Conceptualizing Supports and the Support Needs of People With Intellectual Disability

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This is the third in a series of perspective articles (Schalock et al., 2007; Wehmeyer et al., 2008) from the Terminology and Classification Committee of the American Association on Intellectual and Developmental Disabilities (AAIDD). The purpose of these articles is to share our thoughts on critical issues associated with terminology, definition, and classification in the field of intellectual disability and to seek input from the field as we prepare the 11th edition of AAIDD's *Diagnosis, Classification, and System of Supports Manual* (the working title). In the first article (Schalock et al., 2007), we explained the reasons for shifting from the term *mental retardation* to *intellectual disability*. Although the two terms cover the same population of individuals, we concluded that intellectual disability was the better term because it

(a) reflects the changed construct of disability described by the AAIDD and WHO [World Health Organization], (b) aligns better with current professional practices that focus on functional behaviors and contextual factors, (c) provides a logical basis for individualized supports provision due to its basis in a social-ecological framework, (d) is less offensive to persons with the disability, and (e) is more consistent with international terminology" (Schalock et al., 2007, p. 118).

In the second article (Wehmeyer et al., 2008), we distinguished between operational and constitutive definitions of intellectual disability and discussed their application to understanding the construct underlying the term intellectual disability. The primary function of an operational definition is to assure consistency among diagnosticians by setting parameters for observing and recording evidence of the disability (Wehmeyer et

al., 2008). We supported the continued use of the operational definition of intellectual disability (formerly mental retardation) from the 2002 manual (Luckasson et al., p. 1): "[Intellectual disability is] characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18."

The operational variables included in AAIDD definitions have not changed significantly in 50 years (Schalock et al., 2007). Operational criteria for diagnosis have been generally consistent for the past 35 years, when the IQ criterion was changed from one to two standard deviations (Grossman, 1973). However, the construct underlying the term intellectual disability (and, thus, the constitutive definition of intellectual disability) has changed significantly over the last 2 decades due to the impact of the social–ecological model of disability (Institute of Medicine, 1991; Luckasson et al., 1992, 2002; WHO, 2001). In this model, intellectual disability is understood as a multidimensional state of human functioning in relation to environmental demands.

This article focuses on supports and support needs, as they pertain to persons with intellectual disability, and closely related developmental disabilities. Definitions of each are as follows:

- "*Supports* are resources and strategies that aim to promote the development, education, interests, and personal well-being of a person and that enhance individual functioning" (Luckasson et al., 2002, p. 151).
- *Support needs* is a psychological construct referring to the pattern and intensity of supports necessary for a person to participate in activities linked with normative human functioning.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

This article is organized into five sections: (a) distinguishing the concept of supports from the construct of support needs; (b) conceptualizing supports as the bridge between ''*what is*'' (i.e., a state of incongruence due to a mismatch between personal competency and environmental demands) and ''*what can be*'' (a life with meaningful activities and positive personal outcomes); (c) considering support needs within a model of human functioning; (d) recommending an assessment and planning process to guide planning teams (and organizations) when developing and implementing individualized support plans; and (e) comparing and contrasting support planning with other planning approaches in the field of intellectual disability and related developmental disabilities.

Supports and Support Needs

Supports are resources and strategies that enhance human functioning (Luckasson et al., 2002). Although this definition was developed with people with intellectual disability in mind, it is clear that everyone uses supports. The 17th-century theologian John Donne wrote, "No man is an island" (as cited in Jokinen, 2006) to convey the fundamental truth that human beings do not thrive in isolation from others. We live in an interdependent world and everyone needs a variety of supports to function on a daily basis. However, the types and intensity of supports needed by people with intellectual disability are different from those needed by most other people.
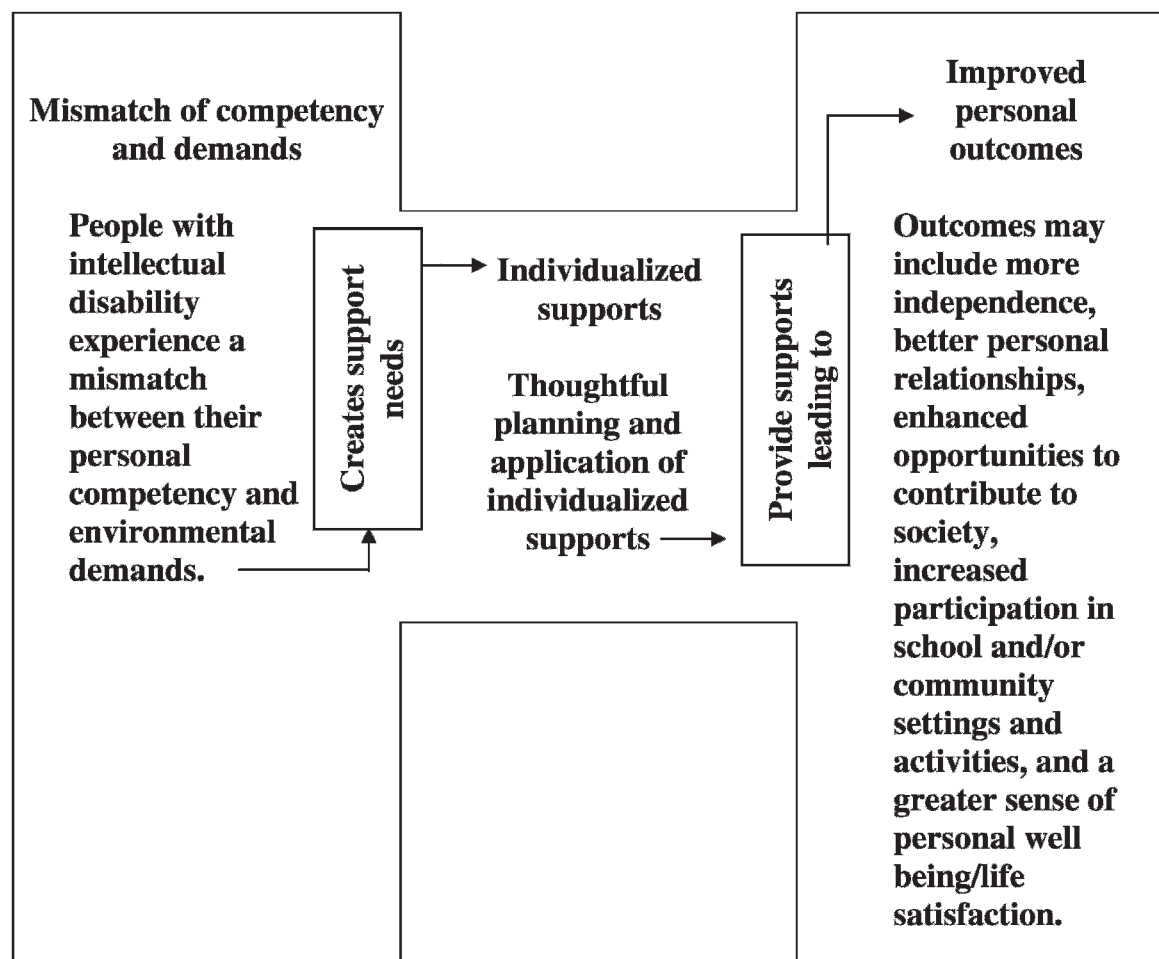
Support needs, as we use it and position it within our understanding of intellectual disability, is a psychological construct referring to the pattern and intensity of support a person requires to participate in activities associated with normative human functioning. Multiple psychological constructs have been identified regarding both "states" and "traits" of humans. For example, anxiety, intelligence, happiness, and morality are all psychological constructs on which there are extreme points (e.g., euphoric vs. depressed) as well as many points in between, just like the construct of support needs. The support needs construct is based on the premise that human functioning is influenced by the extent of congruence between individual capacity and the environments in which that individual is expected to function. Addressing this congruence (i.e., ensuring person–environment fit) involves understanding the multiple factors that shape human performance, determining the profile and intensity of needed supports for a particular person, and providing the supports necessary to enhance human functioning.

The concept of *need* generally refers to a condition characterized by the absence of some requisite necessity. Within professional literature pertaining to health, the concept of need has traditionally referred to a condition characterized as "a disturbance in health and well-being" (Donabedian, 1973, p. 62). Within psychology, need is defined as "what is necessary for an organism's health and well being" (Harré & Lamb, 1988, p. 409) or a motivated state resulting from "a feeling of unfulfillment or deprivation in the biological system…evidenced by a drive to complete such a lack" (Colman, 2001, p. 631). As discussed by Thompson and colleagues (Thompson et al., 2002, 2004b), support needs are identified on the basis of input from the individual and other respondents. Global (i.e., overall) support needs can be understood in at least four distinct ways:

- *Normative need* or *objective need*: what a professional, expert, or social scientist defines as need in a given situation on the basis of an individualized assessment; a professional standard is compared with an individual's actual situation.
- *Felt need:* what the person wants or perceives as needed. This felt need for support can be obtained by asking the person what is needed.
- *Expressed need or demand*: a felt need that has turned into action. An expressed need for support may be a person requesting services.
- *Comparative need*: obtained by studying the characteristics of a population in receipt of a particular service. If there are people with the same characteristics not receiving service, they are "in need" of that service (Bradshaw, 1972; Van Bilzen, 2007).

We do not see a person's support needs as necessarily or exclusively reflecting a disturbance of human capacity (although disability certainly may result in a disturbance of human capacity); rather, the person's support needs reflect a limitation in human functioning as a result of either personal capacity or the context in which the person is functioning. Like other psychological constructs, the level of a person's support needs (like the level of a

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

Figure 1 Supports model.

person's motivation or shyness) is inferred and not directly observable. Moreover, an individual's support needs can be measured with varying degrees of accuracy by self-report and other report indicators of the intensity of support needs, such as is accomplished using the *Supports Intensity Scale* (Thompson et al., 2004a). To be clear, we see the support needs construct as reflecting more of an enduring characteristic of the person than simply a point-in-time description of the need for a particular type of support. People with intellectual disability are people who require the provision of ongoing, extraordinary (when compared with their nondisabled peers) patterns of support. Providing supports to people with intellectual disability enables their functioning in typical life activities in mainstream settings but does not eliminate the possibility that they will continue to need ongoing

supports. Put another way, if supports were removed, people with intellectual disability would not be able to function as successfully in typical activities and settings.

Supports: A Bridge Between "What Is" and "What Can Be"

A major implication of conceptualizing intellectual disability as a state of functioning instead of an inherent trait is that the person–environment mismatch is addressed. The focus is not solely on "fixing" the individual. This implication is shown in the supports model depicted in Figure 1. First, in this model, a mismatch between personal competency and environmental demands results in support needs that necessitate particular types and

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

intensities of individualized supports. Second, to the extent that these individualized supports are based on thoughtful planning and application, it is more likely that they will lead to improved human functioning and personal outcomes. As a bridge between "what is" and "what can be," the focus of educational and habilitation service systems shift to understanding people by their types and intensity of support needs instead of by their deficits. Although there is a reciprocal relationship between impairments and support needs in that greater personal limitations will almost always be associated with more intense support needs, a focus on reducing the mismatch between peoples' competencies and the environmental requirements where they function, rather than a focus on deficits, is more likely to reveal supports that enhance personal outcomes.

Figure 1 also illustrates two related global functions of individualized supports. The first function addresses the discrepancy between what a person is not able to do in different settings and activities and what changes–additions make that person's participation possible (e.g., promote human functioning). The second function of individualized supports focuses on enhancing personal outcomes by improving human functioning. Both functions need to be thoughtfully aligned.

Sometimes, planning teams focus solely on what individuals can and cannot do in a variety of settings and, thus, arrange supports to empower individuals to do more things. Although this type of planning may lead to an individual's improved functioning, that individual's personal outcomes may not be significantly enhanced. Such planning may expand the activities available to the person and may even increase participation by the individual, but if these activities are not based on the person's preferences and priorities, any improvement in personal outcomes may be negligible. Equally misguided would be a focus only on personal priorities and preferences without thoughtfully considering the gaps between a person's competence and his or her environmental demands. This approach to planning increases the risk that supports will be arbitrarily applied. For example, an individual may want to live in his or her own home in the community, but may need some support that peers without disabilities will not need due to specific safety related concerns. A "throw in everything plus the kitchen sink" approach to supporting the individual might involve supplying staff inside the home 24 hr a day, 7 days a week who do all the cooking, cleaning, transporting, and so forth. Such excessive support provisions will not enhance the life experiences of the individual and will certainly result in wasting finite resources. Therefore, it is important to thoughtfully analyze and align both personal priorities and areas of need when planning and delivering supports.

Supports and Human Performance

Supports are resources and strategies that enhance human functioning (Luckasson et al., 2002). Human functioning is enhanced when the person–environmental mismatch is reduced and personal outcomes are improved. Because human functioning is multidimensional, considering supports as a means to improve human functioning provides a structure for thinking about more specific functions of support provision.

Human performance technology (HPT) theorists posit that human functioning results from interactions between a person's behavior and his or her environment (Gilbert, 1978). For example, Wile (1996), who created an HPT model by synthesizing five other leading HPT models, suggested that human performance is influenced by the following seven elements: organizational systems, incentives, cognitive supports, tools, physical environment, skills–knowledge, and inherent ability. Examples of support that correspond to each of Wile's human performance elements are listed in Table 1. Wile noted that some of these elements are external to the person (Elements 1–5), whereas others (Elements 6–7) are internal.

Wile's (1996) seven elements are interdependent in terms of human performance and, more accurately, should be thought of as being cumulative. Therefore, from a supports perspective, solving a problem for any single element may be of limited value if problems with the other elements are ignored. As Edyburn (2000) pointed out when relating Wile's model to decision making in the area of assistive technology, getting a tool (Element 4) to improve performance would have a negligible impact if the person lacked motivation (Element 2) to be productive on the task for which the tool was to be used. Based on Wile's HTP model, supports should not be delivered to address discrete life activities or separate events, or be based on specific support individuals (e.g., job coaches, teachers). Rather, *systems of support* should be conceptualized where multiple aspects of human performance are considered in regard to multiple settings.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

Table 1 Examples of Supports That Correspond to Elements in Wile's (1996) Model of Human Performance Technology (HPT)

HPT element	Example
1. Organizational systems	Passing laws and public policies offering incentives to hire persons with disabilities. Establishing industry standards for constructing and remodeling home and community settings based on principles of universal design.
2. Incentives	Developing a behavioral contract involving positive reinforcement of behaviors to keep one's house clean and sanitary. Increasing opportunities to engage in preferred activities as the result of earning more money because of good performance on a job.
3. Cognitive supports	Reminders from a coworker to transition to different work activities.
4. Tools	Using an augmentative and alternative communication (AAC) device to increase expressive communication. Using a calculator to enable accurate money exchanges when shopping.
5. Physical environment	Providing a less distracting section of the classroom for test taking. Lowering file cabinets for filing by a person who uses a wheelchair.
6. Skills–knowledge	Teaching a person how to use a local health club. Using social stories to prepare a person for a visit to doctor's office.
7. Inherent ability	Exercising to enhance physical vitality and endurance. Intrinsic motivation to do well in an activity or setting. Matching jobs and other activities to an individual's relative strengths.

It is not difficult to envision what a system of support would entail when considering the human performance elements in Table 1. Take the case of a man with intellectual disability working on a community job. The man in our hypothetical example was hired through an on-the-job-training (OJT) program offered by a state vocational rehabilitation (VR) agency (Element 1: Organizational Systems). This person was motivated to do well on the job because of opportunities for recognition and advancement (Element 2: Incentives), but he required assistance from coworkers on specific job tasks that he found to be difficult (Element 3: Cognitive Supports). In addition, this employee used assistive technologies to work more efficiently (Element 4: Tools) and needed to have the physical environment modified slightly to complete certain job assignments (Element 5: Physical Environment). Last, task analyses of aspects of the job were developed and then taught to him (Element 6: Skills–Knowledge), and he was matched to a job that was reasonably consistent with his unique talents (relative strengths) and personal interests (intrinsic motivation; Element 7: Inherent Ability). This example illustrates how each element of human performance was addressed through a system of supports, giving the worker a good opportunity to be successful on his job.
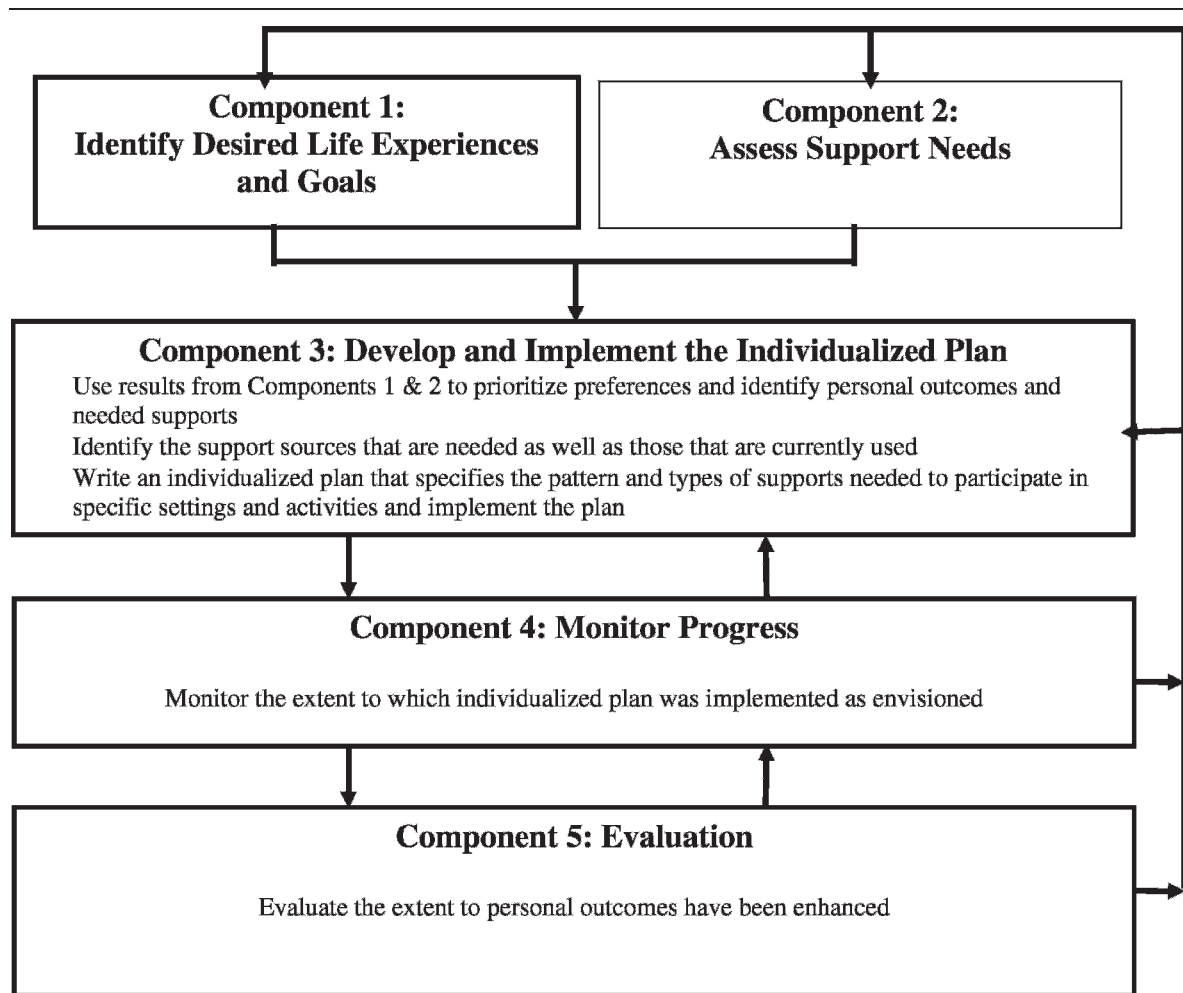
An interesting implication of Wile's (1996) model is the role supports play at the organizational level. Although legislation is not considered an individualized support, it is evident that laws and regulations can have tremendous influence on people's lives. Consider the passing and subsequent reauthorization of the Individual With Disabilities Education Improvement Act of 2004 and its effect on opportunities provided to children with disabilities in the nation's schools. Prior to 1975, it was legal in many states to deny a child with special needs access to a public education. Although federal and state legislation, as well as local policies, would never be listed as distinct supports on individualized plans, it is important to acknowledge the influence that policymakers and advocacy organizations have had on the quality and quantity of supports that are available.

Assessing, Implementing, Monitoring, and Evaluating Individualized Supports

Supports are a universe of resources and strategies that enhance human functioning. No

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

Figure 2 A process for assessing, planning, monitoring, and evaluating individualized supports.

individual will need all of the types of supports that are available. People's support needs differ both quantitatively (in number) and qualitatively (in nature). Planning teams are in the best position to identify the types of supports that people need. As shown in Figure 2, we propose a five-component sequential process for (a) identifying what the person most wants and needs to do, (b) assessing the nature of support a person will require to accomplish what he or she most wants and needs to do, (c) developing an action plan to garner and deliver supports, (d) initiating and monitoring the plan, and (e) evaluating personal outcomes. This support planning and implementation process has evolved from a planning process originally provided by Thompson et al. (2002, 2004b).

Component 1: Identify Desired Life Experiences and Goals

The first component of this support process requires the use of person-centered planning (PCP) processes. A hallmark of PCP is the focus is on the individual's dreams, personal preferences, and interests. The primary purpose of a PCP process is to find out what is important to a person, and it is essential that discussions are not constrained by available services or by perceived barriers such as fiscal restrictions or limitations in a person's skills (O'Brien & O'Brien, 2002). As a team-planning method, PCP has been shown to yield better outcomes for adults with intellectual disability than do traditional methods of service planning (Holburn, Jacobson, Schwartz, Flory, & Vietze, 2004; Robertson et al., 2006). PCP processes involve the

person with the disability and people important to that person. The desired outcome of PCP is a unified vision of a person's life going forward. This vision takes into account those aspects of the individual's current life that are favorable (i.e., aspects to maintain) and adds elements that will enhance his or her life in the future (i.e., aspects to change).

Component 2: Determine the Pattern and Intensity of Support Needs

The second component of the support process involves assessing the person's support needs. As one example, the Supports Intensity Scale (Thompson et al., 2004a) is a standardized measure used to evaluate an individual's support needs across seven life activity domains as well as to identify exceptional medical and behavioral support needs. However, any method that a planning team finds useful to assess support needs could be used, including direct observation of the person in variety of life activities and structured interviews with the person and his or her family members. The critical information to gather is the nature of the extraordinary support that a person would require to engage successfully in an array of activities, especially those associated with the life priorities identified through PCP.

Because support needs assessment and adaptive behavior assessment are both concerned with typical performance in everyday activities, the two can be confused. It is important to understand that assessing a person's support needs is not the same as assessing his or her personal competence. Whereas adaptive behavior scales assess the adaptive skills that a person has learned (and, thus, measure achievement or performance associated with personal competence), support needs assessment scales measure an individual's extraordinary supports needed to participate in the activities of daily life (Thompson et al., 2004b). As discussed by Moseley and Thaler (personal communication, October 2007) of the National Association of State Directors of Developmental Disabilities Services, support needs assessment instruments, to be most useful, should have the following features: (a) be easily placed into practice and used by professionals, nonprofessionals, and stakeholders with a wide range of skills; (b) produce consistent results and outcomes when used across service areas and regions; (c) be person centered; (d) provide accessible and understandable information to a wide range of stakeholders; (e) identify the support needs of people with complex and challenging conditions; (f) generate results that are applicable to decision making across a wide range of issues; and (g) be designed to integrate in the support planning process the perspectives of individuals receiving support, their families and close friends, staff, and providers.

Component 3: Develop the Individualized Plan

The third component of the process builds on the first two components to develop an individualized support plan. Here, the discussion shifts from the future to now, and it is important that an optimistic and realistic plan of action be designed and implemented. Because a plan cannot address all priorities effectively at one time, some personal priorities identified in Component 1 may need to be tempered and some difficult choices may need to be made. However, the result of Component 3 should be "an unambiguous, individualized plan that specifies (a) the settings for and activities in which a person is likely to engage during a typical week, and (b) the types and intensity of support that will be provided (and by whom)" (Thompson et al., 2004b, p. 81).

Component 4: Monitor Progress

The fourth component of the process, monitoring progress, requires that planning teams examine the outcomes of the plan. Specifically, teams should keep a closely monitor the extent to which the person's individual plan was implemented. Monitoring should be ongoing and systematic in terms of periodically scheduled meetings to consider the congruence between what was planned and what has actually come to pass.

Component 5: Evaluation

The final component, evaluation, is focused on the extent to which desired life experiences, goals, and personal outcomes are being realized. This involves examining the individual's life experiences through the lens of personal outcomes. It is important to acknowledge that personal preferences and priorities can change over time, and completing this component of the process will assure that the plans get revised when they no longer continue to meet the person's needs. In addition, aggregate data on personal outcomes can provide organizations and state systems with information regarding the extent to which systems are meeting the needs of individuals.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

Table 2 Quality-of-Life Domains and Exemplary Indicators

Quality-of-life domains	Exemplary indicators
Microsystem (Schalock & Verdugo, 2002)	
Emotional well being	Contentment, satisfaction
Interpersonal relations	Interactions, relationships
Material well being	Employment, possessions
Personal development	Education status, personal competence
Physical well being	Health status, nutritional status
Self-determination	Autonomy, choices, personal goals
Social inclusion	Community integration and participation
Rights	Human (respect, dignity, equality) and legal (access and due process)
Mesosystem (Council on Quality and Leadership, 2005)	
Identity	Personal goals, intimate relations
Autonomy	Choices, privacy, decisions
Affiliation	Participation, interactions, social roles
Attainment	Chooses services, realizes personal goals
Safeguards	Connected to natural supports, safety
Rights	Exercises rights, treated fairly
Health and wellness	Health status, free from abuse–neglect
Macrosystem (HSRI and NASDDDS, 2003)	
Work	Employment status, monthly earnings
Community inclusion	Participation in integrated, community activities
Choices and decisions	Choices
Self-determination	Directs and manages own services, control over budget
Relationships	Family, friends, caring relations
Satisfaction	Satisfaction with current life events and circumstances

Within the field of intellectual disability, there are a number of evaluation frameworks that can be used across individuals, organizations, and systems. Typically, these frameworks are based on the assessment of quality-of-life domains and indicators, using both self-report and direct observation methods (Schalock, Gardner, & Bradley, 2007). Table 2 summarizes exemplary quality-of-life domains and indicators that can provide an evaluation framework at the level of the individual (microsystem) or, through the use of aggregate data, at the organization (mesosystem) or larger systems level (macrosystem; Bronfenbrenner, 1979). Specific details about the development, measurement, and current use of quality-of-life domains and indicators are found in the references listed in the table and in Schalock et al. (2007). It should be noted that, although there are a variety of terms across systems for the domains listed in Table 1, the domains among the three systems are parallel when considering that these frameworks were developed by different authors, at different times, and for different purposes. For example, Schalock and Verdugo's (2002) Self-Determination domain in the microsystem corresponds to the Council on Quality and Leadership's (2005) Autonomy domain in the mesosystem as well as to the Choices and Decisions domain in the macrosystem as proposed by the Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services (2003).

In summary, although this five-component process requires a significant investment of time and energy, a comprehensive planning process is essential to arranging supports that are aligned with individual needs and desired outcomes of people with intellectual disabilities. Planning teams can always return to previous components in the process when needed (e.g., if Component 4

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

[Monitoring] revealed the plan was not implemented due to unforeseen complications, the planning team would want to return to Component 3 and revise the plan). In addition, the cycle of components should be repeated as individuals grow and change and require revised support plans. The process always starts with assessing personal interests and needs for support, proceeds to team planning and implementation, is followed by careful monitoring of implementation, and ends with an evaluation of outcomes.

Approaches to Individualized Planning: How Does Support Planning Fit?

Individualized planning terms and documents differ widely, as reflected in an individualized support plan (ISP), individualized service plan (ISP), individualized program plan (IPP), individualized education plan (IEP), individualized transition plan (ITP), individualized written rehabilitation plan (IWRP), individualized habilitation plan (IHP), person-directed plan (PDP), and individualized family service plan (IFSP). The word or words sandwiched in between *individualized/person* and *plan* may signify something significant (e.g., age group, approach to planning) or, for all practical purposes, mean very little. Some planning documents include legally mandated sections, others are structured by core philosophical values, whereas still others are mostly artifacts of past practices and traditions that have evolved over time. Although specifying what a planning document should include is well beyond the scope of this article, it is instructive to distinguish between different approaches to planning and consider the need to include support planning as a part of any individualized plan.

Before considering different approaches to planning, we recommend that planning teams use only one form to document the specifics of an individual's plan. Multiple planning forms run the risk of being redundant (at best) as well as contradictory (at worst). Practically speaking, it would be unusual for different organizations that are serving an individual in different capacities to use a common planning protocol. However, within an organization, it would be best to use a single form that allows for multiple planning approaches. We believe that a variety of planning approaches can be appropriate depending on individual characteristics and needs.

Service Plans and Support Plans

Whereas supports are resources and strategies that enhance individual functioning (Luckasson et al., 2002), we define *services* as organized means for delivering supports, instruction, therapies, or other forms of assistance (e.g., income assistance). For example, advocacy services provide a means for people to access a variety of advocacy supports, and such supports could range from legal assistance to assuring planning team members consider an individual's preferences. Educational services provide instruction that enhances intellectual development and provides opportunities to learn new skills. Health services provide preventive medical care to treat health problems as well as therapies such as occupational or physical therapy. Not all services will provide the same scope or quality of supports. Differences between service providers might be due to having different missions and purposes, or could be result of different levels of proficiency.

Based on our definition of services, service planning should focus on the types of services that need to be accessed as well as the general scope of involvement that a person should have with a service provider (e.g., how many hours of service a person might need in a given time period). Because services are portals to supports and other forms of assistance, it is important for communities to have coordinated systems of services. A service planning component in an individualized plan is necessary to identify service providers who can deliver the supports or other types of assistance that is needed.

However, service planning is not a substitute for support planning. Simply identifying hours of service or specifying programs in which an individual is going to participate is unlikely to result in individualized supports or optimal personal outcomes. Thus, in our view, distinguishing between support planning and service planning is not just an issue of semantics. Planning teams need to identify services an individual needs to access, but this is not the same as planning the patterns and intensities of supports a person needs to function in activities and settings consistent with his or her preferences.

Achievement Plans and Support Plans

Support plans also differ from achievement plans. Achievement plans are prominent in IEP and IWRP planning documents, where the focus is

on learning and/or achieving observable and measurable skills. Because the purpose of public education and vocational rehabilitation (VR) services is to change people in a positive way, achievement plans target skill acquisition and levels of mastery. However, although support plans might involve accessing educational settings for purposes of learning new skills, the focus of support planning in such a case would be on assuring participation and/or accessing learning opportunities. Unlike achievement plans, support plans are not characterized by long-term goals and short-term behavioral objectives that specify achievement milestones for an individual. Rather, the function of support plans is to identify the resources and strategies that will bridge the gap between the challenges that a person with intellectual disability experiences in life activities (i.e., person–environment mismatch) and the life experiences and opportunities (i.e., outcomes) that the individual values.

In the case of children who are attending school, IEP teams are legally bound to include achievement plans in IEP documents (e.g., measurable learning goals as well as benchmarks for progress monitoring). However, IEP planning forms and processes should also include support plans. For example, planning for the types of accommodations that will be made to support a child to access the general education curriculum and receive an education in the least restrictive environment would be applicable to the vast majority of students with intellectual disabilities. It is important to reiterate that we are not advocating that support planning should dominate the focus of all individualized plans. However, we are suggesting that the need for support planning should not be dismissed in cases where achievement planning processes are prominent.

Conclusion

When the AAIDD (formerly, the American Association on Mental Retardation [AAMR]) Terminology and Classification Committee introduced the concept of supports in the 1992 manual (Luckasson et al., 1992), the authors recognized that supports were an elusive but essential construct. In that regard, the focus was on support resources (personal, other people, technology, and services), support functions (e.g., befriending, financial planning, employee and in-home assis-

tance, and community access and use), support intensity (without benefit of a supports intensity assessment methodology), and desired outcomes. A distinction was made between natural and paid supports. This distinction helped to differentiate services, which tended at that time to be equivalent to "program," wherein "one size fits all," from individualized supports, which are based on the idiosyncratic needs of the individual. Furthermore, a number of natural support standards were offered on the basis of two premises: (a) Natural supports occur in regular, integrated environments; and (b) support activities are performed primarily by individuals normally working, living, or recreating in that environment.

The revised AAIDD manual (Luckasson et al., 2002) reflected a better understanding of the mechanisms for support provision and the need to understand supports in the context of an individualized process that involved assessing, planning, implementing, monitoring, and evaluating. This understanding occurred due to advances in the field between the 1992 and 2002 versions. Chief among these advances were (a) a greater appreciation of the value of PCP as well as expanded implementation of PCP processes, which emphasized personal growth and development, choices, decisions, and empowerment; (b) an ecological approach to disability that stressed the power of person–environmental interactions and the enhancement of human functioning through the judicious use of individualized supports; (c) a renewed emphasis on personal well being, quality of life, and valued personal outcomes; and (d) an expanded range of support strategies, including advances in assistive technology.

As we approach the development and finalization of the 11th edition of the manual, there is much that we can draw from past perceptions as well as emerging perspectives. In this article, we distinguished supports from support needs and discussed how insights on individual support needs can be gleaned through understanding models of human performance. In addition, we proposed a supports model (Figure 1) that illustrates how supports are a bridge between what is and what can be through the reduction of the mismatch among a person's capabilities, the demands of his/her environment, and the consequent enhancement of personal outcomes. We also outlined a five-component process for assessing, planning, monitoring, and evaluating individualized supports (Figure 2) and suggested that support planning

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

can complement other approaches to planning (service and achievement planning) in an individualized planning process.

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INTELLECTUAL AND DEVELOPMENTAL DISABILITIES   VOLUME 47, NUMBER 2: 135–146 | APRIL 2009

Perspective: Supports and support needs   J. R. Thompson et al.

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