POLICY

Policy Title:	Community Living disABILITY Services – Person-Centred Planning	**Date Approved:**	April 2016
Branch/Division:	Adult Disability Services Community Service Delivery	**Applicable to:**	Community Living disABILITY Services
Responsible Authority:	Department of Families	**Next Review Date Reviewed:**	TBD
Policy Owner:	Executive Director, Adult Disability Services	**Date Revised:**	

1.0 Policy Statement

Person Centred individual planning is a dynamic process in which the individual with a disability, with or without the assistance of his or her support network, identifies personal strengths, needs, current interests and aspirations and makes choices, sets goals and identifies actions to achieve these goals. A person-centred holistic planning process is utilized to assist the individual to identify the services and supports required to meet his or her needs and goals.

2.0 Background

The Vulnerable Persons Living with a Mental Disability Act (VPA) is enabling legislation that recognizes the rights of individuals to make their own decisions and receive advice, support or assistance, where necessary, in a manner that respects their independence, privacy and dignity.

Part 2 – Support Services of the VPA provides the legislative authority for the department to provide or arrange for support services for vulnerable persons as defined by the VPA. Supports to vulnerable adults are primarily provided on a discretionary basis and eligibility does not confer entitlement to funding or services.

Sections 11(1), 11(2) and 12 of the VPA sets out a series of requirements and principles which regulate individual planning practices. Under the VPA, the Executive Director or delegated departmental staff:

- shall develop an Individual Plan for every vulnerable person who receives support services from Community Living disABILITY Services;
- shall take reasonable steps to ensure that each vulnerable person and his or her substitute decision maker or committee (if any), has an opportunity to participate in the development of the plan;
- shall take reasonable steps to inform each vulnerable person and his or her substitute decision maker or committee (if any), of all decisions respecting the individual's plan; and
- may review an Individual Plan and vary it.

3.0 Purpose

Person-Centred individual planning is a dynamic process in which the individual with a disability, with or without the assistance of his or her support network, identifies personal strengths, needs,

current interests and aspirations and makes choices, sets goals and identifies actions to achieve these goals. A person-centred holistic planning process is utilized to assist the individual to identify the services and supports required to meet his or her needs and goals. This process results in a plan document which identifies and provides rationale for the support services provided through Community Living disABILITY Services (CLDS), as well as other community-based supports that may be accessed.

By knowing the personal supports budget in advance of the planning meeting, the individual, family, support network and if applicable, service providers, can bring the information to the meeting and be prepared to talk about how CLDS services can complement the supports that are available from other places (family, friends, support network members).

Throughout this process the individual is encouraged to make independent decisions, but he/she may request the assistance of a support network in making those decisions. As a result, throughout this document where the term individual is used, it may also include the involvement of a support network or substitute decision maker (SDM)/committee.

4.0 Definitions

Individual Plan: means a plan for a vulnerable person under section 11 of the VPA.

Person-Centred Planning: a process, directed by the individual served and their support network, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The Supports Intensity Scale (SIS) process supports person-centred planning goals by monitoring progress and identifying support needs in order to achieve success.

Support Network: means family, friends and/or community members who provide personal support, advocacy and/or help with monitoring services and who have reciprocal relationships with individuals.

5.0 Policy

The person centred individual planning process is based on the belief that the individual should have the opportunity to direct and lead a life which is personally satisfying, secure and productive. In keeping with the principles contained in the preamble of the Act, the following provide the basis for all individual planning activities.

1. Empowerment and Self Determination

Planning activities are based on the assumption that an individual is capable of making decisions respecting his or her life, unless demonstrated otherwise. Planning activities must therefore:

- make the individual the centre of the planning process during all stages in order to enhance his or her level of control
- recognize that the individual's wishes are most important and are to be respected to the fullest extent possible
- actively encourage the individual to make choices, provide opportunities to exercise those choices and where necessary, change those choices over time

- ensure the consideration of the widest possible range of services and supports to enable the individual to make choices which are real and substantial

2. Holistic Orientation

Holistic planning methods provide for the consideration of every individual as a whole person in a positive and integrated way. Planning must; therefore, address the individual's health, safety and basic comfort needs and recognize and respond to each person's:

- need for respect, privacy and dignity
- need for friendships/relationships
- need for meaningful community presence and participation
- need for valued social roles
- employment/habilitation issues
- need for supports in the least restrictive and least intrusive way possible

3. Cooperation and Collaboration

Planning activities seek to build cooperation and collaboration between and among those who provide formal and informal services and supports. Planning activities are based on the belief that:

- the contributions of individual planning team members are equally valued
- individual planning team members have equal opportunity to contribute to the process
- developing linkages within the total community is an essential part of increasing the range of choices available to individuals and of responding to their personal and social needs in a meaningful way

6.0 Core Supporting Standards, Procedures and Guidelines

6.1 Standards

1. A plan must be developed for each individual in receipt of support services from CLDS.

2. All planning activities must be in keeping with the principles contained in the preamble of the VPA.

3. Only one Individual Plan is required for each individual, regardless of the number of service providers for that individual. The plan is to be reviewed on an annual basis. The service provider(s) and/or CLDS Community Service Worker (CSW) will lead the development of the Person-Centred Individual Plan; however, it is important that the Individual/SDM and their support team are actively involved in the plan's development and implementation.

4. All planning activities undertaken shall ensure the participation of the individual at least in the following:
    - selection of a facilitator
    - selection of participants
    - selection of the planning method
    - selection of the scope of the plan

5. The Individual Plan may take any format from formal to informal, but must contain the following components:

    - the Individual's desired outcomes
    - the Individual's goals
    - important/relevant assessed support needs, especially those supports required to address safety concerns
    - the Individual's specific support strategies
    - measureable support objectives
    - the person(s) responsible for implementing the support strategies
    - timelines for review

6. The following required components are addressed in those portions of the plan that deal with the provision of support services through CLDS:

        - knowing the individual and his or her vision;
        - goal planning;
        - action planning; and
        - planning for accountability.

7. The CSW should participate in discussions and planning meetings which address the provision of support services through CLDS.

8. Regardless of the planning format (PATH, MAP, etc.), a written Individual Plan document needs to be completed and shared with designated team members. The written Individual Plan can be completed by the service provider or individual identified through the planning process. The plan document is to be filed in the individual's case file with a case note recorded in inFACT.

9. The CSW is required to monitor the implementation of support services by external agencies/persons where these services are funded or arranged through CLDS.

10. When the plan involves the provision of long term stable support services through CLDS, the CSW may use their professional discretion to determine whether their attendance at the planning meeting is required. For example, the individual has been supported in a long term stable placement for over five years and there are no concerns with the care and support the individual is receiving. A written Individual Plan is required and the plan document is to be filed in the individual's case file. The CSW will take appropriate steps to initiate the planning process should the individual wish to engage in further planning.

6.2 Procedures

The planning process should occur when:

- an eligible individual is referred for service and a plan needs to be developed
- planning has occurred but the existing plan does not meet the required departmental planning standards
- an individual is dissatisfied with the existing plan
- there is a need for further planning to ensure that the existing plan remains relevant

INITIATING THE PLANNING PROCESS

Anyone can initiate the individual person-centred planning process. Typically, the process begins when the CSW initiates contact with the individual in order to:

- become familiar with the individual and his or her situation
- assess the urgency of need for service
- the delivery and coordination of services through a personal supports budget based on the level assignment and where the individual lives
- explain the importance of person-centred individual planning
- if appropriate, provide the individual with information and support to complete the following tasks. (Note: other members of the planning team may assume responsibility for assisting the individual with these tasks.)

1. Selection of: The Facilitator

The individual has the opportunity to invite the person of his or her choice to serve as the facilitator for the individual planning process. Some individuals may wish to select their CSW while others may wish to select someone else (e.g., representative from Community Living, agency staff or staff of another departmental program). It should be noted that remuneration for the involvement of external facilitators falls outside the department's responsibility.

2. Selection of: The Participants

Participation in the planning process by persons who are knowledgeable and supportive of the individual significantly enhances the development and implementation of an effective plan. Conversely, the participation of persons with whom the individual is uncomfortable can have a negative impact on the process. Therefore, the individual has the opportunity to choose who is to be invited to participate in planning activities.

A departmental staff person should participate in discussions and meetings which focus on accessing support services from CLDS.

Participants in the planning process may include:

- the individual with whom the plan is being developed *(If the individual chooses not to attend planning meetings, the CSW should gather information about the individual's current situation and desires to share with planning team members.)*
- spouse
- family members
- the individual's friends
- advocates
- current service providers
- potential service providers, if known
- professionals with expertise in areas pertinent to the individual (e.g., physician, speech therapist, occupational therapist)

Persons selected to be a part of the planning team must have a clear understanding of the role(s) they are to play. It is suggested that the roles and responsibilities be shared with individual planning team members at the outset of the planning process.

3. Selection of: The Individual Planning Method

The individual, in consultation with others, has the opportunity to select a planning method or to agree with the method suggested by the facilitator. The individual planning method should include the following components:

Knowing the Individual and his or her Vision – identifies who the individual is, his or her current situation and the individual's dreams, hopes and interests for the present and the future.

Goal Planning – identifies and develops goals towards realizing a better quality of life for the individual.

Action Planning – identifies the activities through which goals are to be realized and assigns responsibility to specific persons or agencies, along with timelines for completion.

Planning for Accountability – determines responsibilities for ensuring that specific actions identified during planning have been attended to.

There are a number of planning methods which can be adapted to meet the department's planning requirements. When selecting a planning method, the individual's ability and means of communication should be considered. For example, a planning method which includes a pictorial display may enable support network members to communicate more effectively with the individual.

Person-Centred Planning Tools

A number of approaches or tools exist for Person-Centred Planning. Some of the most commonly used are described below.

CLDS Person-Centred Planning Tool

CLDS has developed a personal centred planning template to be used to document the person-centred planning process. The template can be incorporated into the various person-centred planning options and is to be used as the standard to document the outcome of person-centred planning and updated to reflect that the plan has been revisited on an annual basis.

Sorting Important To/For

Sort what's important TO (what makes us happy, content, fulfilled) from what's important FOR (health and safety, being valued) while working towards a good balance. This tool helps as a way to think through a situation before deciding what should happen next. The tool can be used as an everyday tool, as part of reviews and at the beginning of an individual, family or team plan.

Circles of Support and Circle of Friends

Circles of support is a mechanism for building a circle around the individual to improve the individual's quality of life. Generally, the "circle" is comprised of individuals who are not paid to assist or work with the person. It includes four steps which begin with a "vision" of what the individual wants to accomplish and ends with "connections" in the person's community and life. Circle of Friends, developed by Robert Perske, is a similar method.

Essential Life Planning (ELP)

Essential Life Planning, developed by Michael Smull, looks at essential quality of life components, explores how a person wants to live and finds ways to make it happen. The process includes a "Learning Wheel" which guides those involved in planning. The heart of the process is "listening to" and "understanding" the individual.

Group Action Planning (GAP)

Group Action Planning, developed by Ann Turnbull and Rud Turnbull at the University of Kansas, is a person-centred planning process that engages a team in creative brainstorming to help individuals live their dreams. The goal of the process is to build the best life possible for the person. GAP contains five major components (and seven steps) built upon traditional action planning: "inviting support, creating connections, envisioning great expectations, solving problems, celebrating success".

Making Action Plans (MAPS)

MAPS, developed by Marsha Forest and Evelyn Lusthaus, is a person-centred planning process that asks eight guiding questions from which a team works together to assist individuals with defining their dream and building a plan to achieve their dream. Key questions address the individual's "history, dream, nightmare, strengths, needs". The process culminates with a "plan of action".

Personal Futures Planning (PFP)

Personal Futures Planning, developed by Beth Mount, contains a series of six tasks designed to help find capacities in individuals, identify options in their communities and develop supports and services that will meet each individual's strengths and needs.

Planning Alternative Tomorrows with Hope (PATH)

Planning Alternative Tomorrows with Hope, developed by John O'Brien, Marsha Forrest and Jack Pierpoint, "begins with the end in mind". The process begins by looking at the desired outcome, also known as the "North Star". The process focuses on ideals, values, passions and dreams. It looks at the "positive" and engages the support of others. Those involved in planning with the individual work backward into the present.

4. Selection of: The Scope of the Plan

The spirit of the legislation is that individual planning should actively encourage decision making by individuals. Therefore, the scope of the planning process is determined by the individual in

consultation with the support network, the selected facilitator and the CSW. Individuals may choose to concentrate planning activities around a single area (e.g., community participation) or they may wish to participate in a more comprehensive process.

Decisions regarding the scope of the plan may be reached by examining gaps and/or the desire for increased participation in a particular area of the individual's life. As well, there may be points of transition in an individual's life when it may be desirable to address several areas of need. It may be useful to consider the following areas when planning is required to meet the need for alternate living options, day service options or gaps which exist in an individual's life:

Communication	Self-Direction
Personal Care	Health and Safety
Home Living	Relationships/Friendships
Community Use/Participation	Leisure/Recreation
Education	Personal Finances
Work/Day Activities	Transportation
Retirement	Other

INDIVIDUAL PLANNING MEETINGS

For many individuals, the purpose of the initial planning meeting is to discuss the tasks required to initiate the planning process and the options available. Depending upon the outcomes of this discussion, planning activities may commence immediately or may start at a later date in order to allow additional persons to participate. In the latter case, the coordinator will assist the individual with scheduling a planning meeting and ensuring that the persons identified by the individual are invited to attend.

The purpose of planning meetings is to work with the individual to identify personal goals and needs so that appropriate support services may be arranged.

Information shared about the individual at planning meetings is confidential and not to be disclosed by planning team members outside of these meetings without the individual's knowledge and consent.

During meetings, the CSW:

- acts as a resource to the planning team by sharing information about support services and the process for accessing same
- ensures that the required components described below are addressed in the portion of the plan that deals with the provision of support services through CLDS
- encourages planning team members to address the same four components as described below in other areas of the individual's life that are to be addressed in the plan

1. <u>Knowing the Individual and His or Her Vision</u>

The first component of the process seeks to know the individual and his or her desires in the area(s) in which planning is to occur. The individual is encouraged to describe his/her strengths, abilities and needs and his/her past and present relationship to the community, people, places

and activities. Individual planning team members may provide information verbally or may share written reports which assist other team members in knowing the individual.

Once team members have an understanding of who the individual is, they can begin the visioning process. Visioning is the active process of exploring the individual's dreams, hopes and interests for the present and future. Members of the planning team are encouraged to provide their vision for the individual.

It is useful to record the vision using vivid imagery. Pictures can be referred to throughout the planning process and are helpful in keeping all team members focused.

During the visioning process, ideas are to be expressed without limitations. It is from the ideas expressed during visioning that goals are developed.

2. Goal Planning

Goals aimed at improving the individual's quality of life in the identified areas are developed in this phase. At this time, opportunities, resources and barriers to realizing a better quality of life are noted, while maintaining a focus on the individual's abilities. The individual's dreams, hopes and desires are documented in the form of realistic attainable goals. The following goals/areas should be explored:

Aspirational Goals

Aspirational goals focus on setting goals, aims and objectives based on the individual's aspirations or what the individual desires to do. Where they want to be and what will make them most happy.

Learning and Skill Building Goals

Learning and skill building goals focus on developing skills that the individual has identified as being important to him or herself. Perhaps the individual would like to learn to cook or do the laundry.

Daily Support Goals

Daily support goals focus on the individuals day-to-day support needs and how to support the individual in achieving these goals identified through the person centred planning process.

If planning is occurring in a number of areas, there should be at least one goal for each area. Throughout this phase, the individual should be encouraged by team members to identify the goals he or she wishes to set for the immediate future.

3. Action Planning

Action planning is the identification of activities through which goals are realized. These activities may include taking advantage of appropriate opportunities and resolving barriers facing the individual. Action planning also identifies the specific supports and resources that need to be in

place to achieve a particular goal. This may include the identification of new resources that need to be developed or innovative approaches to the provision of supports.

The first step is to determine how the individual will attain these goals. The individual may be able to accomplish these goals independently or may require the support of a planning team member.

The next step is to discuss and assign specific responsibilities and timelines to the individual and/or team members for the required activities. If the action plan calls for the implementation of support services funded by CLDS, the CSW will be designated to request the funding and report back to the team by a specific date.

4. Planning for Accountability

During the planning meeting, team members develop a plan for accountability which identifies the member(s) who will be responsible for assisting the individual, with ensuring that agreed upon activities have been attended to within the given timeframes. The CSW may be designated to monitor some or all of these activities. The CSW; however, must monitor the implementation of support services by external agencies/persons where these services are funded or arranged through CLDS.

DOCUMENTATION

1. Individual planning team members are encouraged to track and document the outcomes of the planning process; however, the individual(s) responsible for transcribing, documenting and distributing the planning document are identified at the beginning of the planning process.

2. The CSW must file the Individual Plan document in the individual's case file and record/reference that the plan occurred on inFACT.

IMPLEMENTATION

At this point in the planning process, goals to attain the future desired by the individual have been identified. Implementation involves putting the plan into action and ensuring that responsibilities assigned to team members are carried out within the agreed upon time frames. Depending upon the individual's goals, the following activities may be undertaken by planning team members in order to assist the individual with attaining his or her goals.

1. Referrals to Appropriate Resources

Where the plan has not identified a specific resource to provide the required supports, the CSW informs the individual and the members of the planning team of the individuals level assignment, personal supports budget and about the resources available. The individual may wish to visit several service providers to select the resource that is most suitable for him or her.

Where support services are accessed through CLDS, the CSW, with the consent of the individual, forwards a written referral to the service provider selected. Dependent on the resource and the region, the referral may be forwarded directly to the service provider selected, to the regional resource coordinator or to a regional placement/resource allocation committee.

For support services not provided by CLDS, designated planning team members may gather information about appropriate community resources and supports and make referrals as agreed upon by the individual and the team.

2. Securing of Funding

Once the service provider expresses a willingness to provide supports to the individual, appropriate funding may have to be secured. Where funding is required from CLDS, the CSW follows established processes to secure the necessary funding approval.

The individual and others involved with the individual (i.e., support network, SDM or committee, if any) should be informed if funding requested from CLDS is not available. The CSW will continue to work with the individual and planning team members to secure other suitable resources.

3. Service Implementation

Upon receiving confirmation of support service(s) and funding, the designated team member notifies the individual and relevant others identified during the planning process. The designated team member ensures that the necessary arrangements are made and that the service provider has sufficient information about the individual to provide the supports required. Planning team members may provide assistance and support to the individual in accessing these resources.

Ongoing liaison and communication between the individual and planning team members needs to occur throughout implementation in order to keep members apprised of:

- significant changes in the individual's circumstances
- the overall progress of the implementation of the Individual Plan

4. Accountability

Accountability activities assist the individual to reach his or her goals and may include identifying and dealing with additional opportunities or obstacles that arise.

Designated planning team members monitor the provision of community resources/services in accordance with the accountability portion of the individual's plan.

The CSW monitors the implementation of support services by external agencies/persons where these services are funded or arranged through CLDS. The CSW also monitors the implementation of any other services as designated by the person-centred individual plan (which can take the form of phone calls, reminders and follow-up by the CSW).

Follow-Up and Ongoing Planning

Where the plan involves the provision of support services through CLDS, the CSW contacts the individual at least once every year to assess the individual's level of satisfaction with the planning process and its outcomes. The CSW discusses the need for further planning efforts with the individual to ensure that the plan remains relevant. If the individual is satisfied with the current plan and does not wish to engage in further planning, the CSW will enter a case note that contact occurred and the plan has been updated accordingly.

If the individual wishes to engage in further planning, the CSW will take appropriate steps to initiate the process. However, if the individual does not wish to pursue further planning efforts, his or her wishes are to be respected.

6.3 Guidelines

N/A

7.0 Policy Documents

N/A

8.0 Resource Documents

N/A