questions. How can the principles of person-centered care be adopted within the realities of the current system? What are the barriers and impediments to making necessary changes? How can each provider change his or her own practice and the larger system in which he or she works?

There will be times when the wisdom of the Serenity Prayer needs to prevail:

> God, give me the serenity to accept things that cannot be changed; the courage to change things that must be changed; and the wisdom to distinguish one from the other.

Hopefully the following chapters will provide the information required to promote the new attitudes, skills, knowledge, and abilities needed to support all those who travel down the pathway of change.

REFERENCES

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