

Challenges to the Systematic Adoption of Person-Centered Planning

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Previous reviews of person-centered planning indicate a need for more comprehensive training to promote skill generalization. A three-phase training intervention was implemented with 22 planning teams for people with a disability in the Detroit metropolitan area. Independent observers rated team meetings posttraining on consumer orientation regarding three components of person-centered planning: meeting structure, interpersonal skills, and planning strategies. Analyses of ratings indicated that structural skills were significantly more readily incorporated than either interpersonal or strategic skills. Exploratory analyses indicated that the number of family members, friends, and advocates at the planning meetings was positively correlated with planning strategies, while living arrangements were negatively correlated with planning strategies. Implications for the acquisition and generalization of more complex planning skills are discussed.

Keywords: *person-centered; consumer-directed; complexity; feedback; personal futures*

The advent and incorporation of person-centered planning (PCP) followed an extended period in which disability advocates and families believed that the current formal support system did not maximize the potential of those individuals with disabilities whom it served. They sought to support the social work perspective of *person in environment* by creating a process that would build on the interests and personal commitments of friends, families, and supportive professionals; empower people with disabilities and their family members in their goal seeking; and organize these people and their divergent views into a holistic plan of action in support of the person with disabilities (O'Brien, O'Brien, & Mount, 1997). In

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theory, this consumer-based planning method decentralizes the system by shifting the philosophical and practical responsibility for service planning from human service professionals to people with disabilities and their families.

Given the characteristics of the intervention focusing on the individual, the availability of feedback to support and modify decisions, and the resulting self-organizing behavior, we used a complexity approach when designing the project (Patton, 2002; Wolf-Branigin, 2006). The project used both positive and negative feedback to focus on decision-making issues. Positive feedback used information outside its system, whereas negative feedback kept the teams in equilibrium (Proehl, 2001). PCP strategies additionally need to confront the loss of energy from limited external information feeding back into the decision-making process (e.g., not knowing their clientele's strengths) and represent the use of information for continued improvement (Johnson, 2002; Shafritz & Ott, 1987).

Numerous training programs have sought to establish this service philosophy within these complex systems and create a practice that invites support, creates connections, envisions possibilities, solves problems, and celebrates progress, consistent with the philosophy driving PCP (Turnbull, Turnbull, & Blue-Banning, 1994). However, indications show that the practice lags behind the demand for implementing a new PCP service. Specifically, researchers have found that brief (6 to 8 hour) didactic training programs are insufficient to promote the generalization of PCP-related skills (Hagner, Helm, & Butterworth, 1996; Heller, Factor, Sterns, & Sutton, 1996). Researchers found that people with disabilities were rarely meeting facilitators or were not speaking freely at their meetings, that decisions about services were not different from traditional service plans, and that family members were frustrated by a lack of qualitative change in the meetings' atmosphere. These findings have led researchers to caution against the widespread adoption of PCP without further consideration of training methodology and outcomes. Researchers suggest extending the learning period and augmenting didactic instruction with role-playing, mentoring, and sustained technical assistance (Hagner et al., 1996; Heller et al., 1996; LeRoy, 2000) to support people with disabilities or family members as they self-organize (Rhee, 2000).

The current study evaluated a training program designed to address these concerns by adopting a sustained learning format and incorporating components that are based in adult learning theory (Wlodkowski, 1999). It was expected that the use of an extended training program grounded in learning theory will lead to greater mastery of these techniques and a subsequent increase in using PCP skills in natural settings (i.e., planning meetings). However, knowledge or mastery may not be the only factor driving the implementation of PCP techniques. Evidence from the fields of social work, psychology, and education indicates that aspects of service delivery vary as a function of client demographics. For instance, individuals from lower socioeconomic status (SES) or minority ethnic groups may receive services that differ in type and quality from services received by individuals from higher-SES categories or majority group ethnicity (Ford, 1998; Swartz et al.,

1998; Wallace, 1991). Actual and perceived resources of people with disabilities may be related to their standing on a number of demographic characteristics; a person's standing on various demographic measures may influence the actions of team members within PCP meetings. We have noted the dearth of research regarding the interplay of ethnicity and PCP (Blue-Banning, Turnbull, & Pereira, 2000). Literature from related service fields and the call for research on this topic from within the disability field indicate that a variety of demographic characteristics may be associated with PCP.

Two research questions guided the evaluation of this intervention. One, are specific types of skills involved in PCP meetings easier to demonstrate than other types of skills? Two, do significant relationships exist between the demographic characteristics of people with disabilities and the ratings of team skills?

Method

Participants

Participants in the intervention program consisted of 160 people associated with five county-funded social service agencies in the Detroit metropolitan area. These agencies ranged in size with respect to the number of people with disabilities served (200 to 1,800 people), budget (\$1.5 to \$140 million), number of staff supporting people with disabilities (10 to 300 staff), and geographic location (urban, suburban, and rural). Among the 160 participants were 22 people with disabilities, 43 family members and friends, and 95 professional staff. Table 1 presents the characteristics of the people with disabilities in this program.

Table 1 Sample Demographic Characteristics

Characteristic	Percent Frequency
Gender	
Male	54.5%
Female	45.5%
Race/Ethnicity	
European American	86.4%
African American	13.6%
Disability Type	
Intellectual disability	90.9%
Psychiatric disability	9.1%
Level of Support	
Continuous support	63.6%
Partial support	9.1%
Minimal support	27.3%
Living Arrangement	
Three or fewer people	31.8%
Four to eleven people	54.5%
Twelve or more people	13.6%

A single measure assessed a variety of client demographics, including age, gender, race/ethnicity, type of disability, level of support received, and current living arrangement. People with intellectual disability and with serious or persistent mental illness used the planning teams. Study participants represented a variety of living arrangements (group homes, semi-independent living, living with family members, and living independently) and received differing levels of support (continuous support, partial support, and minimal support). The mean age of participants in the sample was 38.6 years. Participants had an average of nearly two ($M = 1.8$) family members, friends, or advocates present at their PCP meeting. Table 1 lists additional demographic characteristics of the sample.

Procedure

The 160 participants were organized into 22 teams, each of which was centered on a person with a disability. Participants were recruited in three stages. Support coordinators were recruited by their supervisors based on their interest in learning PCP strategies. Individual clients were then selected by their support coordinators based on their perceived need for the use of PCP strategies. Family members, friends, and professionals were recruited by the individual client; if the client was unable to generate a list of people for the team, the support coordinator suggested people for the client to consider inviting. Team size ranged from 3 to 18 people. At minimum, each team consisted of the person with a disability, a family member or friend, or both, and a support coordinator. Additional members on some teams included direct-support professionals, psychologists, medical personnel, speech therapists, and employment specialists. Additional team members were identified and assigned by support coordinators based on the unique needs of the target person; the inclusion of team members chosen by the consumer was assessed as part of the intervention “participants” indicator (see table 2). Teams participated in the intervention training as units, receiving all training and technical assistance together.

Table 2 Scores on Person-Centered Planning Components and Associated Skills

Planning Component	Skill	Team Scores by Implementation Level ^a				Index Mean
		FP	PP	NP	Total	
Meeting Structure	Participants	33	20	1	54	
	Agenda	57	2	2	61	
	Location	66	0	0	66	
	Time	66	0	0	66	
	Facilitation	45	12	1	58	61
Interpersonal Skills	Culture	15	30	2	47	
	Self-Assess.	33	14	4	51	49
Planning Strategies	Supports	12	18	9	39	
	Consistency	24	16	6	46	
	Remedies	15	18	8	41	42

^aImplementation ratings: fully present (FP), 3 points; partially present (PP), 2 points; negligibly present (NP), 1 point

A three-phase intervention program was designed to support the demonstration of PCP skills consistent with the McGill Action Planning System PCP perspective (Vandercook, York, & Forest, 1989). Phase 1 of the program was a didactic curriculum created to promote awareness regarding PCP and its implementation. The curriculum was broadly consistent with available curriculum in its focus on the person and on respecting the person, the person learning through shared actions of those committed to helping, viewing ongoing support as reflective of the person's commitment and courage, and the ultimate goal of changing common patterns of community life (Butterworth, Hagner, Hikkinen, DeMello, & McDonough, 1993; Mount, 1987; O'Brien, 1987; Vandercook, York, & Forest, 1989). Specific modules included an overview of the philosophy and historical development of PCP, specific planning tools for use in PCP, the nature of the planning process, and creating desired planning outcomes (Wolf-Branigin, 1999). Curriculum delivery expanded on our formats to include a variety of instructional strategies: lectures, videotapes of planned meetings, testimonials by individuals who had implemented planning tools and processes, and role-play exercises.

The curriculum also was explicitly based on research regarding enhancing learning acquisition, namely instructional design theory (Hunter, 1994) and adult learning theory (Wlodkowski, 1999). Consistent with instructional design theory, the curriculum emphasized establishing an overall outlook and providing new content, guided practice, and an opportunity for independent performance. Tenets of adult learning theory that were infused in the program included a focus on relevance, self-initiated learning formats, simple and accessible information, mechanisms for individual supports, and learning transfers. Groups typically attended two to three curriculum sessions. These sessions were self-paced based on the learning needs of group members, and each session typically lasted between one and two hours. The purpose of this first phase in the intervention program was to educate participants about the basic components of PCP and to create a framework for future implementation.

Phase 2 of the program was a guided practice using a preplanning meeting for an identified consumer as the practice exercise. In this phase, team members practiced the skills identified in phase 1 under the tutelage and guidance of an external facilitator. The facilitator was skilled in PCP and was well versed in the processes and procedures of the mental health service system (the same facilitator observed all preplanning and planning meetings). Teams were provided immediate feedback and were given opportunities and strategies to practice new skills during the meeting. The preplanning practice session typically lasted two to three hours. Additionally, each team member was provided with written feedback (a checklist) about that person's performance immediately following the guided practice. Independent of the learning component of the preplanning meeting, the specific goal of the preplanning session was to organize the planning meeting. Consumers' preferences regarding the planning meeting agenda, which participants to include, and the meeting time and place were identified, and then evaluated for implementation in the actual planning meeting.

Phase 3 of the program was an independent practice using the planning meeting as the practice activity. This practice typically took place approximately three weeks after the practice preplanning meeting. In this phase, team members were expected to use the skills that were identified in phase 1 and practiced with guidance in phase 2. Team members used the checklist to assist them in implementation. The external facilitator observed each team meeting, providing prompts to improve PCP skills throughout the meeting. This session typically lasted between two and three hours.

Measures

To examine the effectiveness of the training program on three components of PCP, post-training team meetings were rated by independent observers on the teams' ability to incorporate structural, interpersonal, and strategic skills into the planning process. A PCP utilization scale, developed for this study, was used as the rating instrument. In this sample, the full-scale reliability was $\alpha = 0.85$, indicating good internal consistency. This instrument uses a three-point scale (3=*full*; 2=*partial*; 1=*negligible*) to determine team skills within each planning component. Training staff videotaped each planning meeting ($n = 22$). Subsequently, each team meeting was rated by two independent observers, using the 3-point scale to rate the use of PCP skills across each of the three planning components (meeting structure, interpersonal skills, and planning strategies).

Each component of the PCP utilization scale contains a number of indicators to rate the degree to which the meeting reflects PCP principles. The meeting structure component is composed of five indicators encompassing participants, agenda, location, time, and facilitation. The interpersonal skills component is composed of two indicators: environment and culture, and assessing the process. Last, the systemic component is composed of three indicators: selection of supports; supports in relation to the person's vision, choice, and community; and remedies for lack of supports. The criterion variable for this study was the relative presence of each planning component.

The interrater reliability (kappa) across all observations was .96. Kappa was computed using each rater's score on each of the ten indicators of PCP from the PCP utilization scale (ten indicators by 22 groups by two raters). Disagreement among raters was resolved by discussion between raters until consensus was reached. For each skill, the total possible score was 66 (22 teams times 3 points). The teams' scores across each skill were summed, resulting in a total for that skill. Because of the varying number of skills within each component, the planning component total score was divided by the number of skills rated for that component (see table 2).

Results

To answer the first research question on team skill demonstration, a one-way analysis of variance with a Bonferroni correction was used when comparing the means on the planning component indices. This conservative correction sets the

alpha significance level for tests of the null hypothesis at .05 divided by the total number of comparisons (i.e., .05 divided by 3 = .016). To answer the second question on the influence of demographic characteristics on skill demonstration, correlation coefficients between the demographic characteristics of the target person and the indices were calculated. Because of the number of correlations generated in the correlation matrix, the use of a Bonferroni correction would have resulted, in our estimation, in an overly conservative estimate of the significance of particular relationships (i.e., .05 divided by 18 = .003). However, because such a correction was not used, the significance of the correlation coefficients should be interpreted with caution.

Team Skill Demonstration

Table 2 presents the teams' scores for the three planning components, skill scores within those components, and the means for each component. Because the distribution of scores did not violate assumptions of normality (skew and kurtosis values were each less than 2), the ANOVA procedure with planned comparisons was employed to test group differences. There was a significant difference between and within scores on the three planning components ($F = 23.90, p < .001$). Because the omnibus test was significant, post hoc comparisons were carried out. In post hoc comparisons using the Bonferroni correction, all means were significantly different from each other. Specifically, the mean meeting structure score was significantly higher than the mean planning strategies score ($F = 19.89, p < .01$). The mean meeting structure score was also higher than the mean interpersonal skills score ($F = 10.52, p < .01$). The mean interpersonal skills score was significantly higher than the mean planning strategies score ($F = 9.38, p < .01$). Overall, teams' scores on the identified skills were highest for meeting structure, followed by interpersonal skills, and finally planning strategies.

Demographic Characteristics and Skill Demonstration

Two of the six demographic variables identified in this study were significantly correlated with mean scores on planning components. Specifically, the number of client friends, family members, and advocates present was positively related to teams' scores on the planning strategies component ($r = .46, p < .05$). The target person's living arrangement was negatively correlated with team score on the planning strategies component ($r = -.44, p < .05$), indicating that teams meeting to plan for people who lived in group homes with more than four peers had lower scores on the planning strategies component. The age of the target person with disabilities, sex of the target person, the level of support for the person, and the target person's race were not significantly associated with team skill demonstration.

Discussion

Several factors may be influencing these findings, including the structure of the teams' organizations, a lack of ability or practice among team members, or a

lack of sufficient exposure and practice to such skills in training. Nevertheless, these findings indicate that the skills for implementing PCP is a complex process. Teams were able to use and incorporate structural skills, yet they had more difficulty discussing and implementing creative, person- and culture-specific resources and remedies in the context of a planning meeting. These, in fact, may be the most critical tasks at these meetings because they speak to enabling the individual consumer to live a supported, choice-driven daily life.

Training must address critical thinking skills regarding enlisting nontraditional supports, and thinking outside of discipline-specific or institutionally available solutions for issues that arise among people with disabilities. To do this, it may be critical for training to involve additional and nontraditional community and advocacy group members who can both interact with team members and expose them to additional modes of thinking about—and enlisting support for—the clients to remedy issues that are raised. In sum, curricula for personnel development must address how to think, as well as what to think, to be successful.

The preliminary findings regarding the influence of demographic characteristics on team learning provide a possible direction for future research and personnel development. From the findings of this study it appears that family, friend, or advocate presence at team meetings is important to creative problem solving (planning strategies) within the team. This finding is consistent with the long-held belief among families and empowerment advocates that their advocacy is essential to achieving meaningful outcomes for individuals with disabilities.

The second demographic relationship that was found between living arrangements and planning strategies was equally interesting. In this finding, teams who were planning with people who lived in larger group homes were rated as using fewer PCP skills. The type of living arrangement may be related to a more challenging level of disability or lack of family support. These demographic findings do hint at the importance and difficulty in building creative and sustained teams around people with the more challenging needs. For two reasons, caution is in order in interpreting this study's observed correlations. First, the relationships between six demographic characteristics and three components of PCP were examined; only two significant associations were found. Alpha inflation imposed by the number of correlations observed indicates that one of these findings would be expected almost entirely by chance. Second, as with all correlation data, the simple presence of a relationship does not specify the direction or causal path of the relationship, or whether the relationship is the result of a third, unobserved factor. Research replicating and expanding the findings presented here are necessary before drawing conclusions.

PCP is dynamic and responsive to individual needs. It extends beyond the context of a single meeting or the decisions of a single team of individuals. Careful process and outcome research examining effects of both the demonstration of PCP skills in controlled settings (such as the PCP meeting) and in more natural settings (such as in group homes and assisted living environments) is an area of research that has been largely untapped. Nevertheless, the current study had

several strengths. Training and PCP meetings took place in a real world setting, maximizing the study's realism. Intervention followed from theoretically defined rationale, both in the content of the intervention (PCP) and the method of implementation (training based on learning theory to maximize the opportunity for skill demonstration).

The study had limitations. Foremost was the varied size and composition of the teams. This raises important questions as to whether smaller teams are more responsive to intervention than larger teams, whether the process of decision making differs by group size and professional composition, and other issues. The small number of teams studied here prevents the investigation of whether these factors had significant effects on skill demonstration. The brief time in which observation was carried out (the course of two meetings) raises questions as to whether skills demonstrated at one time are present when observation ceases, or whether they are left behind as new, evolving structural restraints are introduced in the form of other system changes, such as the introduction of managed care principles. Last, there was no assessment as to whether PCP skills demonstrated in planning team meetings resulted in greater consumer self-determination outside of the planning meeting. Given these limitations, the research presented in this article represents a small step forward in the effort toward progress in understanding and implementing self-determination for all people. Future research is vital in furthering theory and in identifying best practices for effectively furthering self-determination for people with disabilities.

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