Planning for Individuals

A Resource Kit and Implementation Guide
for Disability Service Providers
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Introduction and context
Purpose of the guide

The implementation guide aims to promote consistent practice

This Resource Kit and Implementation Guide has been designed for use by Department of Human Services (DHS) staff, and staff from Community Service Organisations (CSO’s) that are providing assistance with planning and involved in the development and implementation of support plans under the Disability Act 2006 (the Act).

This Resource Kit and Implementation Guide aims to provide a foundation for shared practice amongst DHS and CSO staff and supplements the Disability Services Planning Policy and a range of other DHS policies such as the Information and Policy Manual available through the Disability Services Division.*

This Resource Kit and Implementation Guide has been developed following the consultation regarding the planning policy (during March and April 2007), and arising out of the Legislation Information Sessions (May and June 2007)

The guide is divided into two parts:

PART ONE: Planning Resource Kit

Provides an individualised planning Resource Kit, which gives practice guidance for all planning with people with a disability.

The Resource Kit includes approaches to individualised planning, things to consider and explore in planning with people, running planning meetings, and setting goals, strategies and outcomes. The Resource Kit provides links to information and resources that can assist when planning with people with a disability.

The Resource Kit does not prescribe processes, but rather offers information, practical advice and resources to guide best practice in planning with people with a disability and their families.

Format

The Resource Kit details the key practice elements of the individualised planning approach. Each element of practice is described in detail and offers planners tips and resources that support good practice when planning with individuals and their networks.

Planning Tools

Planners should be aware of the many tools available to assist them to plan with people with a disability. The planning tools featured in this Resource Kit represent only some of the planning tools available, and may be useful to use when planning with some people.

All planning tools have been referenced to their original sources and while these tools are included in the Resource Kit, no one tool or approach is recommended.

PART TWO: Planning Implementation Guide

This section provides detailed guidance and practice advice in relation to specific issues contained within the Planning Policy, particularly:

- Assistance with planning
The development of support plans; and
- Personal and private information.

This detailed information will support disability service providers in their practice to ensure people with a disability experience a consistent process when planning, particularly in the development of support plans and where a person with a disability chooses to have a coordinated support plan developed.

Consistent with the review of the Planning Policy, this Resource Kit and Implementation Guide will be reviewed in early 2008.

Guiding principles for planning

Section 52 of the Act provides guiding principles for planning

The Act outlines an approach to planning that reflects the reorientation of disability services. Under the Act, planning takes place within an individualised planning framework and is about self-determination, community membership and citizenship. This is achieved by working with people with a disability to plan, and where required, acquire support that is flexible and enables them to pursue a lifestyle of their choice.

The Act provides guiding principles for planning. All planning for people with a disability should be undertaken, to the extent to which it is reasonably practicable, in accordance with these principles. The Act states that planning should:

- be individualised
- be directed by the person with a disability
- where relevant, consider and respect the role of family and other persons who are significant in the life of the person with a disability
- where possible, strengthen and build capacity within families to support children with a disability
- consider the availability to the person with a disability of informal support and other support services generally available to any person in the community
- support communities to respond to the individual goals and needs of persons with a disability
- be underpinned by the right of the person with a disability to exercise control over their own life
- advance the inclusion and participation in the community of the person with a disability with the aim of achieving their individual aspirations
- maximize the choice and independence of the person with a disability
- facilitate tailored and flexible responses to the individual goals and needs of the person with a disability
- provide the context for the provision of disability services to the person with a disability and where appropriate coordinate the delivery of disability services where there are more than one disability service providers.
Individualised planning: an approach

Individualised planning is the approach for all planning with people with a disability

The guiding principles for planning must underpin all planning processes with a person with a disability. These guiding principles, along with best practice approaches to planning form the basis of the approach to individualised planning described below.

Individualised planning is about:

- people with a disability directing planning and making their own choices about how they wish to live their life
- the inclusion and participation of people with disabilities in community life
- assisting people with a disability to identify their goals, aspirations and needs, ways that these can be achieved and the supports required
- the exploration of supports that are flexible, wide-ranging, and may include, but are not limited to, those that may be available from the existing disability service system
- providing information, opportunities and support for people with a disability to make informed choices about the ways to achieve their goals and meet their needs
- planning which is respectful of the views of family members and carers and their role in the life of the person
- family focused planning and support for children and young people with a disability
- support for adults with a disability which impacts on their decision making capacity
- planning which is sensitive to the cultural and spiritual experience of the person
- recognition of the rights and responsibilities of people with a disability as members of the community.

All planning must reflect this approach to the greatest extent possible, ensure it is a dynamic process and its implementation is flexible and responsive to the person with a disability.

For each person, planning will have a different focus. Planning for a child living with their family will be a different process to planning with a young adult who is seeking a job and the opportunity to live independently.

A skilled planner will tailor a planning process after learning about the person and their reason for seeking assistance with planning. For some people, this could be a discussion resulting in some clear actions or a more extensive process that results in the development of plan.
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Working with individuals and families

Elements of Practice
Supporting a person directed approach

What is involved?
A person directed approach means that people with a disability and the people who care about them take the lead in deciding what is important, which community opportunities should be taken or created and what the future could look like.

Professionals move from being the ‘experts on the person’ to being ‘experts in the process of problem solving with others’.

Person directed planning:
- Requires that it is the person who defines what is meaningful in their life.
- Accommodates the person’s style of interaction and preferences regarding time and the setting for planning.
- Occurs with the support of a group of people chosen by the person or people who are important to the person.
- Ensures the person is listened to and chooses their own goals or that goals reflect the things that are important to them.
- Ensures the person’s cultural background and spirituality is acknowledged and valued in the planning and decision making process.

The role of a planner is to support the person to lead planning to the greatest extent possible. In some circumstances, this could mean taking a ‘backseat’ and providing guidance and support only where required, or it could mean making a significant effort to actively encourage and support the person to participate and be heard.

Tips
- Have an initial meeting with the person and their network to find out how they would like planning to occur.
- Take time to pre-plan planning meetings. Get to know the person and any issues.
- Be creative about how the person can be involved during planning. The planner could:
  - Make a tape recording of the person to be played at the start of the meeting.
  - Ask the person to draw a picture of him/her to put up at the meeting/photo board
  - At the start of the meeting, read something the person has written

References and Resources
- Information for my plan is a booklet developed by Ruth Mathiesen and adapted by Deb Watson, Amanda Jones (Scope Victoria) and Gillian Damonze (United Care Community Options) for the DHS Leading Planning Workshop for people with a disability and their networks. It can be used to help people to think through different sorts of questions to better understand what matters in their life. This will be available shortly from: http://helensandersonassociates.co.uk/about_us/HSA_Australia.html
Supporting Communication

What is involved?
Everybody has a ‘voice’ and can be heard when others listen carefully. Some people find it difficult to use speech or to understand what is said to them. They may rely on forms of non-verbal communication such as body language, ways of behaving and sounds to express their views.

The role of the planner is to maximise the person’s capacity to communicate during planning. For planning, the planner will need to find out:

- How does the person best communicate with others?
- Who should be involved to support the person with their communication?
- How does the person best communicate with? Do they use communication aids?
- What visual or audible planning materials could be used to maximise the person’s participation?
- If developing a written plan, what format would be most meaningful to the person?

Tips
- Listening to someone who does not use words means finding out:
  - How does the person show if they are happy or sad, bored or excited, angry or frustrated in different settings and at different times?
  - How does the person indicate choice or preference?
  - What do their facial expressions or posture mean?
  - What does their behaviour mean?
- Plans can be formatted in a number of creative ways including using pictures, photos, posters, audiotapes etc.

Tools
- **Communication Chart** is a person centred thinking tool designed to support people who do not use words or have difficulty in communicating with words. It explores other people’s different perspectives about how the person communicates. An example of this type of chart can be found at: http://www.ldicn.org.uk/upload/public/attachments/28/bpcommunicationchart1.pdf
- **Communication Passport** is a person centred tool that can help a person to communicate how they feel, what they like and dislike, what they want and don’t want. An example can be found at: http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/Communication%20Passport.doc

References and Resources
- **Total Communication Minibook: Person centred thinking, planning and**
practice. Copies of this book are available as a free download from:
http://helensandersonassociates.co.uk/Reading_Room/How/Person_Centred_Practic
e/Person_Centred_Communication.html

- Communication for Person Centred Planning. This information pack was
designed to help staff, self advocates, families and friends to make communication
better and is available for free download:
http://www.learningdisabilities.org.uk/publications?EntryId=22381&p=2
Supporting decision-making and choice

What is involved?

All people have a right to make decisions and choices in all areas of their life and about everything that affects them. Some people will need support to make decisions and choices when identifying their needs and goals and plans for the future.

Planners play a very important role in supporting the person to make decisions and exercise choice during the planning process. They have a role to:

- **Provide information and help the person to explore their options.** This includes listening, talking things through, asking questions to help the person think about their life, hopes and dreams and offering support and encouragement.

- **Explain the implications of some decisions.** This includes supporting the person to understand how decisions could change their life, and the impact their decisions may have on them and the people around them.

- **Engage the person’s support network.** The members of the support network (e.g., family members or friends) can provide information, ideas and advice that help the person understand their choices and to make decisions.

Some people may rely on family or a representative to make decisions on their behalf or in their best interest during planning. In these circumstances, the planner may need to facilitate good decision making through checking to see if a decision:

- helps the person achieve their goals and preferences
- respects the person’s individual personality
- helps build the person’s relationships with other people
- increases the person’s skills and capacities
- develops the person’s participation within the community
- keeps the person and others healthy and safe.

A planner does not have a role to influence a person’s decision or make decisions on behalf of the person.

Tips

The following strategies are good practice ideas for maximising a person’s ability to make their own major decisions:

- Identify all sources of relevant information the person needs to consider and understand to make the decision. Help to identify the different options. Don’t make it harder by adding unnecessary information.

- Break up the information into stages that follow logically. Put each stage to the person and assess whether they understand each stage before adding more information.

- To check whether the person has understood, go back over the information, ask the question in another way or have the person explain their decision to you. Be sure to reassure the person that you are checking this so that you are clear about their wishes and not because their previous answer was wrong.

- Allow the person plenty of time to take in and respond to each piece of information. Encourage questions and discussion.

- Things are often better explained by using pictures, examples and, better still, personal experience. Be creative! For example, the best way to explain going to hospital may be to visit or talk to another patient; to explain work options may be to have a trial period at the different options.
• Be aware of non-verbal messages you may be sending and receiving.
• Be careful not to ask questions in such a way as to suggest an answer. For example, ‘You’re happier working here, aren’t you?’
• Assist the person to identify the likely results of possible decisions.
Supporting a family focused approach

What is involved?

A family focused approach is a process that empowers a family of a child with a disability to direct the development of a plan that meets the needs of the child and the family. It is supportive of the self-determination of the child, reflects the family’s goals and what they are wanting to achieve, and accommodates the family’s style of interaction and preferences regarding time and setting.

In most situations, families have the most knowledge about the preferences, capacities, and contributions of their child and of themselves, while professionals have knowledge of resources available in order to provide appropriate supports and services. All should play an active and collaborative role in order for the planning process to be effective.

Tips

When planning with families with a child with a disability it is important to:

- Respect all families for their unique qualities.
- Work in partnership with families to identify their strengths and unique support needs, and plan towards achieving the goals as identified by the family.
- Develop plans that support the family’s capacity to enhance their child’s development, and help them connect with natural sources of support through friends, neighbours, community members and others.
- Strengthen, preserve and promote positive relationships between the child and the child’s parents, siblings, other family members and people significant to the child.
- Recognise that the child and family’s everyday routines, activities and places of daily life provide the best opportunity to promote early childhood learning and development. A child’s natural learning environment includes places such as the family home, childcare, kindergarten, playground, and library.
- Encourage the active participation and inclusion of children in a range of environments with children of all abilities.
- Support the family’s capacity to independently locate and access resources, and find their way through the service system.
- Show respect for the cultural and social diversity of the family and maintain their dignity at all times.

References and Resources

Planning with young adults

What is involved?

Adolescence is a time where many young people begin to express themselves as independent people and attempt to distance themselves from their family, and particularly their parents. It is often a time of risk taking and experimentation and young people often have a feeling of invincibility.

For young people with a disability, particularly those who rely on their parents and families for care and support, taking some steps towards independence may not be easy. For parents and families who have also spent many years supporting and protecting their child, allowing the space for them to express themselves as independent people can be a scary and challenging.

Tips

While supporting young people and families as part of a family focussed approach is important, when working with a young person it is important to:

- Consider what experiences the young person’s peers may be having and new things they may be doing.
- Think about what is happening in the young person’s school or community and any activities they are interested in and could participate in without their parents or family.
- Encourage the young person and family to think about opportunities to maximise the young person’s independence. This might involve the young person walking to the bus stop on their own or staying home alone for an hour or two after school.
- Encourage the young person and family to create opportunities for the young person to take on more responsibility for themselves and as part of the family. This can include helping the young person to get a part time job, increasing their chores around the house or taking responsibility for ensuring the bins are put onto the street each week.
- Work with the young person, their family and their school to consider plans for the future and their transition beyond school. What is the person interested in and good at? Do they require further education, apprenticeship or supported employment?

References and Resources

- Futures for Young Adults An initiative by the Department of Human Services http://nps718.dhs.vic.gov.au/ds/disabilitysite.nsf/sectionthree/future_young_adults
Planning with ageing carers

What is involved?

Planning for the future is often the number one priority of ageing carers caring for a person with a disability. Carers need reassurance that the person they care for will be safe, happy and well supported in the future. People with a disability living with ageing carers often worry about what will happen to them once their ageing carers can no longer provide support or support to the same extent.

Ageing carers often have their own increasing health and practical needs. In many cases, the person with a disability is providing an increasing amount of care and support for their ageing carer and they may have become mutually dependant on each other to be able to live in the community.

People with disabilities and their ageing carers need support to plan for emergencies and the longer-term future. Understanding and respecting the journey ageing carers have made already is usually the key to being able to take forward plans effectively and inclusively.

A skilled planner ensures that the needs of the person and their ageing carers are taken into account and handled with great sensitivity throughout the process.

When supporting ageing carers to plan, there are a number of key issues that face older families that facilitators should be mindful about, including:

- **A family’s previous experience with professionals**: Some families may have had very little contact with professionals while others may have seen a succession of professionals come and go in their lives. These experiences may influence whether, or how quickly they feel able to trust a planner.

- **The shift in thinking about how to best support people with disabilities**: In the past, professionals may have worked to convince a family that putting their son or daughter in a Community Residential Unit (CRU) is the best thing they can do. Now, support for people with disabilities is about self-determination, community membership and citizenship.

- **Respecting a family’s experience**: Ageing carers may bring a rich history and experience of dealing with difficult issues like discrimination, and resourceful ways of including their relatives in their local communities. Many people have lived very inclusive lives and it is only when a carer is less able to facilitate these opportunities that their lifestyle becomes more restricted.

- **Different perspectives**: Like members of any family, people with a disability may have different perspectives and priorities from their parents or other family members.

**Tips**

- Don’t take a lack of trust personally. It may be worth asking a family directly what experience they have had with professionals and work from there.

- Build trust by always turning up when you say you will and following through on agreed actions.

- Ask families about what have they previously been told about the future for their relative and what their impressions of this are. A great deal of sensitivity is required to separate what may have been true years ago, but is now not.

- Don’t use jargon. For example, the phrase ‘independent living’ raises particular concerns for many ageing carers. Independent living sounds like a person would be left without support. Many people do not realise that someone can be living independently and receiving the right amount of support to ensure they are safe, well cared for and able to live a full, meaningful life.

- Enable family members to share their own priorities, see where these are complementary and where they differ, and work out ways to address any
• Know about the aged care service system too.
• Address practical issues. For example, where meetings are held can make a real difference, as transport and mobility can be major issues for many older family carers. Similarly, make sure written information is provided in a large font (at least 14) and that the style of font is clear.

References and Resources


• **Victorian Carers Services Network Website** [http://vcsn.infoxchange.net.au/](http://vcsn.infoxchange.net.au/)

• **Parent to parent Queensland Website** [http://www.parent2parentqld.org.au/](http://www.parent2parentqld.org.au/)

• **Person-centred approaches and older families**, Dalia Magrill, Helen Sanderson and Alison Short, May 2005 [http://www.helensandersonassociates.co.uk/PDFs/Person%20Centred%20Approaches%20and%20Older%20Families.pdf](http://www.helensandersonassociates.co.uk/PDFs/Person%20Centred%20Approaches%20and%20Older%20Families.pdf)
Exploring goals, needs and aspirations

Elements of Practice
Finding out about the person

What is involved?

Generally, people will want to plan when:

• they are excited by new possibilities and options; or
• things are not going right or they want their life to be better.

For planners, deciding how much information to find out about a person will depend on the type or focus of planning they have been engaged to do. For example, learning about a person’s history when planning for support to access a community recreation program, may not necessarily need to be as in depth as when planning for future accommodation and support needs. In this case, knowing where a person has come from in order to plan for the future may be very important.

Gathering information about someone does not need to occur in a planning meeting with a large group of people. It can occur separately with the individual or family and those who know the person well.

There are three main ways to really learn about someone:

• **Listen to them:** Listening to someone means listening to their words and to the things they say through their actions and behaviour. People reveal important things about themselves in all sorts of situations. Not everything can be learnt by sitting down with someone for a formal interview with specific questions.

• **Spending time with them in different situations and different settings:** To learn what life is like for someone, it sometimes helps to ‘walk with the person in their shoes’. This might be more important if that person does not use words to communicate. It may be valuable to spend time with the person in all sorts of different situations, doing a range of different activities with a variety of people, and at different times of the day and week.

• **Talking with others who know them well:** Other people can add valuable information about what seems important to the person as well as what their past has been like.

Depending on it’s relevance, a person’s life history and personal information may be gathered from a number of life stages and areas of importance, such as:

• **childhood:** birth place, home life, parents/grandparents, brothers/sisters
• **adolescence:** school, favorite subjects, friends, sports/hobbies
• **young adulthood:** further education, jobs, relationships, family, clubs
• **middle age:** children, family role, work
• **later years:** grandchildren, life achievements, travel
• **favorite things:** food, clothes, pets
• **other information:** religion, skills, awards

**Tips**

• What are the great things about the person, their skills and gifts?
• Focus on the person, not their inabilities or any illness
• Life history includes achievements, interests, hobbies, holidays and life events. It includes anything that has been of importance to the person, including negative life experiences.
• Help the person gather information in photos, letters, tickets, mementos and other items.
• Don’t ignore painful or upsetting memories. They are an important part of someone’s experience. Listen to the person and let them express their emotions.

• The more information gathered, the better others can understand what is important to the person and why.

**Tools**

- **Like and Admire** is a person centred planning tool that can be useful to identify the qualities that people like and value about each other. An example of this tool can be found at: [http://valuingpeople.gov.uk/dynamic/valuingpeople139.jsp](http://valuingpeople.gov.uk/dynamic/valuingpeople139.jsp)
Learning what is important

What is involved?

Learning about what is important to a person involves exploring the things that increase or would increase the person’s happiness and wellbeing today and in the future.

It is also important during planning to explore and consider the things that are important for the person. These are generally things that help to keep the person safe and healthy, such as diet and exercise.

Exploring things of importance to the person is a key component of individualised planning and forms the basis for setting meaningful goals.

After consulting people with a disability, the Quality Framework for Disability Services describes areas of life that are important to people with a disability as:

- Being safe
- Looking after self
- Being independent
- Moving around
- Choosing supports
- Paying for things
- How to live
- Where to live

- Doing valued work
- Always learning
- Communicating
- Building relationships
- Being part of a community
- Having fun
- Expressing culture
- Exercising rights and accepting responsibilities

A planner should see the above areas as a guide for some of the areas that can be explored to gather information about the person.

Tips

- Ask the person what makes a good day for them? What makes it enjoyable? Then help the person to think if there are any things that they would like to add to this day that would make it even better or perfect.
- Find out what would make an awful day for the person. What is the worst day of the week and what makes it a bad day? What could make it even worse?
- Help the person to express their hopes and dreams for the future. Build on what you have heard about what a great day would look like and what opportunities exist to make this happen, and how an awful day could be prevented.
- Ask what life would look like for them in an ideal world? What would they be doing? Who is there? What does it sound, look, smell and feel like?
- Are there adventures or experiences that they seek or new things that they haven’t tried?
- What hobbies or activities make them excited and enthusiastic?
- Ask others to think about the people, places and activities that bring enjoyment and fulfilment to the person’s life. Then think of the people, places and activities that create boredom or frustration for the person.
### Tools

- **Sorting important to/for** is a person centred tool that helps to sort out what’s important to (what makes us happy, content, fulfilled) from what’s important for (health, safety, being valued) while working towards a good balance. A sample can be found at: [http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/'For%20-%20To]%20Balance.doc

- **Dreams and Nightmares** is a person centred thinking tool that is useful for identifying things that the person wants and things to avoid. It can also be useful for getting the carers perspective on what they think the person’s fears are and to separate what their own fears are. A sample can be found at: [http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/dreams%20nightmares%20tool.doc](http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/dreams%20nightmares%20tool.doc)

### References and Resources

Balancing Risk and Happiness

What is involved?

The shift towards people with a disability being supported to pursue their own lifestyles based on self-determination and choice, and having more control over the supports they receive may pose some challenges for those who care about the person and for service providers.

In developing goals and plans for the future, people with a disability may aspire to live a life or participate in activities that may be seen as a risk to their health, safety or wellbeing. Service providers might also consider providing the support for the person to achieve specific goals as a potential risk to those who are supporting the person. In some cases, this can lead to conflicting views about what the person should or should not be supported to do.

As these issues arise, it is the role of the planner where necessary to support the person and their network to work through any differences and resolve how the person can best be supported to reach their goals. This could include breaking goals into smaller steps so that the person and their network can mitigate risks step by step and build confidence along the way.

In working through differences, the planner should be mindful about the roles others have in the person’s life and the importance of preserving positive relationships.

It is not possible to eradicate all risks; however good planning that includes assessing the risk, creative thinking and open discussions, are positive approaches to balancing risks with the person’s quality of life and happiness.

Tips

- Encourage the person to articulate what they actually want to do or achieve. They may be able to achieve this by choosing a different activity.
- Support the person to express why the activity is important to their happiness – why it would be a good thing to do?
- Get clarity around exactly what the perceived risk is; what do people see as things that are likely to go wrong and the consequences?
- Facilitate an exploration of ways to reduce or remove the risk of it happening. Think of as many ways as possible – encourage imagination and creativity.
- Support the group to think through the various responses to check whether it does actually reduce the risk and decide on strategies.
- Make sure the actions are recorded and mechanisms to monitor and regularly review if things are working are in place.

Tools

- **The doughnut sort** is a person centred thinking tool that can help to:
  - Know where you can be creative without fear
  - Clarify the roles of the different professionals and agencies supporting people and families
  - Inform a plan
  - Clarify roles and expectations in a person’s plan

An example of this tool can be found at: [http://www.ldicn.org.uk/upload/public/attachments/28/bpdoughnut1.pdf](http://www.ldicn.org.uk/upload/public/attachments/28/bpdoughnut1.pdf)
References and Resources

- **Person centred Risk Assessment**, Peter Kinsella
  [http://www.paradigm-uk.org/pdf/Articles/personcentredriskassessment.pdf](http://www.paradigm-uk.org/pdf/Articles/personcentredriskassessment.pdf)
Exploring Culture

What is involved?

Understanding people and their needs involves valuing people’s diversity in the most inclusive and dynamic sense and acknowledging the role that ethnicity, race, nationality, language, spiritual and religious beliefs, migration and other life experiences play, in forming diversity.

Recognising and acknowledging the importance of one or more ethnic groups in a person’s background, the values that are characteristic of that group, their migration experience if relevant and the significance of cultural networks, is a vital step in planning supports with people and families with diverse backgrounds.

Culture may influence some people’s total lifestyle. It is important to recognize however, that not everything they choose or do will be related to their culture.

Tips

The following areas and questions should be used as a guide to learn how culture is important to a person and to plan culturally appropriate supports. Planners need to make a judgement about when and how to ask these types of questions, which may be sensitive to some people.

Cultural background

What is the person’s:

- Country of birth, Indigenous status and cultural background including ethnicity and religion?
- Preferred language and literacy in English and other languages?

Migration experience

- Determine the person’s migration experience as a person’s health status and education may have been significantly affected by their migration experience and priorities may be focused on settlement (housing, employment) and education.

Family and Support network in Victoria

Does the person:

- Have parents or siblings living in Victoria?
- See one or more of them or talk to at least one of them on a regular basis?
- Have extended family, friends or other community members in Victoria and does he/she wish to see or talk to them on a regular basis?
- Attend or wish to attend family or community gatherings and celebrations (eg. weddings, funerals, holidays, reunions, christenings, bar mitzvahs?)
- Attend or wish to attend events and activities organized by their own ethnic group or other community groups?

Customs (including diet)

Does the person:

- Regularly eat food similar to the food they ate growing up?
- Eat particular foods from their ethnic or religious background for special occasions?
- Avoid certain foods and why?
- Regularly listen to a television or radio station or read a newspaper or magazine specifically marketed to his/her ethnic or religious background.
- Have or wear clothing from their ethnic or religious background?

Decision-making

- Who does the person wish to involve in decision-making about services and
supports?

- Determine who has responsibility for decision making about care – this may not rest solely on the person with a disability, but possibly with other family members, community members or even other workers.

### References and Resources


- **Centre for Culture, Ethnicity and Health (CEH)** website: [http://www.ceh.org.au/](http://www.ceh.org.au/)


Exploring spirituality

What is involved?

Just as physical, intellectual and emotional/social needs should be addressed through planning, a person’s spiritual needs should also be explored and addressed where appropriate.

Spirituality can be a valuable source of social and psychological support, friendship, acceptance and self-worth and give meaning to people’s lives. As such it may well be beneficial in helping to overcome the stigma, social isolation, low self-esteem, hopelessness, and loneliness experienced by many people with disabilities.

Spirituality has a wide range of meanings for people. Spiritual needs can be met through friendships or through involvement in communities where there is a sense of belonging and value, by getting in touch with nature and the wonder of the world, or by expressing things that are important through music, art or writing. For some people God and involvement in formal religion is important.

The role of the planner is to affirm the importance of spiritual expression and religious activities as part of planning with people with disabilities.

Tips

Some questions that can be helpful in exploring spirituality include:

- What gives meaning to your life?
- Are friends/family important in your life?
- When you are sad do you know whom you can talk to?
- Where do you find peace?
- Do you have a place where you can be quiet? Inside? Outside?
- What music/art/books are special to you?
- Do you belong to a particular faith community?
- If so, do you attend church/synagogue/mosque (or other religious service) and observe special religious days or periods?
- Are various faith materials (for example, icons, pictures, books) important to you?

References and Resources

- **What is important to you?** This booklet contains information about ways in which spirituality can make a difference and help people to discover what is important in their lives. Free to download from: [http://www.learningdisabilities.org.uk/publications/?EntryId=22362&char=W](http://www.learningdisabilities.org.uk/publications/?EntryId=22362&char=W)

- **No box to tick** This booklet contains information and practical advice on meeting the spiritual and religious needs of people with disabilities free to download from: [http://www.learningdisabilities.org.uk/publications/?EntryId=22352&char=N](http://www.learningdisabilities.org.uk/publications/?EntryId=22352&char=N)
Building Relationships

What is involved?

For most of us relationships are the basis of our lives. We need to belong, to be part of other peoples lives and have them a part of ours.

Planning can help a person to think about their relationships, increase the number of relationships and strengthen the relationships they already have. The very nature of relationships means that the more friends and family someone has involved in their life, the safer they will be in community. More relationships also mean contacts with other community members and less isolation.

Assisting the person to think about relationships is a good way to discover with whom they might want to get to know better and whom they might be able to spend some time with.

Planning can assist the person to consider:

- What relationships does the person want to nurture and explore?
- What things can happen now to strengthen the relationships already in their life?
- Based on their vision, who might understand what they desire? How could the person connect with them?
- What support does the person need to build more relationships in their life?

Many people with disabilities spend time only with those people who are paid to be with them. Under these circumstances, planning towards building relationships aims to realign the balance between paid and non-paid relationships.

Tips

Some things to think about include:

- How can the person meet new people?
- Who from the person’s past do they want to see again or see more of?
- Who do they already know, and with whom do they want to spend more time with?
- Who are the people in their life that they want to get to know better?
- How will the person stay connected to immediate and extended family members?
- How can the person increase social contact with others?
- How might the person become more socially involved with peers at work?
- What can the person do to be more neighbourly and come to know their neighbours better?

Tools

- **Relationship Circles** is a person-centred planning tool that is useful for:
  - Finding out who could contribute to getting the person connected
  - Identifying relationships that could be developed or strengthened
  - Showing the balance of family, friends and paid workers in the person’s life.

An example of this tool can be found at: [http://valuingpeople.gov.uk/dynamic/valuingpeople139.jsp](http://valuingpeople.gov.uk/dynamic/valuingpeople139.jsp)
Community links and participation opportunities

What is involved?

Participating in community life is a principle upon which individualised planning is built. It offers people with a disability a range of benefits including a sense of belonging, identity as a member of community, opportunities to develop friendships and relationships and experiences that provide meaning and a sense of purpose.

In planning with people with disabilities to develop connections with their community, it is important to explore what people are interested in and how they can share these interests with other members of the community.

A good planning process will help the person to think about their own community, what it has to offer, its diversity and their place in it. It will also help them think about how to use their gifts and talents to contribute to a life in community, and how to build a day that brings meaning to their life.

Tips

- Assist the person and their network to discover and explore what is available in their community.
- Use informal contacts and connections to find out more about what is happening in the community and to identify possibilities and opportunities for people with disabilities.
- Role model and demonstrate good networking skills to people with disabilities and their support team so they too develop confidence and competence in building community connections.
- Contact your regional DHS Community Building contact to connect with local and regional recreation/carer/community building networks and forums to receive valuable community information.

Tools

- **Associational Map** is a tool used to map out possible associations, activities and services in an individual’s community. This tool and other useful tools are available as part of The Guide to Developing Community Connections available on: [http://www.allenshea.com/CIRCL/connections.pdf](http://www.allenshea.com/CIRCL/connections.pdf)
- **Gift Sheet and Community Map** is can be useful to think about the persons gifts, the things that people like and admire about the person, the skills and attributes that make them who they are. Then think about places in the community where these gifts might be welcome. An example is available at: [http://www.csRpcp.net/default.aspx?page=16600](http://www.csRpcp.net/default.aspx?page=16600)

References and Resources

- **Community Mapping Reports** provide information and identify a range of community opportunities across local communities. These documents are available upon request from RuralAccess, MetroAccess and Deaf Access Victoria workers.
- **Department for Victorian Communities**.
www.dvc.vic.gov.au (then go to ‘Building Stronger Communities’)

- **Sport and Recreation Victoria - Access for all Abilities Program:**
  esaccess+for+all

- **Scope Leisure Action**
Exploring accommodation options

What is involved?
The Victorian State Disability Plan 2002–2012 outlines the Government’s policy that people with a disability should be able to choose where they live, with whom and in what type of housing—just like most other members of the community.

Previously some people with a disability seeking both accommodation and support would have considered shared supported accommodation as being the only available or suitable option.

With the introduction of more individualised approaches, the opportunity for greater choice to live in more independent settings with the right amount of support, is a realistic and desirable goal for many people with a disability.

When assisting a person to plan for accommodation, a good planning process:

• assists the person to create a vision of where and how they want to live
• assists the person to consider a range of accommodation options
• assists the person to consider the support they require to make it happen
• provides information to enable them to make appropriate contacts
• challenges pre-conceptions

Tips

• Make sure the person has a clear understanding that ‘independent’ means receiving the right amount of support to ensure they are safe, well cared for and able to live a full, meaningful life. Some people may think independent living sounds like a person would be left without support.

• Become familiar with alternative approaches to providing housing support that might enable people with a disability to live more independently. For example, there may be a technological solution, such as personal alerts, or informal support solution, such as a circle of support.

• Obtain copies of relevant documents, such as Housing Options Unlocked (see References), for both personal reference and for discussion with people seeking accommodation and support.

• Develop relationships with local housing providers.

References and Resources


• **Get Moving** This booklet is for people with disabilities who are thinking about leaving home and moving to new accommodation. Although written for the UK, it provides a useful framework to consider: [http://www.learningdisabilities.org.uk/publications/?EntryId=15135&p=6](http://www.learningdisabilities.org.uk/publications/?EntryId=15135&p=6)
Considering options

Elements of Practice
Engaging informal supports

What is involved?

Informal support relates to supports that are naturally present in settings and activities, such as family, co-workers, neighbours or other community members.

Individualised planning has a strong focus on building and maintaining informal networks. A person who has a good balance of informal support in their life tends to:

- be more connected with their community
- have more social connections
- be integrated rather than segregated
- use their funded supports more efficiently and effectively.

The role of a planner is to assist the person and their network to consider the informal supports that can be engaged to assist the person to achieve their goals. Things to consider include:

- matching common interests
- matching required support to the right people. For example, a co-worker might be able to take the person to and from work, but not be the right person to provide personal care support.

Sometimes people with a disability have a more structured support network or ‘circle of support’ made up of people who care about them and their future. A circle of support is a group of people who are committed to the person, and agree to meet together on a regular basis to help accomplish their personal vision or goals.

Where appropriate, a planner should provide information about circles of support to the person and their family to consider within their own circumstances. For some people, developing this type of network may become an important component of the person’s plan.

Tips

- Encourage the person not assume that people won’t want to help.
- Don’t be afraid to ask people in the person’s network to become involved.
- Identify the people the person knows. Important sources of support are: family, friends, and their friends.
- Think about people who have the same interests or are well connected in the community.
- Use your contacts to find supporters.
- Think about people in the person’s life who share their interests.
- Ask the person’s family and friends if they have contacts.
- Find out whom the person wants to spend more time with and who wants to spend more time with them. Are there people who want to spend more time with the person but need some help or support to do so?
- Consider the roles people have in the person’s life and how they could be expanded.
- Find out more about Circles of Support and put people in contact with others who are involved with a circle and can talk about their experience.
References and Resources

- Circles Network has interesting articles and information about circles of support projects in the UK: www.circlesnetwork.org.uk
Accessing Generic Services

What’s involved?

The generic or community service system provides wide-ranging services accessible to all members of the community. These include hospitals, general practitioner services, community health services and activities, pre-school, primary, secondary and tertiary schooling, public transport, housing, sport, leisure and recreation and services for people who are ageing.

Individualised planning involves the exploration of generic supports that may be available to the person to meet their needs before accessing disability supports. This can involve referral and putting people in contact with services and where necessary, looking at how the person could be supported to access services, such as accessibility requirements, aids and equipment, transport or someone to support the person at the time.

The role of the planner is to assist the person and their network to explore and consider the generic services available to the person and how these can be accessed. For example, a family seeking respite for a child may be able access family day care through the local council rather than facility based respite.

Tips

• Contact the Local Council or Community Health Centre in the person’s community to find out what supports and services are available.

• Search for local services in the local paper, Yellow Pages or on the Internet.

• Think about how a person without a disability would go about having their needs met. This can include thinking about the person’s peers and asking them about supports and services they access in the community.

• If a generic service appears reluctant to include a person with a disability, try to find out why. They may simply require some information and support about the person’s particular needs or ideas about small changes (such as installing a sliding door instead of a swing door) to make their service more accessible.

• Make sure the service or support meets the person’s needs and is something they really want to be a part of. Often generic services that are adaptable and supportive to people with a disability become well known. People with a disability may be drawn to these supports and services because of the ease of access rather than it being something they really want to do.

References and Resources

• Local council websites have valuable information about community events and recreation opportunities. Find a link to your local council here: http://www.dvc.vic.gov.au/web20/dvclgv.nsf

• Better Health Channel information to help improve the health and wellbeing of the Victorian community. The website provides online health and medical information that is quality assured, reliable, up-to-date, easy to understand and locally relevant: http://www.betterhealth.vic.gov.au/

• Victoria Online helps Victorians to find local, state and federal government information and services: http://www.vic.gov.au/sl/68331-Victoria-Online-Culture-Sport-Recreation.html

• Sport and Recreation Victoria maximises both the community value of physical activity and the considerable value of the sport and recreation sector to the Victorian economy: http://www.sport.vic.gov.au/
Accessing Disability Supports

What’s involved?

Disability supports are those supports funded through the Department of Human Services (DHS), Disability Services. These supports may be provided by DHS or by a Community Service Organisation (CSO).

Not every planning process will lead to the need for specific disability support, however some people with a disability may require access to disability support when they have support needs that are beyond what can be provided by informal networks and generic services.

Individualised planning aims to enable the person to pursue their own lifestyle and where disability support is identified as part of the person’s plan, they should aim to maintain and build the person’s community connections and personal networks. Disability supports should compliment and strengthen the person's other supports, rather than replace them.

Some disability supports are short-term or episodic in nature, while others are ongoing. Where the planning process identifies the need for disability supports, the planner may assist the person to make a request for access to disability supports through the appropriate pathway. For episodic supports, this may be direct to a CSO or DHS and for ongoing disability supports an application for the Disability Support Register (DSR) must be made to DHS.

Tips

- Be familiar with the types of disability supports that may be available to people with a disability and their families and the pathways to access support. Reconsider the person’s goals and ask if that type of support is going to help the person to achieve them.
- Think about supports that are available in a person’s local area.
- Make sure you have thoroughly considered how informal supports and generic supports can help a person to achieve their goals before thinking about disability services.
- Provide accurate information about how access to ongoing disability support is determined through the DSR (see Access to Ongoing Disability Support Guidelines). Make sure the person and their family understand the process and there may be some wait before they receive supports.
- Be familiar with the Individualised Funding Principles and Disability Services Supported Accommodation Principles when discussing ongoing supports with people with a disability and their families.

References and Resources

- **Disability Online** this site provides people with a disability, their families and carers with access to online disability related information across governments and the non-government sector, which is, quality assured, reliable, up-to-date and locally relevant. [http://www.disability.vic.gov.au/dsonline/dssite.nsf?open](http://www.disability.vic.gov.au/dsonline/dssite.nsf?open)
Planning meetings

Elements of Practice
Setting the scene and pre-planning

What’s involved?

Putting time and effort into preparing for a planning meeting can have a significant impact on the success of the process and outcomes for the person. Learning how a person wants to arrange their planning process comes from asking questions and listening to them through their words and behaviour and where necessary, asking others who know the person well.

A planner will need to consider with the person:

- What will the focus of the planning meeting be (if known)? For example, getting a job, moving out, having a break?
- What’s the right setting for a planning meeting? Often people will be more comfortable or it may be more convenient for the person or family for planning to occur at a suitable time at their home. Others might prefer meeting at a favourite or mutual place.
- Who should be invited? People who are important in the person’s life, are there other people who need to be involved?
- What time should it be? How long should it take? Can the person engage in a long meeting or would a series of shorter meetings suit the person better? Does the person have a best time of the day or week?
- What would make the person feel comfortable? For example, music, favorite food?
- How does the person need to be supported in the meeting?
- What information will be shared and what will remain private?
- What planning tools could be used?
- What style of communication or materials may assist during the planning meeting?
- What should people think about before the meeting or bring along to the meeting

Tips

- Let people know what things they need to think about or bring with them.
- Arrange morning or afternoon tea if the meeting is going to take a while. The person or another participant might like to bring something along.
- Minimise any distractions to help remain focussed on the person.
- Arrange what might be needed in terms of pens & paper, textas and poster paper, video recorders, music and anything else needed to make sure planning is meaningful to the person.

References and Resources

- **Information for my plan** is a booklet developed by Ruth Mathiesen and adapted by Deb Watson, Amanda Jones (Scope Victoria) and Gillian Damonze (United Care Community Options) for the DHS Leading Planning Workshop for people with a disability and their networks. It can be used to help people to think through different sorts of questions to better understand what matters in their life. This will be available shortly from: [http://helensandersonassociates.co.uk/about_us/HSA_Australia.html](http://helensandersonassociates.co.uk/about_us/HSA_Australia.html)

- **Information for planning booklet** for family and other important people - is a booklet developed by Ruth Mathiesen and adapted by Deb Watson, Amanda Jones (Scope Victoria) and Gillian Damonze (United Care Community Options) for the DHS Leading Planning Workshop for people with a disability and their networks. It can be used to help other people to think through the things that matter in the life of their family member. This will be available shortly from: [http://helensandersonassociates.co.uk/about_us/HSA_Australia.html](http://helensandersonassociates.co.uk/about_us/HSA_Australia.html)
Facilitating a planning meeting

What’s involved?

Once all of the right people are in the same room ready to participate in a planning meeting for someone who is important to them, planners or people facilitating the meeting need to make sure the meeting is productive and positive.

The role of a planner is to support the person to lead the planning process to the greatest extent possible. For some people, this could be by supporting the person to maximise their participation and engagement. Participation can be as simple as the person handing out written materials or as detailed as the individual going over each line item with an appropriate level of support if required.

Planners have a role in making sure that all people, regardless of the level of their disability, are encouraged and supported to actively participate in and lead their planning process.

During the meeting, planners or those facilitating the planning meeting must make sure that everybody has their say and is listened to, that there is agreement about how the meeting will be run and what is to be achieved, and that the meeting runs on time.

Tips

- Starting the meeting on time and make sure people introduce themselves to people they don’t know.
- Seek agreement about the purpose of the meeting and the process for the meeting. It’s also good to set any ground rules at the beginning.
- Make some collective decisions about what type of information is going to be recorded (for example - what is important to the person, their goals and how those involved are going to support them), who is going to record the information and in what format.
- Before the meeting starts, discuss a process for how conflict is going to be resolved. What is going to happen if people don’t agree?
- Keep an eye on the time – help people to stay on track and stay focussed on achieving good outcomes for the person. If the meeting is likely to run over time, get some agreement from the group about keeping the meeting going for a little bit longer or meeting again at another time. Be mindful of the person with a disability and whether or not they can truly participate if the meeting goes for too long.
- Be respectfully firm in encouraging others to commit to actions with set time frames.
- Close the meeting with some firm statements (and agreement) about what is going to happen next. For example, is it the responsibility of one of the members of the meeting to develop a written plan of what has been agreed upon?

Tools

- **Meeting Map - this tool is useful to:**
  - Clarify the purpose of meeting and develop agendas
  - Ensure everyone is listened to and can contribute
  - Provide a meeting process for sharing information, thinking together and agreeing actions
  - [http://helensandersonassociates.co.uk/Resources/Templates_for_person_centred_thinking_and_planning.htm](http://helensandersonassociates.co.uk/Resources/Templates_for_person_centred_thinking_and_planning.htm)
References and Resources

- The Learning Community for Person Centred Practices website has links and information about facilitating positive and productive meetings using person centred thinking techniques.
  
  http://www.elpnet.net/ppmtgs.htm
Developing a plan

Elements of Practice
Setting meaningful goals

What’s involved?

Effective planning can help a person with a disability, with the support of their family and network, to decide what is important to them. Setting goals is the next step and helps the person to work towards the things that are most important to them, to keep things they are happy with and to change those things they are not happy about.

The role of the planner is to assist the person, and their family and network, to turn their plans into reality by setting goals and helping people achieve them.

For goals to be meaningful, they must belong to the person and reflect what is important to them. Goals must capture what it is that the person wants to have in their life now or work towards for the future. Goals also must be written in a way that makes it clear what the person wants to achieve.

Goals are not about what other people or service providers can provide. Goals that are restricted to only what is available do not generally result in actions towards the best possible life for the person. For example, ‘for a person to access respite’ is not a goal. This may be a strategy to support a person and their family to achieve the goal of ‘maintaining a positive and productive family home’.

Tips

- Ask questions to find out the ‘why’ behind someone’s dreams. Explore what the dreams mean. Even an ‘impossible’ dream holds important clues to a person’s goals and needs.
- Where possible, longer-term vision should be broken down into goals that can help the person progressively work towards their vision.
- Think about whom the goal really belongs to. While it may be appropriate for the family of a young person to request some respite from their caring role, the form this respite takes (the young person being supported to play basketball in their local league) may support the person to achieve one on their own goals.

Goal: I want a job where I can get paid to work with children.

Tools

- What is working/not working is a person centred thinking tool that is useful to:
  - explore what ‘working and not working’ from the individual’s perspective, the families perspective and support workers/providers perspective
  - agree to actions that maintain or aim to increase what is working and change what is not working. A free template can be downloaded from:
    http://helensandersonassociates.co.uk/Resources/Templates_for_person_centred_thinking_and_planning.htm
Developing strategies

What is involved?

Once meaningful goals have been set, people with a disability and their family and networks need to turn their mind to how these goals can be achieved. Strategies are specific tasks and actions that will assist the person to achieve their goals.

Strategies describe what needs to happen, the steps involved and how the person will be supported. A person may have a number of strategies that are helping them work towards the achievement of a single goal.

Effective strategies must to be specific and clear, and the role of a planner is to encourage creativity, and challenge any ideas that do not support what is important to the person.

Good strategies aim to build or maintain the person’s capacity, independence, relationships and community connections and have a positive impact on the person’s life now, even if the person’s goal reflects a vision for the future.

Tips

The following questions should be explored when developing strategies:

- Is the goal simple and “one-step” or are a number of strategies required to assist the person to achieve their goal?
- What time frame would be acceptable to the person (and their family and network) for the achievement of a particular goal? This might have some impact on the strategies that are selected?
- Are their particular people in the person’s life who are willing and able to support them, or opportunities in the person’s local community that can be considered?

<table>
<thead>
<tr>
<th>Goal</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want a job where I can get paid to work with children.</td>
<td>Contact the local employment service to find out what skills I need and find out if there are any courses I can enrol in.</td>
</tr>
<tr>
<td></td>
<td>Get some experience in looking after my nieces and nephews and playing with them</td>
</tr>
<tr>
<td></td>
<td>Explore volunteering opportunities at childcare, kinders and schools in the local community</td>
</tr>
<tr>
<td></td>
<td>Develop a resume and practice interview skills</td>
</tr>
</tbody>
</table>
Matching Resources

What is involved?

Resources and supports need to be identified in a plan so that those involved in its implementation know their role and what is required.

Resources can include both people and funding where this is required. Planners should support people to consider if the person with a disability has any preferences for the ways they are supported. For example, a young person may prefer the support of someone a similar age if they are in the community but would be quite happy for an older person to support them around the house.

Planners should encourage people with a disability and their families to see beyond what is available right now and give some thought to some small changes that might change the resources a person requires. This can include any changes to the environment or equipment that could enhance a person’s independence.

Planners should also encourage people to consider a range of options and not simply paid supports.

Tips

- Consider informal supports that are naturally present in the person’s life including family, co-workers, neighbours or other community members. Who in the person’s network could be involved?

- Don’t underestimate how much the people can do for themselves. It can undermine their independence or development if they rely too much on other people to do things for them.

- Find out when the person really needs other people around and when support is for ‘just in case’. Some plans have too much support – try and get the right balance.

- It may be useful to develop a timetable of a usual week that sets out the different times of the day and the kinds of things the person needs support with.

- Build on the supports and resources already available to the person. This should include assisting the person to map out their current supports and then considering the gaps.

- What role does or should community play in supporting the individual? What community building strategies would increase the individual’s ability to attain their goals?

- What informal supports are in place? How can informal supports be increased? How can the person be supported to increase their informal networks?
<table>
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<td>Contact the local employment service to find out what skills I need and find out if there are any courses I can enrol in.</td>
<td>Mum (by next week)</td>
</tr>
<tr>
<td></td>
<td>Get some experience in looking after my nieces and nephews and playing with them</td>
<td>Michelle - sister (once a fortnight)</td>
</tr>
<tr>
<td></td>
<td>Explore volunteering opportunities at childcare, kinders and schools in the local community</td>
<td>Me with support worker - 1.5 hour each week until settled (initially 6 weeks)</td>
</tr>
<tr>
<td></td>
<td>Develop a resume and practice interview skills</td>
<td>Short course at TAFE</td>
</tr>
</tbody>
</table>

**Tools**

- **The Staff Matching Tool** is a person centred learning tool that can help to match people with supporters who share common interests, have a compatible personality and the skills needed for their care. An example of this tool can be found at: [http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/Staff%20Matching%20Tool.doc](http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/Staff%20Matching%20Tool.doc)
Determining Outcomes

What is involved?

An outcome describes the change that is likely to take place for the person as a result of implementing strategies to achieve a goal.

Outcomes help all involved to understand what ‘success’ looks like for a person and to make sure the person is on track to achieving their goals. Outcomes assist those responsible for implementing the plan to monitor and review its success.

Outcomes and how progress towards these outcomes will be measured should be discussed and agreed to during the planning process. This must include setting a review date.

Tips

In helping to define outcomes, a planner should:

- Ask the person what life would look like for them once they have achieved their goal - how would they feel, how will they know?

<table>
<thead>
<tr>
<th><strong>Goal</strong></th>
<th><strong>Strategies</strong></th>
<th><strong>Resources</strong></th>
<th><strong>Outcomes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I want a job where I can get paid to work with children.</td>
<td>Contact the local employment service to find out what skills I need and find out if there are any courses I can enrol in.</td>
<td>Mum (by next week)</td>
<td>I understand the skills I need (including formal qualifications &amp; experience) and know which courses I can enrol in that are in my local area.</td>
</tr>
<tr>
<td></td>
<td>Get some experience in looking after my nieces and nephews and playing with them</td>
<td>Michelle - sister (once a fortnight)</td>
<td>I spend time (up to 2 hours) looking after my nieces &amp; nephews on a Saturday or Sunday.</td>
</tr>
<tr>
<td></td>
<td>Explore volunteering opportunities at childcare, kinders and schools in the local community</td>
<td>Me with support worker - 1.5 hour each week until settled (initially 6 weeks)</td>
<td>I have visited five places where I could volunteer and chosen two I like. I have spoken to the two places and arranged a further visit</td>
</tr>
<tr>
<td></td>
<td>Develop a resume and practice interview skills</td>
<td>Short course at TAFE</td>
<td>I have found out the course that are on offer and received the enrolment forms.</td>
</tr>
</tbody>
</table>
Tools and other planning resources

Many links to different Person Centred Planning and Person Centred Thinking Tools: 
http://www.csrpcp.net/default.aspx?page=16600

Examples of different Person Centred Planning and Person Centred Thinking Tools: 
http://valuingpeople.gov.uk/dynamic/valuingpeople139.jsp

The Learning Community for Person Centred Practices website has free downloads for persons 
centred thinking tools and resources: 
http://www.elpnet.net/what.html

Information and a reading room about person centred thinking and practice with some free 
publication downloads: 
www.helensandersonassociates.co.uk

The Foundation for People with Learning Disabilities produces a range of publications, including 
reports, briefings and information booklets. Most of these can be downloaded free of charge 
from this site: 
http://www.learningdisabilities.org.uk/welcome
PART TWO
Planning Implementation Guide
Contents

PART TWO

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Assistance with planning

A person with a disability or a person on behalf of a person with a disability may request assistance with planning from a disability service provider.

Where a person with an intellectual disability, or a person on behalf of a person with an intellectual disability requests any service from a disability service provider, the disability service provider must offer them assistance with planning.

A request may be verbal or written and in circumstances where a person other than the person with a disability makes the request, the disability service provider should, where possible, make contact with the person for whom the request has been made to determine their wishes in relation to the request.

All disability service providers must ensure that an offer of assistance with planning is made to all people with an intellectual disability. Options for ensuring this offer is made include:

- Screening questions to determine if the person has an intellectual disability when a request for any service is made.

For DHS staff, where a Contact Note is created in CRIS under the type ‘Request for support, a prompt message asking the worker if an offer of assistance with planning has been made, will be automatically generated for people with a target group determination related to intellectual disability.

All disability service providers need an appropriate information system to record:

- When a request for assistance with planning has been received
- When an offer of assistance with planning is made; and
- The outcome of that request or offer.

Arranging assistance with planning

Where a request for assistance with planning is made, or an offer of assistance with planning is accepted, a disability service provider must arrange for the assistance to be provided within four (4) weeks.

The term arrange refers to the obligation of the disability service provider to:

- Provide the assistance with planning; or
- Register the person for assistance with planning; or
- Refer the person to an alternative disability service provider (who has capacity) for assistance with planning.

Disability service providers must clearly communicate all decisions and actions with the person requiring assistance with planning, particularly where the person is to be referred to an alternative provider. Refer to
Assistance with planning can help people to build a ‘vision’ for their lives.

**Making a referral for assistance with planning**

**Purpose of assistance with planning**
For people who are seeking support from the disability service system for the first time, assistance with planning can assist people to build a vision for the sort of life the person would like to lead and consider the types of supports required to make this vision a reality.

For people with a disability who are receiving disability supports, assistance with planning can be considered when they:

- Wish to make significant changes to their goals
- Want to explore different support options; or
- Are anticipating or experiencing a major life change.

Where a person is currently in receipt of a disability service, disability service providers must consider assistance with planning where there is a need to explore options beyond the services that are currently being accessed.

The need for broader planning may arise during a discussion as part of the development of a support plan, or a plan for any disability service.

Disability service providers responsible for assisting people to develop support plans, or other plans, should discuss the possibility of assistance with planning with the person and their family and network, and where required, make a referral to an appropriate provider.

Assistance with planning can include any one or a combination of:

- Planning related to natural or informal supports
- Planning related to generic or community based supports
- Assistance to develop an individual plan; or
- Assistance to access disability supports.

**Providers of assistance with planning**
It is expected that assistance with planning will be provided by a disability service provider with:

- Planning and case management support as one of their core functions and
- The expertise to develop informal, generic and disability specific responses and;
- Knowledge or experience in a specific disability area (where required).

Disability Partnerships and Service Planning in each region must develop a list of agencies in their region that meet the criteria and can therefore provide assistance with planning.

DPASP should ensure that:
• All disability service providers in the region are aware of to which CSO’s referrals for assistance with planning can be made

• Disability service providers who are responsible for providing assistance with planning are supported to understand their role and ensure that they provide assistance with planning where required and;

Making a referral for assistance with planning

A disability service provider that has been approached to provide, or who has offered assistance with planning to a person with an intellectual disability, may not be able to provide this support for reasons including:

• Limited expertise such as not being a provider of planning or case management or with limited experience in developing links and relationships with other services

• Limited specific knowledge to provide assistance with planning to a person who has specific needs. This may include people who have specific conditions such as multiple sclerosis or an acquired brain injury; or

• Limited capacity where the provider has both the expertise and specific knowledge however cannot provide the requested support at the time.

Disability service providers who do not meet the criteria (as listed above) as providers of assistance with planning, or who do not have the capacity to provide assistance with planning, may consider a referral.

Referrals for assistance with planning can be verbal or written and both the referring provider, and the provider to whom the referral is being made have a number of responsibilities.

Responsibilities of the referring disability service provider include:

• Discuss this with the person who has made the request or accepted the offer of assistance with planning. A referral should only be arranged where the person has agreed

• Make contact with the provider to whom the person is being referred to ensure this provider has capacity to respond to the person without a subsequent referral. Disability service providers must not refer a person for assistance with planning unless the provider to whom they are referring has capacity to provide this assistance

• Provide referral information as agreed with the disability service provider to whom the referral is being made; and

• Ensure that a record of the referral including the date and the disability service provider to whom the referral has been made, has been recorded on the organisations information management system.
Responsibilities of the disability service provider to whom the referral is being made include:

- Consider the request and the capacity to respond without subsequent referral
- Make contact with the person requiring assistance with planning and negotiate follow up actions and a time frame for the assistance to be provided; and
- Record the referral details and any agreed actions on the organisation’s information management system.

Providing assistance with planning
Consistent with the guiding principles for planning in the Act, assistance with planning should take place in a way that most suits the person with a disability and their family or network. This may include a full exploration of all aspects of the person’s life, or a number of key areas that they consider most important.

Exploring goals, needs and aspirations in the Planning Resource Kit can guide disability service providers when providing assistance with planning.

Disability service providers should consider initial information gathering to determine the scope of the assistance with planning required by the person.

As outlined above, there are a number of elements to assistance with planning. These include:

- **Planning related to informal or natural supports**
  While people with a disability may not readily consider the role that family and friends can play, exploring a person’s natural and informal networks is a critical part of supporting a person with a disability to achieve their goals.

  Disability service providers can assist a person to consider the things they want to achieve and how the person can engage with their family and friends. For disability service providers, this may include planning and running a meeting that includes a person’s family and friends, working individually with a person’s family and friends on how they can be more involved, setting up arrangements between a person with a disability and a member of their network, or providing support and guidance to a member of a person’s network.

  Refer to Considering options: engaging informal supports in the Planning Resource Kit.

- **Planning related to generic and community supports**
  When a person with a disability is thinking about their goals and the possible ways to achieve them, they may consider seeking support only from the disability service system.
In providing assistance with planning, disability service providers can assist people with a disability and their families to consider the availability of generic supports available to all people in the community, as a way to assist them to achieve their goals. Assistance with planning can help people with a disability to think about what is available within their local community and how they can access these supports. This may include making contact with different supports and services, arranging referrals and providing information and consultation on the needs of the person accessing the service.

Refer to *Considering options: accessing generic supports* in the Planning Resource Kit.

- **Assistance to develop an individual plan**

Some people with a disability and their family and network may choose to have the things they have talked about and agreed upon, written down in a plan. This can include their goals, aspirations and the ways they are going to be supported to achieve their goals.

Where a person with a disability and their family and network choose to develop a plan, the disability service provider must work with them to discuss the right format and language and ensure that it is meaningful to the person and their family and network.

The development of any plan must take place according to the guiding principles for planning in the Act, and best practice in planning would ensure that a review date is also set in the development of any plan.

Refer to *Developing a plan* in the Planning Resource Kit.

- **Assistance to access disability supports**

Where it has been identified through the planning process that a person requires access to disability supports, a disability service provider may be required to support the person to access those supports.

Where this is identified, assistance with planning will include a referral to:

- Disability Services at one of the DHS regional offices for services such as those included on the DSR or
- An appropriate disability service provider.

Refer to *Access to Disability Supports* in the Planning Resource Kit.
Planning for service provision

The Act and the Planning Policy both discuss the essential need for planning that is required in the context of all service provision.

Where a person is in receipt of any disability service, planning is an **essential** component in the provision of that service. All plans **must** be developed in line with the guiding principles for planning in the Act.

The Act describes a ‘support plan’ which is required where a person is in receipt of an **ongoing** disability service and the Planning Policy describes the planning that is required for both ongoing disability supports and other disability supports.

For a number of Disability Services programs such as Futures for Young Adults, the development of a plan is a requirement under the program guidelines, however this is not a support plan as defined in the Act.

In the development of any plan, disability service providers should consider the best practice approach described in the Resource Kit (Part One).
Support plans

A support plan is required when a person is receiving an on-going disability service. The Act specifies that a support plan is required for a person who is regularly accessing an on-going disability service. A disability service provider must ensure that a support plan is prepared within 60 days of a person commencing to regularly access the service.

The support plan must be developed through an individualised planning process, which is underpinned by the guiding principles for planning in the Act.

The support plan must:

- Reflect the goals of the person with a disability; and
- Describe how the support from the disability service provider is intended to address their goals. This includes an exploration of the strategies and resources required to support the individual.

Where a person is accessing more than one ongoing disability service, the Planning Policy describes a best practice approach to developing a single, coordinated plan that covers all ongoing disability supports as well as other supports the person may be receiving.

Where possible, the development of a support plan should build on any previous planning that has been undertaken.

Previous planning may include:

- people who have received assistance with planning
- people who had a GSP or IPP developed under the previous legislation
- people who were registered on the Disability Support Register (DSR) for ongoing disability support after April 2006 and have participated in individualised planning prior to their need being registered; or
- people who have undergone planning for other disability supports (for example, FFYA or case management).

On-going disability services

A support plan is required where a person is in receipt of an on-going disability service. The Planning Policy defines an on-going service as a service which:

- involves the recurrent allocation of resources (subject to review) for an individual
- does not provide a short term or episodic service, and
- does not involve the provision of goods (exclusively).

Applying this definition, the following Disability Services activities are defined as on-going disability services:

- Community Options
Providers of ongoing disability support differ depending on the service

- Congregate Care
- Day Programs
- Flexible Support Packages (FSP)
- HomeFirst
- Individual Support Packages
- Outreach Support
- Shared Supported Accommodation.

Provider of ongoing disability support

For a group based support such as a day program or accommodation placement, the disability support provider directly providing the ongoing service must ensure a support plan is in place.

For an individualised support, the disability support provider responsible for ensuring a support is in place may be:

- DHS or a CSO for an Individual support package
- DHS for HomeFirst
- CSO for a Flexible Support Package
- DHS or a CSO for Outreach

Support plans have a number of key elements

Elements of a support plan

The Planning Policy describes best practice in planning and the development of support plans. A support plan contains a number of key elements including:

- **Information about the person:** what the person wants or needs the disability service provider to know about them (for example, their likes and dislikes)
- **Goals and aspirations:** the things the person wants to achieve
- **Actions and strategies:** the ways a person can achieve their goals
- **Resources:** the support a person requires to implement the strategies such as people who will assist or funding that is required
- **Outcomes:** how actions and strategies will be measured
- **Monitoring:** how the plan will be monitored
- **Reviews:** when the plan will be reviewed and who will lead the review

When a support plan must be in place

The Act states disability service providers must ensure that a support plan is in place within 60 days of a person commencing to regularly
access a disability service.

It should be considered that a person has commenced to regularly access an Individual Support Package following the allocation of funding.
Preparing for the development of a support plan

Choosing the scope of the support plan

In line with the Planning Policy and the transition provisions for planning where a person’s support plan, GSP, IPP, or other plan related to disability supports, requires a review, the on-going disability service provider must discuss the upcoming review with the person and their network to consider a number of key decisions including:

- Where the person is in receipt of more than one on-going disability service, do they want a coordinated support plan developed?
- Where the person is in receipt of any other disability service, do they want to include these in the development of their support plan?
- Where the person has a GSP, do they want the support plan to be considered as a review of their GSP?
- Where a person has other service providers involved (for example HACC or mental health) and do they want these included in their support plan?
- Are there other people involved in the person’s life, such as family and friends that they want involved in the development of their support plan?

Refer to Appendix 1 for further information.

Benefits of a coordinated support plan

Where a person is receiving more than one on-going disability service, the person with a disability and their network may choose to have one support plan developed that includes all or more than one ongoing service.

A coordinated support plan:

- Involves all or some ongoing disability service providers for ongoing services for which the support plan covers; and
- Has input from people close to the person who are involved in the person’s life and have a part to play.

Benefits for people with a disability and disability service providers in contributing to a coordinated support plan include:

- The person is more likely to achieve their goals when everyone is working together
- Sharing of knowledge, ideas and expertise
- Coordination of supports and services
- Potential to use resources more effectively; and
- Promotes collaboration between service providers to work together towards common goals.
Where a person makes a choice to develop a coordinated support plan, disability service providers must work with the person and other on-going disability service providers to develop this plan.

See below Developing a support plan

Including other supports

While the Act specifies that a support plan is required where a person is in receipt of an on-going disability service, consistent with best practice for planning, a support plan should also include goals and strategies related to:

- other disability supports
- generic supports; and
- informal supports.

Disability service providers responsible for coordinating a support plan, should discuss the option of including other supports with the person and their family or network.

A coordinated support plan can also provide the basis for the bringing together informal, generic and disability supports (including ongoing disability supports) in working to meet the person’s goals.

Where it is the wish of the person with a disability, the on-going disability service provider responsible for coordinating the development of the support plan should:

- Where requested, make contact with those people who the person has nominated to discuss the support plan process, what it is intended to achieve and the contribution they could make to the support plan
- Discuss times they might be available and ways they could prepare for the meeting; and
- With the permission of the person, forward any current plans or information about the person that would assist them in preparing for the development of a coordinated support plan.

While only providers of on-going disability services are obligated to be part of the preparation of support plans, all people chosen by the person with a disability and their family and network should be encouraged to participate.

Coordinating the support plan

Following decisions regarding the scope of the support plan, disability service providers should discuss with people with a disability and their family and network, who is going to coordinate the development of the support plan. This is an important discussion regardless of whether one or a number of services are involved.
People with a disability and their families and networks can choose:

- To lead the development of the support plan themselves
- Request that their service provider coordinate the development of the support plan; or
- Where the person has chosen to develop a coordinated support plan, request one of their on-going disability service providers to coordinate this process.

For people with a disability and their families who choose to take on this role for themselves, they may require information and support.

Where a person with a disability and their family request that a disability service provider coordinate the development of their support plan, the disability service provider must consider if the person nominated has the skill and capacity to coordinate the development of the support plan. In some circumstances, it might be necessary for the disability service provider to negotiate with the person and their family regarding who, within the service, will be responsible for coordinating the development of the plan.

In all circumstances, the disability service provider should endeavour to comply with the wishes of the person with a disability, and must discuss any alternative arrangements with them.

Refer to Appendix 3 for further information.

**Independent facilitation**

Where a person is receiving an on-going disability support, it is the responsibility of the disability service provider to ensure that a support plan is in place. There may be some situations however, where an independent person may be required to facilitate the development of a support plan. An independent person is someone who is separate from the person and their family and of the disability service providers involved in the support plan.

Independent facilitation may be appropriate where:

- There are conflicting views about the person’s goals that have not been able to be resolved; or
- Relationships between service providers or people who are important to the person are complex.

The regional Intake and Response team should be contacted to discuss the availability of independent facilitation.
Developing a support plan

The Resource Kit Part One: Exploring goals, needs and aspirations provides comprehensive information on exploring what is important to people, how they can best be supported to achieve their goals and how to develop a plan that reflects the person needs and goals.

This information also provides a best practice approach to developing plans with people with a disability.

In developing a support plan, some additional considerations are required.

Role of participants in the development of the support plan

All participants in the development of the support plan must:

- Plan with the person according to the guiding principles for planning in the Act
- Agree on the strategies and supports they will put in place with the person and their network
- Implement the strategies as agreed
- Monitor the persons progress towards their goals; and
- Participate in any reviews as required.

Role of the coordinator of the support plan

In addition to the responsibilities listed above, disability service providers responsible for coordinating the support plan must:

- Work with the person, their family and network to:
  - Identify and invite participation of those who need to be involved
  - Decide how and when planning will occur
  - Decide what issues will be discussed in a group (publicly), and those that will be discussed more privately
- Negotiate administrative tasks with other disability service providers including documenting and formatting the plan
- Notify all relevant parties of the development of the support plan. (See Notifying all relevant parties below.)

Refer to Appendix 3 for further information.

Considerations for all disability service providers

For disability service providers, the planning provisions in the Act provide new opportunities to think, plan and work more flexibly with people with a disability and their networks, particularly in the development of a support plan.

While all disability service providers have led and been part of planning
processes with the people they are currently working with, some additional considerations to maximise the development of support plans include:

- how the guiding principles for planning can be incorporated in any planning process
- how people with a disability and their family and network can direct the planning process
- the information needs of people with a disability when their plans are due for review (refer to Appendix 4 for further information)
- planning meetings: – being flexible, hosting meetings where the service is coordinating the support plan, releasing staff to attend meetings where an alternative provider is coordinating the support plan, considering how attendance at after hours meetings can be supported
- coordinating support plans: engaging all the right people, facilitating the meeting.

**Working with other disability service providers**

Disability service providers **must** respond to a person’s request to develop a coordinated support plan. Given this will involve working closely with other disability service providers they may not have traditionally worked with in the past, disability service providers should consider:

- proactively building relationships with other disability service providers working with people they also provide service to (for example, if a number of people living in a CRU all attend the same day program)
- reviewing the different ways planning has been undertaken, in each service and the way plans are developed and documented
- running joint professional development sessions; and
- developing a protocol for the joint development of support plans.

**Resources**

Identifying how resources will be used to implement a strategy is an important component of any plan. Refer to *Developing a plan* in the *Planning Resource Kit* for further information.

In developing a support plan, the type of on-going support the person receives, may impact on things to consider when allocating resources towards a strategy.

In matching resources to strategies, where appropriate, consideration must be given, to:

- ensuring available resources are used effectively and efficiently
as stated in the objectives of the Act; and

- specific program guidelines (such as Flexible Support Packages, HomeFirst, Support & Choice).

### Setting a review date

The Disability Act requires a support plan to be reviewed at least once every 3 years or more often as requested. A person who is living in a residential institution must have their support plan reviewed every 12 months.

(For the purposes of the Act, a residential institution is Kew, Colanda, Sandhurst and the Long Term Residential Placement [LTRP].)

Best practice is to review support plans every 12 months, particularly where the person has an individual support package where funding arrangements require review on an annual basis.

A date for review of the support plan and who will lead the process should be determined when the support plan is developed. In determining a review date, things to consider may include:

- Are the person’s goals short term or long term?
- Is the person’s support stable?
- Is the person anticipating any significant change to their needs or circumstances?
- Are there any other circumstances where the support plan may require more intensive monitoring and review?

A person with a disability and their family or network may request a review at any time.

### Agreeing to the content of the support plan

Those who have been involved in developing the support plan and have some responsibility for its implementation must agree to the strategies, resources and outcomes in the support plan.

The person with a disability with their network must endorse that the support plan reflects their goals and choices.

The person with their network and the ongoing disability service provider(s) must agree to the strategies that the provider will be accountable for implementing.

The support plan can be considered prepared once the person with their network and the disability service provider(s) agree with the arrangements.
process must agree on how changes will be negotiated and incorporated into the support plan (including family and friends and providers of episodic disability services) are part of the development of a support plan with a person with a disability, agreement must be reached about how changes will be incorporated into the support plan.

Given each person or disability service provider who has some responsibilities within the support plan will have a copy, even small changes need to be communicated with everyone involved.

People involved in the development of the support plan should also agree on the extent and type of changes that can be negotiated between the person with a disability and the person supporting them, and when it would wise for the group to reconvene to consider a broader review.

In some cases people who were not involved in the development of the support plan will need to be notified

Notifying all relevant parties

Following the development of the support plan, and the agreement by all parties on the content of the support plan, all relevant parties must be notified.

People with a disability and their family and networks, along with those disability service providers who participated in the development of the support plan, need to consider the scope of the support plan as agreed.

If the plan was intended to be a review of the person’s GSP, and Disability Client Services (DCS) did not participate in the development of the support plan, DCS must be notified.

The person and their family or network, or, where requested, the on-going disability service provider responsible for the coordination of the support plan must notify DCS, either by phone or in writing, that the person’s GSP has been reviewed. This notification must take place within 10 working days of the support plan being finalised.

Where DHS are notified of this, they must:

- Create a ‘Contact Note’ in CRIS and include details of the review information provided; and
- Create a ‘Support Plan’ record in CRIS including the plan date, the plan review date and the plan status as ‘final’. Where DHS has a copy of the support plan, this can be attached to the record, however it is not a mandatory requirement.

This will ensure that the person’s name will not appear on the GSP review report as requiring review.

The person’s support plan must be formatted in a way that makes most sense to

Format

A person’s support plan must be formatted in a way that is most meaningful to them. Some people will relate to photos and pictures or a tape-recording, whereas others will prefer a structured format similar to the disability service provider’s copy.
Disability service providers will need to consider how they can prepare plans in alternative formats and how this information can be both easily accessible for people with a disability, and meaningful for disability service providers.

Copies of the support plan
In addition to the person and their network, a copy of the support plan must be provided to any disability service provider and any other party who has responsibilities listed in strategies and resources section of the support plan.

The person and their network should also decide if there is anyone else who should have a copy and what information should be shared.

Disability service providers who are responsible for coordinating the development of the support plan must keep a record of who has received a copy of the support plan.

Recording information
Once the support plan has been completed, the disability service provider must record that the support plan has been prepared and include it as part of any person’s files or information management systems within the organisation.

Where DHS is the disability service provider, details of the support plan must be entered on CRIS and an electronic copy attached.

Preparing a support plan where the person does not wish to have one
Disability service providers are required under the Act to ensure a support plan is prepared for a person in receipt of an on-going disability support.

Disability service providers also have a responsibility to provide information to the person about the disability services being provided, which includes the requirement for a support plan for people who receive on-going disability support.

The disability support provider must discuss with the person:

- That the development of the support plan is an opportunity for an individual and service provider to agree on how the disability support provider will support the person on a day-to-day basis or to work towards their goals
- The legal requirement for the disability support provider to ensure a support plan is prepared
- The option to involve advocates in the planning process or engage independent facilitation
Where a person declines to be involved in the development of their support plan, the disability service provider must:

- Document that the person has declined and the reason provided
- Develop a support plan for the person based on previous planning, their knowledge of the person and the day-to-day support the person is receiving or will receive
- Give a copy of the support plan to the person in a format that is most meaningful to the person, and where required, explain what is contained in the support plan; and
- Provide ongoing opportunities for the person to direct the review of their support plan.
Monitoring and Review

The *Resource Kit Part One* provides comprehensive information on exploring how to develop outcomes and monitor and review people’s progress toward these outcomes.

This information provides a best practice approach to monitoring and reviewing plans with people with a disability.

In monitoring and reviewing support plans, there are some additional considerations listed below.

**Disability service providers are accountable for monitoring strategies relating to their service**

**Monitoring progress**

How to monitor the progress towards each of the person’s goals should be discussed and decided during the development of the support plan.

Regardless of who has been responsible for the coordination of the support plan, each ongoing disability service provider is accountable for monitoring strategies relating to their service.

**Review of the support plan**

In developing a support plan, a review date and a person responsible must be nominated. It is the responsibility of the nominated disability service provider to contact all parties and negotiate a review process at the time specified in the person’s support plan.

A review of the support plan occurs around the time specified when the support plan was developed. A support plan may also be reviewed when the person, someone on their behalf or the disability service provider asks for it to be reviewed earlier than the specified time.

This would be necessary when:

- a person’s needs change and this impacts on the resources required. See *Change in need* below.
- a person’s goals are met or change
- strategies need to be reviewed
- the person is allocated another service (disability or other) and decides to have the new allocation included in a coordinated support plan.

The review of the support plan involves bringing people back together to:

- Check if the person has reached their goals, what is working and not working, and what needs to change
- A review of their funding plan where a person has an individual package including:
  - How the funding was used to meet the person’s goals
Some people may need a more extensive review process

Change in need

Some people may experience a significant change in their circumstances that may lead to a more intensive review process. An example of this could be the loss of a carer or physical deterioration due to the nature of the person’s disability.

Where the person has needs that cannot be met through their existing formal and informal supports, or they require a different type of disability support, the disability service provider may refer the person for more extensive planning. The process to request assistance with planning is described in both the Planning Policy and this Resource Kit and Implementation Guide.

Where a person is in receipt of an individual support package and the need for additional funding is identified, the person may need to engage some interim arrangements or prioritise their goals until additional funding becomes available. The process for requesting additional resources should be discussed with the Intake and Response Team. The Access to Ongoing Disability Support Guidelines provides additional information on seeking additional funding. These guidelines are available from the Disability Services Division website.

Termination of a support plan

The Act states that a support plan is no longer required when a person ceases to receive on-going disability supports.

- Where a person is receiving only one on-going disability support

The disability service provider must discuss the cessation of the support plan with the person and any follow up actions that are required. Where other disability service providers, or other people were involved in the development of the support plan, the person and their family and network must make decisions regarding:

- if the plan will continue with the removal of strategies and supports that were the responsibility of the on-going disability service provider
- if a new plan coordinator is required
- if the plan is still relevant
- if the plan review date is still relevant
- if assistance with planning is required; and
- how to notify other parties involved in the development of the support plan, that the support plan will be terminated.
The disability service provider must ensure that they have an appropriate information system to record:

- the date the person ceased the service
- the reasons the person ceased the service; and
- any follow up referrals or support provided to the person.

For DHS staff, the “Plan End Date” field within CRIS must be updated to reflect the termination of the support plan.

- **Where a person is receiving more than one on-going disability support**

In addition to the considerations listed above, a number of additional considerations are required where a person continues to access on-going disability services. These include:

- If the on-going disability service to be ceased is provided by the coordinator of the support plan, a new coordinator must be selected by the person
- Reviewing the goals, strategies and supports in the support plan to remove those relating to ongoing the disability service being ceased

Appendix 4 provides a Support Plan Requirements Checklist for disability service providers.
Transitional provisions for planning

The Act specifies transitional provisions for planning that describe the arrangements for planning that will enable the transition from the former legislative framework to the requirements for planning under the Act.

To support people with a disability and their family and networks, and disability service providers to understand the transitional provisions for planning, two documents have been developed:

- Appendix 1 *Transitional provisions for planning* provides information for disability service providers
- Appendix 3 *Transitional planning: what it means for you* is a guide for people with a disability and their family and networks to support them to understand how the new planning provisions may apply to them.
Other requirements

Best practice in planning ensures that other plans a person may have are developed in a way that supports consistency

Consistency with other plans

A person with a disability may have a number of other plans in place in addition to their support plan. These can include a justice plan or a behaviour management plan.

As part of the planning process, the impact and influence of other plans, where they exist, must be considered, and where appropriate, strategies are to be incorporated into the development or review of a support plan, to ensure consistency and information sharing.

For individuals who have an individual support package, in addition to a support plan, they will have ISP Funding Plan. An ISP Funding Plan details specific funding arrangements including the cost of supports, and in some circumstances, where these services will be purchased.

As detailed above, an individual’s ISP funding plan must be part of the review of their support plan.

See Review of a support plan.
Personal and private information for daily living

The information included in a support plan helps everyone to understand the person’s goals and the best way to meet them.

To assist staff working with the person with a disability to understand how best to support them, more detailed information may also need to be recorded, for example, information on how to assist the person with a disability during meal times or while dressing and bathing.

Personal and private information is used to support a person with a disability in a specific setting (for example: residential service or day program), however, with the permission of the person with a disability, this information may be shared between service providers.

Some examples of the areas that may be included in personal and private information are:

- personal care such as dressing, bathing, personal hygiene
- meal assistance
- health care issues
- behavioural issues
- therapy support
- communication issues

Personal and private information does not form part of the support plan, but is essential in supporting many people with a disability. This information should be discussed by the person with a disability and the disability service provider, and recorded in a manner that best suits the needs of both.

The development of personal and private information must take place in line with the guiding principles for planning. People with a disability and their families and networks, along with disability service providers coordinating the development of a support plan, must discuss and consider how and where personal and private information is going to be developed and recorded (for example, during the planning meeting to develop the support plan or at a separate meeting), and how and to whom the information is going to be distributed.

Disability service providers must not share any aspects of personal and private information with other parties without the express permission of people with a disability and their family and network.

Disability service providers must ensure that this information is stored in an appropriate information system and is accessible to people who are working with the individual and require this information.
Appendices
Appendix 1: Transition provisions for planning


<table>
<thead>
<tr>
<th>Legislative Requirement</th>
<th>Implementation Strategy</th>
<th>Comments</th>
</tr>
</thead>
</table>
| (1) If on commencement of this section a person with an intellectual disability has an individual program plan prepared under the **Intellectually Disabled Persons’ Services Act 1986**, the individual program plan continues to have effect for the purposes of this Act until the next review as specified in the individual program plan. | **Pre 1 Jul 2007 – IPP Reviews**  
- The disability service provider needs to undertake the IPP review at the scheduled time and set a review date in 12 months, unless the needs of the person indicate an earlier IPP review is required. | |
| (2) When a review of an individual program plan referred to in sub-section (1) is conducted, a support plan may be prepared. | **Post 1 Jul 2007**  
- When the IPP review is due the disability service provider, in consultation with the person with a disability, needs to **facilitate** the preparation of a support plan.  
- The support plan should be prepared in accordance with the arrangements described in the Planning Policy.  
- If the person with a disability chooses to have one support plan with all on-going disability service providers involved, then the review date that is set, is the date for review of the support plan by all the participating disability service providers. |  
- In line with good practice, the preparation of the support plan should involve liaison with all the disability service providers involved in the person with a disability’s life.  
- That where a single support plan is developed, the person with a disability and the disability service providers need to agree that the new support plan constitutes a review of all existing plans (IPP or GSP) and the review date will then apply to all participating disability service providers. |
### Planning Resource Kit & Implementation Guide

<table>
<thead>
<tr>
<th>(3) If on commencement of this section a person with an intellectual disability has a general service plan prepared under the <em>Intellectually Disabled Persons’ Services Act 1986</em>, the general service plan continues to have effect for the purposes of this Act until; the next review as specified in the general service plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre 1 Jul 2007 – GSP Reviews</strong></td>
</tr>
<tr>
<td>- The disability service provider (Disability Client Services) needs to undertake the GSP review at the scheduled time and set a review date in 3 years, unless the needs of the person indicate that an earlier GSP review is required.</td>
</tr>
<tr>
<td>- Although the Intellectually Disabled Persons’ Services Act 1986, allows for a 5 year GSP Review date to be set, a 3 year review date (maximum) must be established as this is in accord with the review timeframes in the new legislation.</td>
</tr>
<tr>
<td><strong>Post 1 Jul 2007</strong></td>
</tr>
<tr>
<td>- When the GSP review is due the disability service provider (Disability Client Services), in consultation with the person with a disability, needs to facilitate the preparation of a support plan.</td>
</tr>
<tr>
<td>- The support plan should be prepared in accordance with the arrangements described in the Planning Policy.</td>
</tr>
<tr>
<td>- If the person with a disability chooses to have one support plan with all ongoing disability service providers involved, then the review date that is set, is the date for review of the support plan by all the participating disability service providers.</td>
</tr>
<tr>
<td>- Although Disability Client Services is required to facilitate the preparation of the support plan, the person with a disability may choose that one of the other on-going disability service providers prepare the support plan. This circumstance may particularly arise if the person with a disability is no longer receiving support from Disability Client Services at the time of the GSP review.</td>
</tr>
<tr>
<td>- In line with good practice, the preparation of the support plan should involve liaison with all the disability service providers involved in the person with a disability’s life.</td>
</tr>
<tr>
<td>- That where a single support plan is developed, the person with a disability and the disability service providers need to agree that the new support plan constitutes a review of all existing plans (IPP or GSP) and the review date will then apply to all participating disability service providers.</td>
</tr>
<tr>
<td>(4) When a review of a general service plan referred to in sub-section (3) is conducted, if the person with an intellectual disability is receiving ongoing disability support a support plan must be prepared.</td>
</tr>
</tbody>
</table>

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| (5) When a review of a general service plan referred to in sub-section (3) is conducted, if the person with an intellectual disability is not receiving on-going disability support, the person must be offered assistance with planning in accordance with section 55.  | Post 1 Jul 2007  
- When the GSP review is due, the disability service provider (Disability Client Services) needs to offer the person with a disability assistance with planning in accordance with the arrangements described in the Planning Policy.  | Post 1 Jul 2007  
- If the person with a disability is no longer receiving support from Disability Client Services at the time the GSP Review is due, contact should be attempted and assistance with planning offered. Based on the available knowledge of the person with a disability, contact should be made in a manner most suited to the person. This may be by telephone or in writing. The outcome of this contact, or attempted contact, must be recorded in a case note.  |
| --- | --- | --- |
| (6) If on the commencement of this section a person with a disability which is not an intellectual disability is receiving on-going disability support and has a plan for the provision of disability services, the plan continues to have effect until the next review as specified in the plan or the expiry of a period of 12 months after the commencement of this section, whichever occurs first.  | Pre 1 Jul 2007 – ‘Plan’ Reviews  
- The disability service provider needs to undertake the review of the person’s plan at the scheduled time and it is recommended that a 12 month review date be set, unless the needs of the person indicate an earlier review is required.  |  |
| (7) If a person to whom sub-section (6) applies is still receiving on-going disability support when the plan ceases to have effect under sub-section (6), a support plan must be prepared.  | Post 1 Jul 2007  
- When the review is due the disability service provider, in consultation with the person with a disability, needs to facilitate the preparation of a support plan.  | Post 1 Jul 2007  
- In line with good practice, the preparation of the support plan should involve liaison with all the disability service providers involved in the person with a disability’s life.  |
|  |  |  |
|  |  | That where a single support plan is developed, the person with a disability and the disability service providers need to agree that the new support plan constitutes a review of all existing support plans.  |
| going disability service providers involved, then the review date that is set, is the date for review of the support plan by all the participating disability service providers. | plans and the review date will then apply to all participating disability service providers. |
Appendix 2: Roles and responsibilities of on-going disability service providers

The following table represents the various responsibilities of a provider of ongoing disability support depending on their role in relation to the preparation of the support plan, as requested by the person.

### Table 1

<table>
<thead>
<tr>
<th>Provider of ongoing disability support:</th>
<th>Developing a support plan for one ongoing disability service</th>
<th>Coordinating development for more than one ongoing disability service</th>
<th>Contributing to a coordinated support plan but not coordinating it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure a support plan is prepared within 60 days of the person receiving the service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Work with the person, their family or network</strong> to identify and invite participation of those who need to be involved</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Work with the person, their family or network</strong> to decide how and where planning will occur</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Work with the person, their family or network</strong> to decide what issues will be discussed in a group (publicly) and those that will be discussed more privately.</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Work with the person, their network or family</strong> to facilitate planning</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Make sure that the person has a copy of the plan in a format that is most meaningful to them</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Make sure other participants who have a role to play have a copy</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Make sure a review date is set and the person responsible is nominated</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Plan with the person according to the guiding principles for planning in the Act</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Record that a support plan has been prepared and the date for its review</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Implement strategies that relate to the ongoing service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Monitor the person’s progress towards the goals that relate to the ongoing service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Review the support plan according to the person’s need and legal requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ensure all ongoing disability service providers participate in the planning process where the support plan is intended to cover their service.</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Negotiate administrative tasks with other disability service providers including documenting and formatting the plan.</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: Transitional planning – what it means for you

1. Introduction

Many people with a disability, particularly those getting a service, currently have a plan in place. This plan may be called a General Service Plan (GSP) or an Individual Program Plan (IPP) or another type of plan.

Planning under the new Disability Act 2006 (the Act) will happen differently.

This information explains what you need to do if you have a GSP, IPP or another type of plan, and how and when you get to be part of the new planning arrangements.

All planning must take place in line with the guiding principles for planning. These principles say that you have a right to direct planning and make choices about the way you want to live your life. The principles also say that planning should help you be a part of the community and that people important to you such as your family and friends can be a part of the planning process.

2. Current Plans

Depending on the services you are receiving, you may have just one kind of plan, or several different plans such as IPPs, a GSP or another type of plan. Every plan, whether you have one or many, has a set review date.

The first time any of your plans—IPP, GSP, or another type of plan for ongoing disability service—comes up for review after 1 July 2007 is when you will have the opportunity to be part of the new planning arrangements.

3. Plans for ongoing disability services

The Act says that there are some different planning arrangements for people who have ongoing disability services and people who have episodic disability services.

Ongoing disability services include: residential services, day programs, individual support packages such as HomeFirst, Support & Choice, Making a Difference etc, and Outreach support.

If you are accessing one or more of these services, the information in the rest of the fact sheet is very important for you to understand.

4. Plans for other disability supports

Other disability supports include things such as therapy, respite, case management and Futures For Young Adults.

If you are accessing one or more of these services, each time one of these plans comes up for review, this review should take place with your disability service provider and
5. **If you only have a GSP**

When your GSP comes up for review, you will be contacted by Disability Client Services to talk about the new planning arrangements. You will be offered assistance with planning.

This is a chance for you to look at what you’re doing, and decide if you’re happy with things as they are, or if you want to explore new options. Planning can help you set new goals and strategies for achieving them.

If you’re happy with how things are, you may decide not to accept the offer of assistance with planning at the moment. It is important to know that if you change your mind later on, you still have the right to ask a disability service provider for assistance with planning.

If you decide to accept the offer of assistance with planning, you will need to think about how you want the planning process to happen. You can choose to lead this process, perhaps with your family and friends, or have the disability service provider lead this process.

At the end of the planning process, you may choose to write down the things you have talked about and agreed on in a plan. This plan is about you and should be written down in a way that suits you best. This can include words or pictures or even a video if you would like.

During the planning process, it is a good idea to think about when you might want to review what you have decided upon. This can help you to think about the things you have decided to do and whether or not they are working. Agreeing on a time for a review means that everyone knows when they will get together again. It is important to know that even if you agree on a time for a review, if things change or you want to talk to people before the review time, you are able to do this.

6. **If you have:**

- **a GSP and one or more IPPs OR**
- **no GSP but one or more IPPs**

Your GSP and your IPP(s) will all have different review dates. The first time any of your plans comes up for review, the disability service provider involved will talk to you about the new planning arrangements.

One of the key changes in the planning arrangements is the option to review all of your plans at the one time. Reviewing all your plans at the same time is a chance to take a look at
what you’re doing, and all the services and supports you have in place, and decide if you’re happy with things as they are, or if you want to explore new options. Planning can help you set new goals and strategies for achieving them.

When your disability service provider talks to you about the new planning arrangements, you will need to make some important decisions:

**THE FIRST QUESTION** is ‘Do you want to review all of your plans at once and have a single plan that covers all your ongoing disability supports?’

If you say YES then all of the disability service providers involved with you **must** be involved in one planning process. This means that everyone will know what is important to you, what your goals are and how their services can help you to achieve those goals.

If you say NO then you can work with the disability service provider who has asked you about the review and develop a support plan just for this service.

**THE SECOND QUESTION** is ‘Do you want to coordinate the process for the development of a support plan yourself or do you want a disability service provider to do it?’

The person coordinating the planning process will be responsible for contacting all the service providers involved and leading the planning process.

If you choose to do this yourself, you may want to think about someone in your family or support network helping you lead the process.

If you decide you want a disability service provider to coordinate the support plan process and there is more than one disability service provider involved, you **must** choose one of these providers to lead the process.

Once your support plan is finalised and everyone who was involved in the process agrees that it reflects your current goals and strategies, then you can choose to agree that your previous plans (GSP or IPP) can be considered as reviewed.

If you have a GSP, and Disability Client Services who would have helped you prepare your GSP, were not involved in this new planning process, the person coordinating your support plan must contact them. They need to let them know that a support plan has been developed and it has been agreed that your GSP can be considered as reviewed.
7. If you have another type of plan or plans

If you have another type of plan or plans in place for an ongoing disability service, it is the review date that triggers your opportunity to be a part of the new planning arrangements. The process described in Section 6 will apply in the same way.
## Appendix 4: Support Plan Requirements Checklist

### Legislative requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the support plan prepared within 60 days of the person regularly accessing the service?</td>
<td></td>
</tr>
<tr>
<td>Was it prepared in consultation with the person with a disability?</td>
<td></td>
</tr>
<tr>
<td>Does it identify the disability services being provided to the person?</td>
<td></td>
</tr>
<tr>
<td>Was planning undertaken in accordance with the guiding principles for planning?</td>
<td></td>
</tr>
<tr>
<td>Does the support plan review date meet legislative requirements? (Within 3 years or 12 months if the person is residing in a residential institution)</td>
<td></td>
</tr>
</tbody>
</table>

### Policy requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the person is in receipt of more than one ongoing disability support, were they given a choice to have a coordinated support plan?</td>
<td></td>
</tr>
<tr>
<td>Does the support plan include relevant background information about the person? For example: people and things important to them, what they like and dislike</td>
<td></td>
</tr>
<tr>
<td>Does the support plan include goals and strategies related to on-going disability services?</td>
<td></td>
</tr>
<tr>
<td>Does it identify the support required to implement the strategies (resources) such as people who will assist or funding?</td>
<td></td>
</tr>
<tr>
<td>Does it describe outcomes and how these will be measured?</td>
<td></td>
</tr>
<tr>
<td>Does the support plan describe how the plan will be monitored?</td>
<td></td>
</tr>
<tr>
<td>When the plan will be reviewed and who will lead the review?</td>
<td></td>
</tr>
<tr>
<td>Has the support plan been recorded as prepared?</td>
<td></td>
</tr>
</tbody>
</table>

### Best practice

<table>
<thead>
<tr>
<th>Practice</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the person supported to lead and participate in planning?</td>
<td></td>
</tr>
<tr>
<td>Do the goals relate to things that are important to the person or what they want to achieve? This can include things not limited by what the disability support provider can provide?</td>
<td></td>
</tr>
<tr>
<td>Do the goals promote well being, independence, relationships or inclusion?</td>
<td></td>
</tr>
<tr>
<td>Does the support plan include strategies related to informal supports?</td>
<td></td>
</tr>
<tr>
<td>Does the support plan include strategies related to generic supports?</td>
<td></td>
</tr>
<tr>
<td>Is a review of the support plan planned within the next 12 months?</td>
<td></td>
</tr>
</tbody>
</table>