Illinois Department of Human Services

MODULE 4

THE PLANNING LOOP

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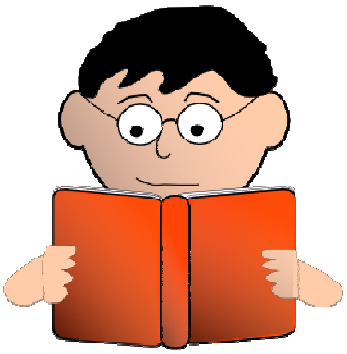
What will you do today to make someone's dream come true?

Source: New Visions: The Power of Dreams

Background Reading



Developing Staff Competencies for Individuals with Developmental Disabilities by James F. Gardner & Michael S. Chapman. Chapters 5, 6, 7, 8, 9, 10, 11, 12, & 13

Reach for the Dream! Developing Individual Service Plans for Persons with Disabilities by Dale DiLeo.

It's My Choice... by William T. Allen

It's Never Too Early, It's Never Too Late: A Booklet about Personal Futures Planning by Beth Mount and Kay Zwernik

Making Futures Happen: A Manual for Facilitators of Personal Futures Planning by Beth Mount and Kay Zwernik

A New Way of Thinking by the Minnesota Governor's Planning Council on Developmental Disabilities.

A Handbook For Scenario-Based Active Treatment, edited by Richard R. Saunders, Jim Rast, and Muriel Saunders.

Interdisciplinary Process

Rule 115, Section 115.230 Interdisciplinary Process

- Rule: 115.230 e)4)A)
    - A physical and dental examination, both within the past 12 months, which shall include a medical history.
- Rule: 115.230 e)5)C)
    - An annual psychiatric examination for individuals with a mental illness.
- Rule: 115.230 n)
    - The Community Support Team (CST) shall review the services plan as a part of the interdisciplinary process at least annually for individuals with developmental disabilities and semi-annually for individuals with mental illness and shall note progress or regression which might require plan amendment or modification.

Agencies licensed to operate CILAs must comprehensively address the needs of individuals through an interdisciplinary process.

What we mean by the interdisciplinary process is that the following people need to be involved:

- The individual and/or his or her legal guardian, or both.
- Members of the individual's family unless the individual is not legally disabled and does not desire the involvement of the family or the family refuses to participate.
- Significant others chosen by the individual.
- The QIDP or the QMHP.

Other members of the CST, which may include people who provide habilitation, treatment or training; and professionals who assess the individual's strengths and needs, level of functioning, presenting problems and disabilities, service needs and who assist in the design and evaluation of the individual's service plan.

Through the interdisciplinary process, the IDT is responsible for preparing, revising, documenting and implementing a **single individual integrated services plan** for each individual.

Initial Assessments
The agency shall assure that each individual receives an initial assessment and reassessments that shall be documented in the individual's record and the results explained to the individual and guardian.

The assessments shall determine the individual's strengths and needs, level of functioning, the presenting problems and disabilities, diagnosis and the services the individual needs. Assessments shall be performed by employees trained in the use of the assessment instruments.

Through the selection of the assessment instruments and the interpretation of results, all assessments shall be sensitive to the individual's:

- Racial, ethnic and cultural background;
- Chronological and developmental age;
- Visual and auditory impairments;
- Language preferences; and
- Degree of disability.

Initial assessment for individuals with a mental disability should include:

- **A physical and dental examination**, both within the past 12 months, which shall include a medical history;

- Previous and current adherence to medication regime and the **level of ability to self-administer medications** or participate in a self-administration of medication training program;

- A **psycho-social assessment** including legal status, personal and family history, a history of mental disability and related services, evaluation of possible substance abuse, history of trauma and resource availability such as income entitlements, health care benefits, subsidized housing and social services;

- An assessment with **form IL 462-1215, "Specific Level of Functioning Assessment and Physical Health Inventory," (SLOF)** for individuals with a mental illness and with the **Inventory for Client and Agency Planning (ICAP)** (Riverside Publishing Co., 425 Spring Lake Drive, Itasca IL 60143 (1986)) or the Scales of Independent Behavior-Revised (SIB-R) (Riverside Publishing Co., 425 Spring Lake Drive, Itasca IL 60143 (1996)) for individuals with a developmental disability;

- An **educational and/or vocational assessment** including level of education or specialized training, previous or current employment, and acquired vocational skills, activities or interests;

- A **psychological and/or a psychiatric assessment**; both must be conducted for individuals with both a mental illness and a developmental disability;

- A **communication screening** in vision, hearing, speech, language and sign language; and

- **Others as required** by the individual's disability such as physical therapy, occupational therapy and activity therapy

Within 30 days after the individual's entry into the CILA program, a service plan must be developed.

Annual Reassessments

Annual reassessments for individuals with a mental disability shall include:

- A physical and dental examination including a review of medications.

- The Strauss-Carpenter Level of Function (SLOF) for individuals with a mental illness or Inventory for Client and Agency Planning (ICAP) or Self-Injurious Behavior (SIB) for individuals with a developmental disability.

- An annual psychiatric examination for individuals with a mental illness.

- Other initially-assessed areas, as necessary.

At least monthly…

The QIDP and QMHP must review the services plan and document that:

- Services are being implemented as identified in the service plan developed by the interdisciplinary team.

- Services identified in the service plan are being implemented and continue to meet the individual's needs or need modification to better suit the person's needs.

- Actions are recommended and implemented when needed.

Individuals' Thoughts on the IDT Process

Individuals with developmental disabilities have been the focus of countless staffings. We can learn from their experiences, if we are willing to listen. A consumer group from Macon Resources offers the following tips for you to consider when supporting them in interdisciplinary team meetings (IDT). This is not an exhaustive list, but a sample of the input that is available to staff if we ask and listen. The most important thing to remember is that the meetings belong to the persons and their families. Their input regarding the staffing process is as varied as the persons themselves.

Approaches to Interdisciplinary Team Planning

The traditional approach to team planning focuses on the individual who is involved in a day or residential program. The interdisciplinary team develops goals and objectives that are based on the services provided by the day or residential program, and the team consists of employees of the program. The goals and objectives reflect the services available within the program. This type of interdisciplinary team process takes a narrow approach to planning for the person with a developmental disability and is considered inappropriate by today's standards.

A second, more contemporary planning approach is where the agency responsible for service coordination arranges for the completion of comprehensive evaluations. These evaluations are performed by the staff of the residential or day program or by professionals outside the program. The results of the assessments are shared by the team members. The focus of the team meeting is to determine what services in the community can help the person to reach his or her goals. Decisions as to the long-range goals are based on the person's needs without regard to availability of services. If the needed services are not available in the particular day or residential program, they often can be obtained elsewhere in the community.

A third approach, called Personal Futures Planning, team membership is expanded to include friends, relatives, neighbors, and even local business representatives. The purpose of personal futures planning is to provide an opportunity for the individual with a developmental disability to express personal interests and desires. Professionals, family members, friends, and community representatives all commit to assist the individual in achieving his or her stated goals. Unlike the first two approaches, goals and objectives stated during personal futures planning include issues related to community participation. The individual states that the goals that he or she wishes to achieve in the community and actively solicits the help of the team in pursuing them. Should the goals not be reached, the individual and team members critically review their roles in not fulfilling their obligations.

Preparation

Nearly all of the individuals surveyed indicated that it is very helpful when someone takes the time to meet with them before the formal staffing and discuss the purpose and details of the staffing. A mutual review of the individual's progress and satisfaction during the previous time period should be a topic of discussion, as well as, plans, desires, etc. for the future. If a person knows ahead of time to think about what they would like to learn/do, he/she is less likely to feel 'put on the spot.' It is helpful to go over the results of assessments and get the person's opinion of their assessed needs and strengths. This preparation meeting can also alert the staff member to any topics that the person may find embarrassing or difficult to discuss. This is also an excellent time to select/confirm the best location and the desired/necessary participants.

Location

Individuals vary a lot in their preferred location for their staffing. Some individuals we spoke with expressed a strong preference for their home setting; some preferred to meet at the facility; some expressed a strong preference not to have providers in their homes. (One person said, "Then I'd have to clean for a week!"); and, some individuals had no preference of location. The individual and family should be consulted in planning the time and location for the staffing. Their preferences should be given strong consideration.

Participants

Many individuals expressed how helpful it is to have a 'friend' at their staffing. A friend meant someone they could talk with about serious stuff; someone who listens and knows them well; someone who would help them remember what they wanted to discuss at the staffing; and, someone who would help them feel less alone and more capable. This 'friend' is often a staff member the individual is close

with or a friend of the family. The critical thing is that the person is given the opportunity to invite the important people in their life that they wish to be present.

Communication

As we all know, communication is crucial in our relationships with other people. Individuals with developmental disabilities and/or mental illness are the subject of most communications which occurs during the IDT process. Those of us in the "helping profession" need to remember the person as we are doing our high-tech planning and review processes. It is easy for an individual to feel threatened or outnumbered. Persons we spoke with wanted their input taken seriously and wanted to be believed when they spoke . . . they wanted to be spoken to, not spoken about. As professionals, we need to be aware of our professional lingo and attempt to speak in everyday language. The big words and multitude of acronyms that we use can be like listening to someone speaking in a foreign language.

What's in a name?

A small number of people were bothered by the names "staffing" and "IDT." Some of the terms that providers use with ease can cause some persons to feel threatened. These persons stated they preferred that we called the IDT staffing a "meeting" or a "get together."

Shared by: Shirley Paceley
Director of Blue Tower Training
Macon Resources, Inc.

Active Treatment

What is Active Treatment?

Simply put...Active Treatment means Always Teaching

Jayma Tucker, Division of Developmental Disabilities, Bureau of Quality Review

picture graphics source: www.dshs.wa.gov/

We often hear the term "active treatment" used to describe something that staff are doing at a given time. Example: "I was in the living room doing active treatment." This is not an accurate use of the term. Active treatment is a PROCESS. It's not just "keeping people busy." If you perform your job duties well, active treatment will be the RESULT of your interactions with people. The test of whether or not what you are doing is really "active treatment" is found in the answer to these questions:

- Did the person served LEARN something as the result of your interactions that will allow him/her to function more INDEPENDENTLY?
- Did the person served INCREASE his/her SKILLS as the result of the services you provided?
- Did the activities and services you provided help PREVENT the LOSS of skills the person already had?

How can service providers maximize the success of active treatment efforts?

- Know each person's goals and objectives and consistently implement formal and informal training.
- Look for opportunities to practice skills throughout the day.
- Encourage each person to do as much for themselves as possible.
- Talk to and listen to people you support.
- "Teach" rather than "do".

- Get people actively involved in the routine of their home (doing chores, making choices, etc.)
- Be a good role model.
- Our first responsibility is to protect from harm.
- Remember, we are teachers, not caretakers.
- Focus on abilities, not disabilities.
- RESPECT ourselves, each other, and the people we serve.
- Don't take it personally/Break the chain.
- The best prompts are nonverbal and subtle.
- Remember to reinforce desired/positive behavior.
- Direct care staff makes it happen.
- Watch body language (open hands, don’t cross arms, etc.).
- The best training environments are natural.
- Power struggles mean everyone loses.
- Fade in and fade out prompts.
- Self-esteem and independence go hand in hand.
- Keep your interactions positive and encouraging.
- Provide options and choices for everyone.

Tips for Making Your Interactions More Therapeutic
(Maximizing Opportunities for Active Treatment to Occur)

- Think of yourself as a "teacher." Look at every interaction with people as an opportunity to TEACH something.

- Involve all members of the group in your activities by increasing verbal and physical interactions. Regularly invite people into the group if they are not involved.

- Do things WITH persons, not FOR them. (One noted teacher/author on this subject jokes that staff fingerprints should never be found within areas where persons served receive quality services. That's because persons served are performing all the tasks, not staff, even if persons served are doing it with hand-over-hand guidance.)

- If persons served are resistive to hand-over-hand guidance, try hand-on-hand activity with the hand of the person served on top of the staff person's.

- Consider all the things that must be done for the person served. Find ways to get them more involved, even if initially it is only a small part of the task.

Active Treatment isn't just "table top" activities or implementing formal programs. Involve persons in routine household duties such as cleaning, organizing, storing, etc.

The Importance of Leisure

Leisure involves choices about free time. Many people discover interests by experiencing a variety of experiences and choosing those that they most enjoy. Staff can help people to experience a variety of leisure activities and assist each with participating in those that are preferred.

Leisure time is important because it balances work and learning. Leisure time, or free time, is a perfect time to help people make choices that are important to them – choices that are personal and individualized. Choices are important because they let us know how people want to spend their free time.

Many people with developmental disabilities have a great deal of free time because employment opportunities are limited. Effective use of free time can help with:

- Reducing inappropriate social behaviors
- Teaching social and communication skills
- Promoting physical health

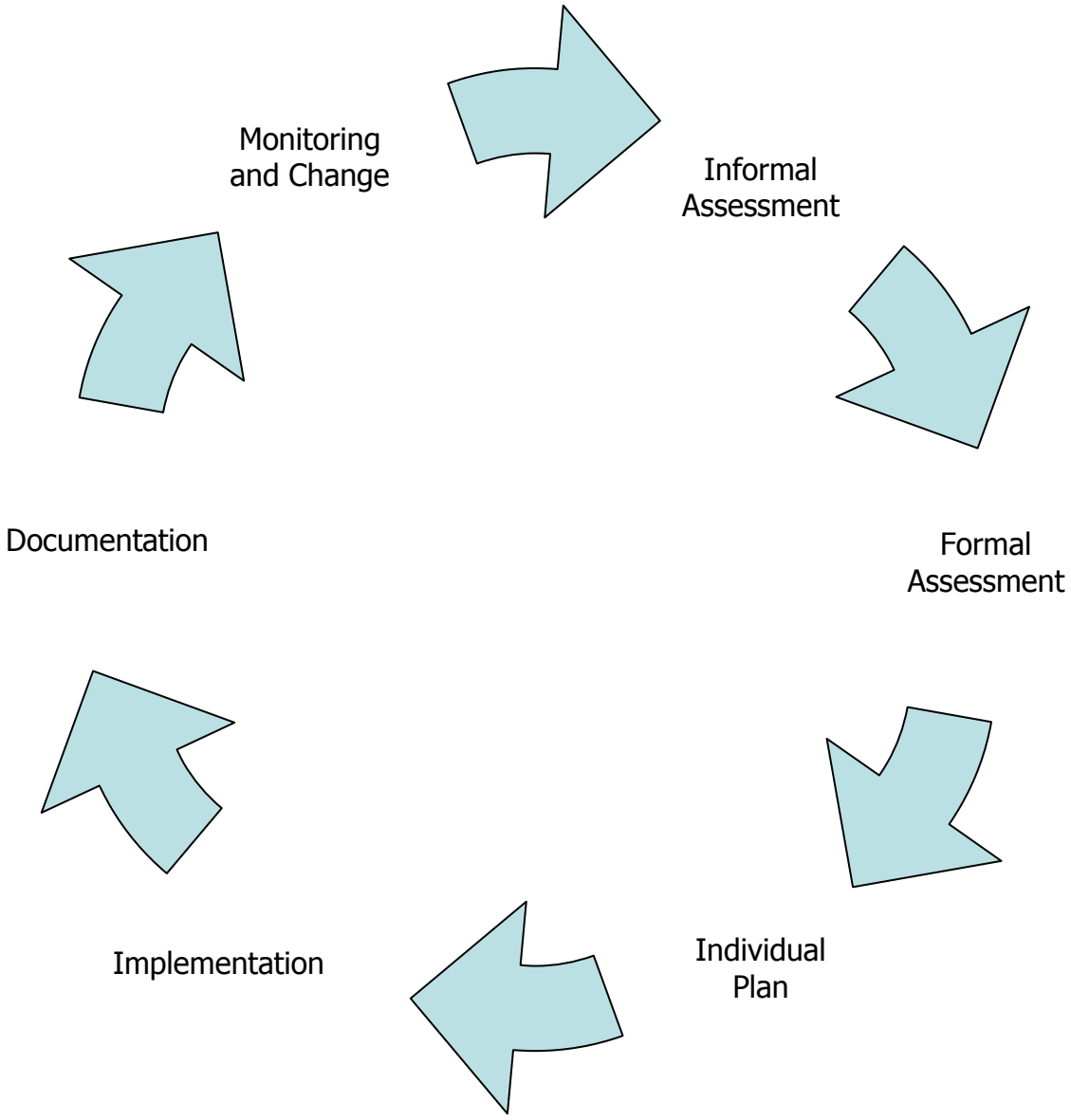
Characteristics of Appropriate Leisure Programs

Appropriate leisure programs should:

- Be consistent with the principle of normalization
- Take place in the community (when appropriate)
- Be based on personal preference
- Be integrated

Activity and Treatment Ideas for Recreation Therapy can be found at:
www.recreationtherapy.com

The Active Planning Loop



The basic components of the Active Planning Loop are:

- Assessment
- Individual Plan
- Implementation
- Documentation
- Monitoring and change

Writing Goals and Objectives

Goals are used as a departure point from which the more specific and complete behavioral objective can be developed.

A goal is a statement which includes a group of related behaviors in a given area; such as: skills of independent living; or; vocational; or social/recreational; etc.

Goals

The goal statement defines the direction of a person's program. It indicates what the person will accomplish in a specific length of time. The goal is based on the person's needs, and should be written without regard to the availability of services. The goal statement is an expectation of what the person will accomplish. Goals are written in a positive manner, stating what the person will do.

Four basic steps to include when planning goals are:

1. At every step of the planning, keep the desires, interests, and needs of the person served in mind;
2. Think about who shall be responsible for monitoring the goal achievement;
3. Determine what steps will be needed to achieve the goal, see if they can be established in a logical chronology;
4. Set a deadline—choose a date when everyone agrees the goal can reasonably be attained.

Behavioral Objectives

A behavioral objective is an attempt to define clearly the successful completion of behavioral change. Objectives are **measurable** intermediate steps between the person's present level of performance and the desired level as stated in the goal.

Qualities of well written Behavioral Objectives are that they be:

- Sequential
- Relate directly to a goal
- Are measurable
- Behavior to be modified to clearly observable
- Are singularly stated (no compound objectives)

When writing a behavioral objective it should be **one sentence** which is **composed of the following five elements in this order:**

- Conditions
- Person
- Behavior
- Performance
- Timeline

- **Conditions** – describes the things that have happened or are required to happen during the program or things the person will be given to carry out the program. **Example: "When handed his checkbook . . ."**

- **Person** – Use the individual's name, not nickname, not "he" "she" or "you"

- **Behavior-** Specify <u>one</u> behavior that the individual will perform in measurable and observable terms. The behavior should be **overt** (sensed through one of the senses and able to be measured), not **covert**. Look at some differences between these: terms:

COVERT	**OVERT**
Distinguish	Draw
Conclude	Fill in
Concentrate	Underline
Think	Repeat out loud
Recognize	Point to
Be aware	Walk
Infer	Count out loud

Performance – Describes the degree to which the person will perform the task satisfactorily. This may be done by various methodologies:

- How many—i.e., the number of responses; ex.: "will walk a straight line 15 times"
- How long—i.e., time-related—for what length of time; ex. "will package plastic soap dishes into the box for 20 consecutive minutes"
- How often--# of responses that are time-related; ex.: "will make his bed four out of seven times in one week"
- How well—to what degree or at what level of accuracy; ex. "write down the sums of addition problems with 80% correct score or higher."

Timeline

The timeline is the date by which the performance criteria should be achieved. The timeline date must always include month, date and year.

OBJECTIVES WORKSHEET

Practice I: Underline the condition statement in each of the objectives below:

1. When shown a red colored card and asked "What color is this?", John will state out loud "red" nine times out of ten by May 14, 2012.
2. Given a bolt-grid and ten bolts of various sizes, Mary will place all ten bolts onto the corresponding bolt on the bolt grid nine times out of ten by June 4, 2011.
3. After using his toothbrush, Randy will place the toothbrush in the holder two out of three times by February 28, 2011.
4. Before leaving the classroom, William will put on his coat nine days out of ten by March 30, 2010.

<u>Practice II:</u> In the spaces below, add condition statements to the beginning of each of the sentences below:

1. **_____,**
   Thomas will tie his shoes nine times out of ten by September 30, 2010

2. **_____,**
   Terry will place the fork to the left of the dinner plate four out of five times by May 6, 2011.

3. **_____,**
   Ellen will write her name cursively on the endorsement section of her paycheck for the next five pay periods, by August 1, 2012.

4. **_____,**
   Jan will select the sugar substitute packet for her cereal for ten consecutive breakfasts by October 31, 2012.

Practice III: Listed below are some statements which contain either overt or covert behavior. Place a C for Covert in the blanks before those statements expressing covert behavior and an O for Overt in the blanks for those statements expressing overt behavior.

_____ Mary will walk. . . . .
_____ John will catch a ball ……..
_____ Henry will remember. . . . .
_____ Sarah will pick up . . . . .
_____ William will indicate. . . . .
_____ Harriet will be able to . . . . .
_____ Jim will learn to . . . . .
_____ Fred will make the sign. . . . . .
_____ Summer will understand. . . . .

Practice IV: Listed below are some statements that are objectives. Look at the objectives and circle whether the objective has overt or covert behavior. If you believe the behavior is covert, in the blank provided, write down how would you re-word the objective to make it overt.

1. Given five coins of which one is a dime and the instruction, "point to the dime", Rosemary will point to the dime nine times out of ten by June 1, 2012.
   COVERT OVERT Reworded?
   _____

2. After using the restroom, Sam will wash his hands with soap and water nine times out of ten by May 15, 2012.
   COVERT OVERT Reworded?
   _____

3. When at meals, Jerry will learn to lift his spoon from the plate to his mouth for ten consecutive meals by December 15, 2011.
   COVERT OVERT Reworded?
   _____

4. When presented with a picture of a dog and asked "What is this?", Jerry will be able to sign "dog" nine times out of ten by January 1, 2012.
   COVERT OVERT Reworded?
   _____

Practice V: In the objectives written below, the performance criteria for each has been omitted. In parentheses next to the blank will be indicated the type of performance criteria you should insert on the blank provided.

1. Given the verbal prompt, "It is time to eat," Rachel will walk to the dining room (How Often) _____ by January 1, 2012.

2. Given a drill and drill bit, Harry will insert the bit into the drill chuck (How Well) _____ by August 1, 2011.

3. Upon sitting at her work station, Marion will assemble battery packages (How Long) _____ by November 30, 2011.

4. Given fifteen double digit subtraction problems, Jason will write the answers (how well and how many) _____ by September 30, 2012.

Source: Chuck Padgett, Kreider Services

Task Analysis

What is a Task Analysis?

Task analysis is a process by which a task is broken down into its component parts. Everyone uses a task analysis at some point, even if it is unconsciously. How else would anyone learn to complete processes? Like the old saying goes, "You have to walk before you can run". We may forget that certain tasks are really complex and need to be broken down into steps because, after a time, they become like second nature. With people who have special needs, it is necessary to break each task down into small manageable steps.

Sometimes a task an individual is learning is too complicated for the person to learn all at once (e.g., brushing your teeth). Therefore, we break the task down into *teachable steps:*

- ❖ Determine what task you want the person to perform.
- ❖ Figure out what steps will be required to complete the task (and figure out how small to make each step based on the strengths of the learner).
- ❖ Teach the person one step until mastery is displayed (mastery must be defined in the individual's plan).

This allows the learner to develop multi-step, complex skills that would otherwise be difficult to acquire. Identifying the step-by-step sequence does this. This requires a task analysis.

You should note that much of our own learning is done in steps. Many of the things we learn, remember, and do are done in this process.

You are going to get practice in doing just this in the next exercise.

Task Analysis Activity

Your instructor will guide you through the next activity. After completion, please consider the following questions:

1. What happens when each staff does a task differently when helping a person with a developmental disability learn to do a task?

2. Why is it important to do a program plan the way it is written?

3. What should staff do if the program plan doesn't seem to be working?

Also consider. . .

- Is there more than one way to do the same thing?
- What happens if each of you does a task differently with an individual?
- Why is it important to implement an individual's training plan the way it is written?

TECHNIQUES FOR TEACHING SKILLS

The task analysis exercise you just did demonstrates a very important step in teaching a new skill. However, many times, a person you support may not be able to learn all of the steps at one time. Teaching techniques sometimes used are:

Shaping

Shaping is a way of adding behaviors to a person's repertoire. Shaping is used when the target behavior does not yet exist. Following are some different types of shaping.

These are:

—**Forward chaining** is a procedure that teaches a task from start to finish. It involves teaching people one step at a time, working forward step by step to accomplish a simple task.

—**Backward chaining** involves teaching the last step first.

Fading

Fading involves reducing the amount of information given in order to decrease dependence.

Remember, as staff members you are always teaching, whether it is by active involvement with the individual or by modeling appropriate behavior with staff and/or individuals. (Dale DiLeo, *Enhancing the Lives of Adults with Disabilities*.)

Teaching Strategies

Active teaching should support each person to reach their maximum potential, encouraging as much independence as possible. The teaching strategy would encourage the individual to perform a skill independently. However, prompts or cues may be necessary for the person to complete the task. The cues or prompts follow a continuum from least to most involved.

The cue or prompt level may be one of the following:

- Natural
- Gestural
- Verbal
- Modeling
- Physical

Natural— The natural cue is also called the independent level. The cue actually comes from the environment. The person does the skill or task without prompting from staff.

Gestural— The gestural cue is performed if performing the natural cue is not possible. Example: A person may not initiate picking up an object, but if the support staff points to the object to be picked up and the person picks up the object, that person did the task at the gestural prompt level.

Verbal— The verbal cue is performed when a support staff member asks the person to perform a task and the person does it.

Modeling— This is completed by the support staff. Member will perform (model) the desired behavior. The staff member would then put the object back and if the person performed the requested task, the person would have completed the task at the modeling level.

Physical— If the task cannot be completed at any of the other levels, then the physical task will need to be used. This is completed by having a staff provide *brief* hand-over-hand assistance in order for the person to complete the task. This should never be forceful in nature. If the person resists, the staff person may try putting the person's hand *over* theirs.

What Is Person-Centered Planning?

It is important to remember that a person centered plan is a means ***not*** an end. The person-centered plan is a process, not a piece of paper. The life that a person wants is the outcome, ***not*** the plan that describes it. Person-centered planning is a written planning tool giving a description of where the person wants their life to go and what needs to be done to get there.

We've talked a bit about what person-centered planning is, but sometimes knowing what it ***isn't*** makes things even clearer. A person centered plan ***isn't***:

- Stagnant (it must be revisited and re-evaluated)
- Limited to available services
- Unrealistic
- A written plan, separate from a process
- A mystical quick or easy process

Person-centered planning involves: keeping the focus on the **person** and his/her abilities. Person-centered planning means **individually** tailoring things for the person.

It starts with the person at the center and grows outward. It utilizes available **resources** to assist the person in obtaining his/her goals and objectives. It incorporates what is important to the person. It focuses on the **strengths** of the person, not the person's deficits or limitations or those of the system.

At all times we should demonstrate **respect** and **dignity** in all that we do to support a person with a developmental disability. This includes protecting the person's **confidentiality**.

Guidelines

These Person Centered Planning (PCP) process guidelines are intended to assist the individual (i.e., the person receiving the services), his/her family members and friends, service coordinators/case managers, and state and local service providers who participate in life planning. The purpose of this document is to guide the team in making the choices and developing strategies that comprise the support plan based on the individual's desired lifestyle rather than the traditional remediation and deficit approach.

Important Concepts of Person Centered Planning

- The person centered planning process requires a shift in traditional thinking, actions, and way of doing business or individual directs the services and supports.
- The individual is the central driving force in determining his or her future vision, goals, supports and services.
- The planning process requires family members, friends, and professionals to:

  - listen to the individual;
  - attend to the details;
  - be open and sensitive to situations that can be difficult and confusing;
  - encourage dreams and desires of the individual and to contribute to those dreams and desires; and
  - identify and support what really matters to the person.

- The person centered planning process is a core component of quality service delivery.
- Person centered planning replaces the deficit-based assessment that traditionally has driven the Individual Service Plan.
- Person centered planning should not be viewed as an "add-on" to the current planning process.

I. Definition of Person Centered Planning

Person centered planning is a process whereby persons with disabilities, with the support of families, direct the planning and allocation of resources to meet their own life vision and goals. This planning process:

- is based on a person's preferences, dreams, and needs;
- understands how a person makes decisions;
- understands how a person is and can be productive;
- discovers what the person loves and dislikes;
- encourages and supports long-term hopes and dreams;
- is supported by a short-term support plan that is based on reasonable costs given the person's support needs;
- includes the individual's responsibilities;
- includes a range of supports including funded, community and natural supports; and
- should be conducted based upon the needs of the individual, but at least annually.

II. Terminology

1. ***Discovery process***: the process of identifying the strengths, preferences, and desires of an individual. It is an information gathering process that provides the foundation for developing/updating an individualized support plan. This occurs on an ongoing basis.
2. ***Facilitator*****:** the person who leads the team through the person centered planning process, which includes developing an individualized support plan. The facilitator is anyone chosen by the individual. The facilitator gets people to share ideas and efficiently leads them through the process. He or she involves the individual and assures understanding of the discussion. The facilitator must be a good listener, check understanding regularly, observe themes, and guard against immediate or old solutions. He or she prepares for the meeting(s), maintains focus and redirects concerns unrelated to the plan development.
3. ***Individual****:* a person with a disability seeking or receiving services.
4. ***Informed Choice*****:** the ability to make a voluntary decision based upon options presented to the individual. The individual will engage in a variety of experiences to identify preferences and choice.
5. ***LAR (legally authorized representative*****):** is a person authorized by law to act on behalf of an individual and who may include a parent or guardian of a child, or a guardian of an adult.
6. ***Natural Supports*****:** supports that occur naturally within the individual's environment. These are not paid supports, but are supports typically available to all community members. Natural supports should be developed, utilized and enhanced whenever possible. Purchased services should supplement, not supplant, the natural supports. Some examples of natural supports are the family members, church, neighbors, co-workers, and friends.
7. ***Open-ended questions***: questions that do not suggest an answer, e.g. not simply yes/no or multiple choice questions.
8. ***Service Coordinator/ Case Manager*****:** an individual who provides assistance to the individual in identifying and accessing medical, social, residential, employment, educational, behavior, and other appropriate services that will help an individual achieve a quality of life and community participation acceptable to the individual (and LAR on the individual's behalf) as follows:
    a. crisis prevention and management-locating and coordinating services and supports to prevent or manage a crisis;
    b. monitoring-ensuring that the individual receives needed services; evaluating the effectiveness, relevancy, and adequacy of services; and determining if identified outcomes are meeting the individual's needs and desires as indicated by the individual (and LAR on the individual's behalf).

c. assessment-identifying the nature of the presenting problem and the service and support needs of the individual; and

d. service planning and coordination-identifying, arranging, advocating, collaborating with other agencies, and linking for the delivery of outcome focused services and supports that address the individual's needs and desires as indicated by the individual (and the LAR on the individual's behalf).

9. ***Support Team*****:** the team established by the individual that typically includes his/her legally authorized representative (if applicable), close family members/advocates, the case manager, providers, and others identified by the individual as being important in his/her life.

III. Guiding Principles for Person Centered Planning

Person centered planning is based on a variety of approaches or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs. Person centered planning process is based on a framework that describes five essential accomplishments: **1) community presence, 2) community participation, 3) choice, 4) respect, and 5) competence**.

1. Individual differences and differences in family dynamics and composition are respected and accepted.

2. Person centered planning requires that it is the individual who defines what is meaningful in his/her life and what really matters most to him/her.

3. All individuals have the opportunity to make informed choices and need to exercise control of their lives. Sometimes in order to do this effectively they must be supported by others and have a variety of experiences, either in their natural environment or from within the system.

4. Person centered planning should not be viewed as an "add-on" to the current planning process, but a central starting point for planning.

5. Individuals must have choice among flexible, dependable services that meet their immediate needs and support their goals and aspirations for a lifestyle that affords personal control, informed decisions, dignity and respect.

6. Person centered planning process builds on an individual's strengths, gifts, skills, talents, and contributions.

7. Person centered planning processes encourage the "building of community" around individuals. They help develop supports to facilitate relationships with people within the individual's community.

8. Individuals should fully and actively participate in making the decisions that affect their lives.

9. Solutions to obstacles and issues that emerge during the person centered planning process are negotiated to ensure that resulting activities are consistent with the individual's preferences and goals.

10. The individual partners with the support team to explore creative options to meet the preferences and goals expressed by the individual.

11. Resources to support the individual are based on identified needs that the individual may have and are available in the community and/or in an agency. Natural resources presently available in the community are used first, then the agency resources. In instances where generic resources may not exist, they may need to be developed within the community.

12. All strategies and resources used must support the desired outcomes and identified needs of the individual. Strategies are developed to increase the likelihood that individuals will increase control over their lives, participate in community life and develop relationships.

13. Person centered planning is a dynamic, rather than a static process. The individualized support plan is revised as new opportunities and obstacles arise or when significant changes occur in the individual's life.

14. A person's cultural background is acknowledged and valued in the planning and decision-making process.

IV. The Differences between Person Centered Planning and Traditional Planning

Person centered planning is an interactive planning process which brings together the people who live with the concerns and issues daily and who are committed to learning together to respond to the situation. Specifically, the differences are:

Traditional Planning	Person Centered Planning
A team of service providers meets annually with the individual and/or family members to develop a plan for services	A support team made up of the individual, legally authorized representative, family members, service providers and other community members meet as frequently as needed to develop and implement a future vision and goals for the individual. The team will meet based upon the needs of the individual, but at least annually.
Relies on standardized and non-standardized tests and assessments.	Spends time getting to know and discovering the person.
Begins with an assessment process that highlights deficits. Looks at the person in need of services and who has to get "ready" for community life.	A support team gathers, organizes, and manages assessment information into a personal profile and future vision and goals using highly visual and graphic maps.
The individual and family members are invited to participate in the development of the individual service plan.	The support team assists the individual in a respectful and competent manner to actively lead and/or participate in the meeting.
Establishes goals that are already part of existing programs. The plan is designed to fit the person into a particular program, even if that program is not exactly what the person needs.	The individual, family members, friends, and general community members define the personal profile and future vision and look to service providers for supports. Programs are developed around the needs of the individual.
Relies primarily or solely on professional judgment and decision-making.	Depends on people, families, friends, and direct service providers to build good descriptions.
An individual service plan is mandated to guide the services.	A future vision and action plan guide the activities and drive the Individualized Support Plan content.
Implementation of the plan is ensured through provisions of professional services.	Implementation of the plan depends upon the commitment and partnership of the team and their connections with the individual.

V. Tips to Implement Person Centered Planning

A. Discovering the Person

1. ***Listen, acknowledge, and discover the personal goals, preferences, choices, and abilities of the individual directing the plan***:
    a. A person centered planning process occurs only when the individual is present.
    b. Prior to the planning meeting, the facilitator goes over the issues to be discussed with the individual or family/primary caregiver. They identify those issues that will be discussed in a larger group (public issues) and those that are to be discussed more privately (private issues).
    c. The facilitator asks open-ended questions to elicit information from the individual or family/primary caregiver in order to discover the preferences, choices, goals and abilities of the individual.
    d. The discovery process may or may not occur in a planning meeting with a large group of people. It can occur separately with the individual, family/primary caregiver and those that know him/her well.
    e. The discovery process solicits information based on the individual's strengths, capacities, gifts, skills, talents, and contributions.
    f. All the information collected from team members (within or outside of the person directed planning meeting) during the discovery process must be confirmed with the individual to ensure accuracy before documenting it.
    g. The individual's goals and preferences are constantly evolving; therefore, person centered planning is ongoing and not a one time/annual planning process. Question-asking, listening and discovering the preferences of the individual is on-going.
    h. Every effort must be made to ensure that the individual is fully informed to make responsible choices based upon options presented.

2. ***Documentation of the information gathered during a person centered planning process is important***

    a. All information should be written in a respectful manner. Information is to be communicated to the individual in a way that she or he understands.

    b. Document all the information gathered from the individual /family to ensure that it is available to all pertinent staff and/or providers (new and old). This helps reduce or eliminate the need to ask the same questions repeatedly by new staff to the individual or family members.

    c. All the information must be documented in the plan without changing the meaning that the individual/family attributes to it.

    d. The documentation should cover the individual's daily routines and desired goals. It should be descriptive, but concise, painting a picture of the individual. This picture should lead to the development of a meaningful day and activities for the individual. For example, identifying that the individual works 25 hours a week as a stocker for the hardware store, volunteers 5 hours a week at the senior center and works out at the community recreational center.

    e. The person centered planning process must include information relevant to any issues concerning the individual's health and safety. Supports to maintain the individual's health and safety should be developed within the context of his or her preferred lifestyle so that it does not conflict with his/her preferences. Describing issues functionally provides a better picture of the individual's need for support. For example, when documenting a behavior such as verbal or physical aggression, a description of how it manifests and the situations in which it occurs must be included. Merely stating that the individual is verbally or physically aggressive may not provide sufficient information to determine the supports the individual may need. Example: Tom often grasps his hands and breathes heavily prior to becoming physically aggressive by hitting or pushing people near him.

3. ***The individual determines who is involved in the planning process:***

    a. The individual chooses the members of the person centered planning team. The team may include the individual's legally authorized representative, close family members/advocates, the case manager, providers, and others identified by the individual as being important in his/her life.

    b. The team members must respect, trust, and support the individual.

    c. If bringing together a team for the planning process is difficult, then developing one should become a priority. However, the planning process can be initiated while the team is being developed.

    d. The team members meet in a comfortable location, as defined by the individual. This may help the individual feel relaxed and open enough to share things that are important to him/her with the rest of the team.

4. ***Identify the existing supports (natural or paid), both used and unused, that are consistent with the individual achieving identified goals***

    a. In most situations family members, friends, and the individual have the most knowledge about the preferences, capacities, and gifts of their children, friends, and themselves respectively. However, professionals usually have knowledge of resources available in order to provide appropriate supports and services for the individual. All members should play an active and collaborative role in order for the planning process to be effective.

    b. The individual, families and professionals recognize and document in the individualized support plan the existing supports in the individual's life.

    c. Previously unexplored natural supports in the community are discovered during the process.

    d. Identified supports match the preferences of the individual.

    e. The planning process considers the supports that the individual may require for issues that may not be directly related to the outcome but influence the strategies and actions that are developed to achieve the outcome. For example, counseling for anger or stress management.

5. ***Other professionals not originally included by the individual in their planning teams are identified as consultants, when needed.***

    a. All professional consultations, such as with a nurse or psychologist, occur in the presence, or with the permission, of the individual/LAR and are conducted in a manner respectful to the individual.

    b. The support team (i.e., individual, family and professionals) and other professional consultants are encouraged to have a trusting and collaborative relationship.

6. ***Issues of safety, health, rights, and freedom from abuse, neglect and exploitation are dealt with in the person directed plan***

    The planning process includes a discussion of individualized health and safety issues in the context of the life desired by the individual. The process maintains a balance between rights (choice/control), responsibilities and risks (health/safety) experienced by all citizens.

B. Individualized Support Plan

1. ***To identify additional natural supports and negotiate needed service system supports***
    a. Both natural and system supports are negotiated to develop the best possible support plan to achieve what is important to the individual.
    b. The individual determines his/her own supports by participating in selecting, evaluating, and when necessary, changing his/her activities and support staff.
    c. The support team members identify opportunities and activities to connect the individual to the community.
2. ***Implementation of the support strategies becomes the responsibility of the planning participants***
    a. The individualized support plan includes i) outcomes, strategies and activities, ii) person/s responsible for the completion of the activity or strategy, and iii) the date by which it is to be completed. Including specific names of people responsible and timeframes facilitates the monitoring process.
    b. The goals and aspirations are prioritized by the individual.
    c. The most important goals and aspirations are addressed first.
    d. A support plan is more easily implemented if the team works on a few goals and aspirations at a time.
    e. The individual is supported to develop community connections.
    f. Preferences should not be considered to be the same as services and supports. Services and supports are used to facilitate the acquisition of the individual's preferences. For example, the individual may express a preference to work in a bank. However, he or she may require the support of a job coach to achieve the desired goal. The support of a job coach is not the expressed preference of the individual in this case. The job coach is the support needed to achieve a goal based on the expressed preference.
    g. In a case where there is a disagreement between the individual and their LAR, every effort should be made to negotiate and clarify conflicting issues. The facilitator must keep the individual's preferences and desires the main focus of the planning process and resolve the LAR's concerns to come up with the best compromise between the two.
    h. There must be a partnership between all the team members to implement the individualized support plan. No single team member should be responsible for its implementation.

3. ***When people choose outcomes that conflict with state/programmatic standards, the following strategies should be considered to meet people's needs***
    a. Identify goals/needs that can be achieved within the existing standards, rules and regulations, while problem solving on how to accomplish the ones that are more difficult to achieve.
    b. Explore resources in other systems and programs serving people with disabilities and services available to all citizens, whether or not they have a disability, in the community to fulfill these needs.
    c. Use the existing system to its fullest potential and negotiate to create the best possible arrangement for the individual.

Discover why a particular choice or the refusal of an alternative presented in place of the original choice is important to the individual.

VI. The Role of the Facilitator

One of the key elements of the person centered planning process is a good facilitator. Good facilitators do not just run meetings. They must get to know and understand the individual and significant others in that person's life. A skilled facilitator is one who clearly understands the change process and the corresponding values. Skillful facilitators have the ability to listen, concentrate, take directions from the individual, and be inquisitive to constantly search for capacities and areas for exploration.

A number of people can serve as a facilitator during the person centered planning process. No one person is excluded from being a facilitator and no person is assumed to serve as the facilitator. However, whoever serves as the facilitator must understand the role and ensure completion of the components.

VII. Monitoring the Quality of the Person Centered Planning Process

The quality of a person centered planning process is defined by the individual and is reflected in more personal outcomes being achieved. There will be a multi-level monitoring process to ensure the quality of person centered plans. The indicators of successful implementation of a person centered planning process are:

1. Evidence that the individual determines his/her preferences during the person centered planning process with the support of family/LAR, friends, and staff if necessary.
2. Evidence that the individual chose whether or not other persons should be involved and identified the people to be included in the person centered planning process.

3. Evidence that the individual chose the time and location of the person centered planning session.
4. Evidence that the individual chose his/her outcomes and support staff whenever possible.
5. Evidence that the individual's preferences and outcomes were seriously considered and in situations where it was difficult to implement his/her preferences and outcomes, the team arrived at a compromise acceptable to all.
6. Evidence that case managers/service coordinators ensure that support plans remain current at all times and are monitored on an ongoing basis for their effectiveness in achieving the outcomes identified by the individual with the support of his/her family/LAR. This is a critical element since an individual's goals and preferences are constantly evolving. It is important to keep asking questions, listening and discovering the preferences of the individual.
7. Quality improvement plans actively seek feedback from the individuals and families receiving services and supports regarding the opportunities they have to express needs and preferences and the ability to make choices.

The Person Centered Planning Process Happens When . . .

people work together to solve the challenges that arise
when individuals live and work where
and how they choose and strive to
reach their dreams and goals.

Person Centered Planning Helps/Hinders

COMMENTS THAT PROMOTE PERSON CENTERED PLANNING	COMMENTS THAT INHIBIT PERSON CENTERED PLANNING
I'll help you find out.	I don't know what you would do here. You might want to call…(i.e., someone other than me).
You can help just like everyone else.	We can't fit that into your schedule.
Let's talk about what other tasks you might like to do.	We can't do that because the state doesn't give us money to do that.
You can volunteer in my Sunday School room, my area, etc.	The rules don't allow that.
You can try that and see if you like it.	I really want to but our schedule just doesn't allow me the time.
Tell me more about what you like about that.	There's a program like that for people with disabilities.
What do you want to discuss at your meeting?	You need this.
What do you need to be able to do that?	This would be much better for you because…
Do you need someone to help you?	I don't think you would want to do that.
Let me make sure that I understand what you are saying.	I know that you expressed you wanted to do this at your last meeting (6 months ago) and we are working on this.
I'm listening.	Yes, I'm listening but…
I'll be there!	You are on the list and by next year you should be able to start interviewing for a different job.
I think you're a neat person!	My Life, My Dream by: Grossi, McCarty, Holtz and Todd

SOCIAL HISTORY

An important part of developing a person centered plan is to understand the social history of the individual. Below is a sample social history of Sue.

Sue is a single, never married, white, 37 year old female. She is the fifth of six children born to _____ and _____. Her father is deceased as of 11/89 and mother resides in a nursing home in southern Illinois. There is sporadic contact with one brother and mother, no contact with remaining family.

Sue attended and graduated from High School in 1983. No other education history is known. She currently works part time at a fast food restaurant and does some volunteer work at a local elementary school. She used to do housework and cleaned in a laundromat.

Sue is overweight, has high blood pressure and is allergic to antibiotics. She has difficulty with speech articulation which makes communication difficult. She is able to read and write simple phrases.

Sue lives with her boyfriend in a house they own together and they split expenses. Sue has no guardian or representative payee. She receives benefits from Social Security and has Medicaid insurance.

PERSONAL SKETCH

Sue is a short, stocky woman with a smile that makes her eyes crinkle up at the corners and that causes those around her to smile back. She is "thirtyish," with thick, brown, wavy hair that is always shining and in place. Sue is working hard to lose weight and get her blood pressure down so her doctor will stop "yelling" at her.

Sue is a dreamer, always has been. There was a time many years ago when it seemed unlikely that any of her dreams would ever be more than that--dreams. Sue is not only a dreamer, she is a doer, against the odds she carries her positive attitude and persistence to make her dreams reality.

Sue was the fifth of six children born to parents with developmental disabilities in rural _____ County in 196-. Her mother was barely 14 years old when she ran away to Mississippi to marry Sue's father. Within seven years she had borne six children while little more than a child herself. Life was difficult for this family. Both parents were overwhelmed and poorly equipped to handle the needs of six children. Sue was so emotionally and culturally deprived that at the age of 5 ½ she had yet to speak her first words. In desperation, the family turned to the Department of Children and Family Services and the Department of Public Aid

for help. Sue's parents agreed to what they thought was a temporary placement of all of their children at _____ State School. Instead, all of the children were placed in foster homes while awaiting placement. Eventually, Sue and two of her siblings were placed at _____ School, the other three siblings whereabouts were unknown to Sue and her parents.
In 1968, Sue's parents moved to _____ in hopes of starting a new life. Sue's father got steady work as a farm hand and he and his wife rented a three room house on the southwest side of town. The home had no indoor plumbing. Drinking water came from a rain barrel that collected water which ran off the roof of the house. Sue's parents were distraught at the loss of their family and angry with the court system that they believed had deceived them. They sought the assistance of the Legal Aid Society and discovered that they could get Sue released from _____ State School. They did this as soon as they were able to make arrangements. Sue was reluctantly released from the state school in 1969. The staff felt that Sue had been making significant progress.

Sue was immediately linked to P_____ School, which was not a public school but an agency that provided services to people with disabilities that were not, at the time, served by public schools. Eventually, she was linked to S_____ School which is a public school and at the time provided services to "E.M.H. and T.M.H" students. The environmental deprivation in Sue's home was so severe that one of the teachers at S_____ School offered to take Sue into her home in order to give her the attention she needed and craved. Sue's parents agreed because above all else, they loved their daughter and wanted to best for her.

Sue's dreams began. Graduation from S_____ School approached and Sue had decided she wanted her own apartment. Sue's friend, the teacher from S_____ School, helped her find an affordable, safe apartment and set her up there. PRC (used to be P School) assisted Sue with her shopping, medical appointments and managing her money.

Sue kept dreaming, she wanted more. She wanted a job and she got one at the Steak and Shake. She loved earning her own money. Sue lived across the street from a laundromat so she approached the owner about keeping the machines clean and the floor swept, he hired her. Soon her reputation as a housekeeper earned her several regular housekeeping jobs. Sue also found time to give of herself in volunteer work at MRI (what used to be PRC). Sue did pet therapy once a week for individuals in training and the staff. Everyone looked forward to the day that Sue brought her contagious smile and some fuzzy little animal to love on.

Sue's dreams continued. Sue dreamed of finding someone to love and share her life with. She met Mr. Right when they shared a bus seat on an outing to St. Louis organized by MRI. Six years later the two of them were sure they had found the love of their life and Sue's dreams grew. They wanted a real home of their own. With support and assistance from MRI and his family, they found and purchased a bungalow in a quiet neighborhood. The white sided house was lovingly decorated and maintained right down to the "Welcome" mat on the

front porch. They each put up half of the earnest money, they are both listed on the title to the house and they split the household bills and mortgage payment.

The dreams continued. Now Sue had her home and life mate and she would like to get married. There were concerns about losing benefits if they married and how the bills would be covered if something happened to her. While MRI would help Sue and her boyfriend to work through this, which Sue appreciated, she also dreamed of being independent. She had succeeded, after years of training, to manage her own money. She had a checking and savings account which she managed independently; however she required assistance in filing her income taxes and completing Public Aid forms.

Through the years Sue had always had the dream of finding her other siblings and reuniting then with her mother. Sue feared time was running out as her mother was ill and in a nursing home in southern Illinois. In part, due to Sue's trying to find a way to do it, a teacher from S_____ School heard the story and something clicked in her memory from when she worked in southern Illinois. Following through on the hunch proved correct. Sue had found her lost siblings and was able to get them together with their mother. What a joyous success for Sue. For those of us who are lucky enough to know Sue, she has a wonderful gift of sharing her joy in a way that enables you to feel her joy in your heart.

Currently, Sue's dream of being married to the love of her life has come to an end. Her boyfriend passed away, suddenly and unexpectedly. Just as those who know Sue and shared her joy, we share her grief. Sue is working hard to stay on track and get on with her life. Her many friends and the family of her boyfriend do all they can to help. Again it seems we who "work with" Sue gain and learn so much more from her than we give. She can sign/say, "I still cry sometimes." Then the smile appears that let's you know she misses him terribly and yet is so very thankful she had him in her life.

Sue's dreams now are focused on keeping the home she shared with her boyfriend. She works part-time and continues at S_____ School as a teacher's aide. She continues to work on controlling her weight and blood pressure. She would like to save money to make some improvements on the house. Sue is staying involved in life by volunteering and doing things with friends.

Scenario Five

Directions: *You have been getting to know Rachel in each of the previous modules. However, it might be helpful to get some insight from her peers, support staff, family, and Rachel herself. The following pages provide you some additional information from their points of view. Use what they say to complete the person centered planning tool included in this module. A person centered planning tool is meant to emphasize the positive qualities of the individual. Pay particular attention to those questions/issues that are raised.*

Peers' Point of View

I go with Rachel on outings with staff. She doesn't talk to anyone but staff. She always wants to go to the mall. When we watch TV, she wants to watch race cars all the time. I don't like to sit next to her because she stinks up the room and laughs too much.

. . . . .

Rachel sits next to me at work and never stops talking about boys and race cars. Anytime I try to talk to staff, Rachel always starts talking and staff can't hear me. When we are supposed to be working, she is talking and doing other stuff so I can't get my job done. At lunch she steals my food and laughs when she stinks up the place. She is always bothering my boyfriend and never listens to me.

Family's Point of View

Family Background: Rachel's mother was forty-three when Rachel was born. Rachel lived at home until she was 29. She is an only child. Both of her parents are alive, although her mother has diabetes and now is on dialysis due to renal dysfunction. This is the reason that she was placed outside of the home. Her parents are her guardians.

She has an aunt in Texas who has minimal involvement due to the distance, although she was involved in her early years. She still corresponds with Rachel.

Father: Rachel was a sickly child and had numerous hospitalizations. We kept her at home and had special tutors on occasion. She did not have a formal education due to her health. She was the center of our lives.

Mother spoiled and smothered her. She did not allow Rachel to learn or gain more independence. She just kept her at home. When Mother's health started deteriorating, I felt we couldn't keep her at home. I used to enjoy shopping with Rachel, but I can't handle both of them now. We just want her to be in a place where she is cared for, happy, and where someone will train her to be more independent and control her when she gets upset.

We are making arrangements for her aunt to be her guardian if something should happen to us.

Mother: I had Rachel late. In fact, I never thought I would have a child. She's been the light of my life, my baby. She was so sick as a child. When she was healthy she helped around the house a little. I just never felt she could handle school and the other children making fun of her. She acts up sometimes, but she's not a bad child. She needs some reminders when she gets upset. She would never hurt me though--she has never hurt anyone.

Rachel likes to talk a lot. She talks a lot when she is nervous or not feeling well.

Support Staff Point of View

- ☐ Rachel's always on the phone.
- ☐ She answers the phone but doesn't pass along the messages.
- ☐ Her talking interrupts her work.
- ☐ Co-workers complain "she's gross."
- ☐ She has a new habit--picking her nose.
- ☐ Rachel likes getting a paycheck.
- ☐ Rachel is not a good listener.
- ☐ She offends people on the bus.
- ☐ She stays up late watching car races and then doesn't want to get up in the morning.
- ☐ She responds well one-on-one with favored staff.
- ☐ She has adjusted well to her diet at home.
- ☐ However, she makes inappropriate choices from vending machines at the workshop.
- ☐ Rachel eats what she wants on home visits.
- ☐ She works well with the floor supervisor at work.
- ☐ At breaks times, she is engaging in inappropriate sexual activity.
- ☐ Parent's are sending care packages with inappropriate food choices.
- ☐ Rachel has a chance at supportive employment if she pays attention.
- ☐ She has a male friend who is riding a bike, so Rachel is interested in learning to ride a bike.
- ☐ Staff now ride the bus to the mall with Rachel. But, she shops independently.
- ☐ Rachel is beginning to invite male friends to her home for supervised interaction.
- ☐ Staff have expressed a desire for Rachel to remain abstinent to prevent pregnancy and venereal disease.
- ☐ Workshop staff has expressed a desire for a time-out program when she is not paying attention.
- ☐ One staff member recommended moving Rachel so that the kitchen doesn't have to be locked to keep her from stealing the food in her CILA home.

Rachel's Point of View

People just don't listen to what I have to say. Everybody treats me like a child. I'm not. I'm a grown woman. I want to meet some new guys and marry like Mom did.

I also want to do real work for real money. There's nothing wrong with me. Why do I have to be with these people.

I don't want to work on these old goals. I want to learn to write so I can write to the bus driver.

Person Centered Planning Tool For Rachel

Directions: *Complete this person centered planning tool using all of the information we have learned about Rachel from the past five scenarios.*

About Rachel

Support people in Rachel's life . . . . . .
Include family, friends, acquaintances, community members, direct support persons, QIDP & other paid staff.

Some great things about Rachel . . . . . .

Some things Rachel needs help with . . . . . .

What does Rachel like to do?
Include: leisure activities, spiritual issues, cultural issues, community activities, work & household activities.

What does Rachel wish she could do?
Do not censor the list. Include everything she would like to do.

What makes Rachel happy?

What makes Rachel sad?

Rachel's current job . . . . . .

Include: job duties, hours, pay, support needed, benefits, coworker relationships & flexibility.

The job Rachel would most like to have . . . . . .

Rachel's current residential situation. . . . . .
Include: neighborhood, location, roommates, privacy, transportation issues & supports needed.

Where does Rachel want to live?

Rachel's dreams for the future . . . . . .
Do not censor the list.

Rachel's medical condition. . . . . .
Include diagnosis, medications, therapies, diet & supports needed.

How Can We Best Support Rachel:

In completing the things she needs help with?

In achieving the things she wants to do?

In finding/maintaining a job she is happy with?

In finding/maintaining a residence she is happy with?

In achieving her goals for the future?

To ensure the stability of her medical needs?

How Can We Make Sure This Works?

Who is responsible for implementing this plan?

How will they ensure the continued success of this plan?

Person Centered Planning Application Exercise #1

Directions: *Work with one individual with an up-coming staffing or IDT meeting. Assist them in completing the first part of this person centered planning tool. Use this tool as a way of helping the individual communicate their wants and needs at the meeting. The second and third parts of this person centered planning tool will be completed with the help of all persons present at the meeting.*

Remember to model the principles of confidentiality at all times. Your actions can influence how others react to confidentiality issues. Share it with your trainer when you are done.

About _____

Support people in _____'s life . . . . . .
Include family, friends, acquaintances, community members, direct support persons, QIDP & other paid staff.

Some great things about _____ . . . . . .

Some things _____ needs help with . . . . . .

What does _____ like to do?
Include: leisure activities, spiritual issues, cultural issues, community activities, work & household activities.

What does _____ wish he/she could do?
Do not censor the list. Include everything he/she would like to do.

What makes _____ happy?

What makes _____ sad?

_____'s current job . . . . . .

Include: job duties, hours, pay, support needed, benefits, coworker relationships & flexibility.

The job _____ would most like to have . . . . . .

_____'s current residential situation. . . . . .

Include: neighborhood, location, roommates, privacy, transportation issues & supports needed.

Where does _____ want to live?

_____'s dreams for the future . . . . . .

Do not censor the list.

_____'s medical condition. . . . . .

Include diagnosis, medications, therapies, diet & supports needed.

How can we best support _____:

In completing the things he/she needs help with?

In achieving the things he/she wants to do?

In finding/maintaining a job he/she is happy with?

In finding/maintaining a residence he/she is happy with?

In achieving his/her goals for the future?

To ensure the stability of his/her medical needs?

How can we make sure this works?

Who is responsible for implementing this plan?

How will they ensure the continued success of this plan?

SECTIONS OF THE SERVICE PLAN

Most service plans contain the following information:

Personal Description- This section describes the person. It goes beyond the old way of describing a person (i.e., 25-yr. old black male with down syndrome*).*

Medical/Dental/Nutritional- This section contains a summary of significant medical issues. This includes any medication the person takes and the reasons. There may be nutritional information mentioned here, as well.

Background/Historical- This is a summary of significant events that have happened in the individual's life. These events may be a clue as to what shaped who the person is today.

Social Relationships- Here is where details of the person's social life are outlined. Important people are mentioned, as well as, all types of relationships (e.g., family, friends, work, staff members). Some of these relationships may be positive and others not. Sometimes we draw maps to show how these people are related. These show graphically, the connections between people. This area would indicate whether the person prefers to be with people or by himself/herself.

Goals/Objectives- This section identifies the areas targeted for development. The information for this section is gathered through interviews, assessments, and on-going interactions with the person. Goals can be from any area, but they need to be important to the person, not necessarily the staff providing input into the plan. We must set goals in various areas to obtain funding. This includes economic self-sufficiency, daily living skills, and community integration. We look at what the person wants to learn and prioritize short and long term goals based on the person's preferences.

Interests and Activities- This is where we learn what interests the person outside of work and home responsibilities. Leisure activities, hobbies, sports, or just about any other interest can be listed in this section.

Personal Values- This section makes a statement about what is important to the person. This is useful to know because often times we are motivated by what we value the most.

Personality, Feelings, & Emotions- We need to know these things about the person in order to develop a supportive environment. Therefore, getting to know the person is essential.

Sources of Comfort and Discomfort- This section will outline what things provide comfort as well as, discomfort to the person. You may want to remember that we can never know everything about a person. So, this section may have information only known to the staff who wrote it. Further, as people grow and change, this area of the plan may have to undergo change. Again, you will learn much about the person as you interact with him/her.

Assessments- The results of assessments or tests may be included here. For example, PT/OT, IQ, speech and language, etc.

Strengths and Needs- Here we learn about the abilities as well as areas which require support.

Vocation- This section will describe the kinds of work the individual likes to do or would like to do.

Education- A summary of the person's educational background as well educational goals.

Financial - This area discusses financial information about the person including sources of income and needs for the future.

Communication Style- The best way to communicate with the person would be spelled out here. People can and do communicate in a variety of ways and it is important for you to understand how to communicate with each person you will be working with.

Learning Style- How the person learns is outlined. This includes strategies you can use to work most effectively given the person's specific situation.

Personal Rights- In this area, we would learn which rights are most important to the person. Also, what if any rights restrictions might be in place and details of the situation.

Recent Life Changes- Anything that has recently occurred in a person's life which may have an effect on his/her day-to-day functioning should be noted here. This is another area that would be updated continually.

Vision for the Future- Just as we have dreams and hopes for the future, so do people we support in our programs. You need to get to know the person. This will assist you in identifying his/her hopes and dreams. Then you can assist the person in realizing them.

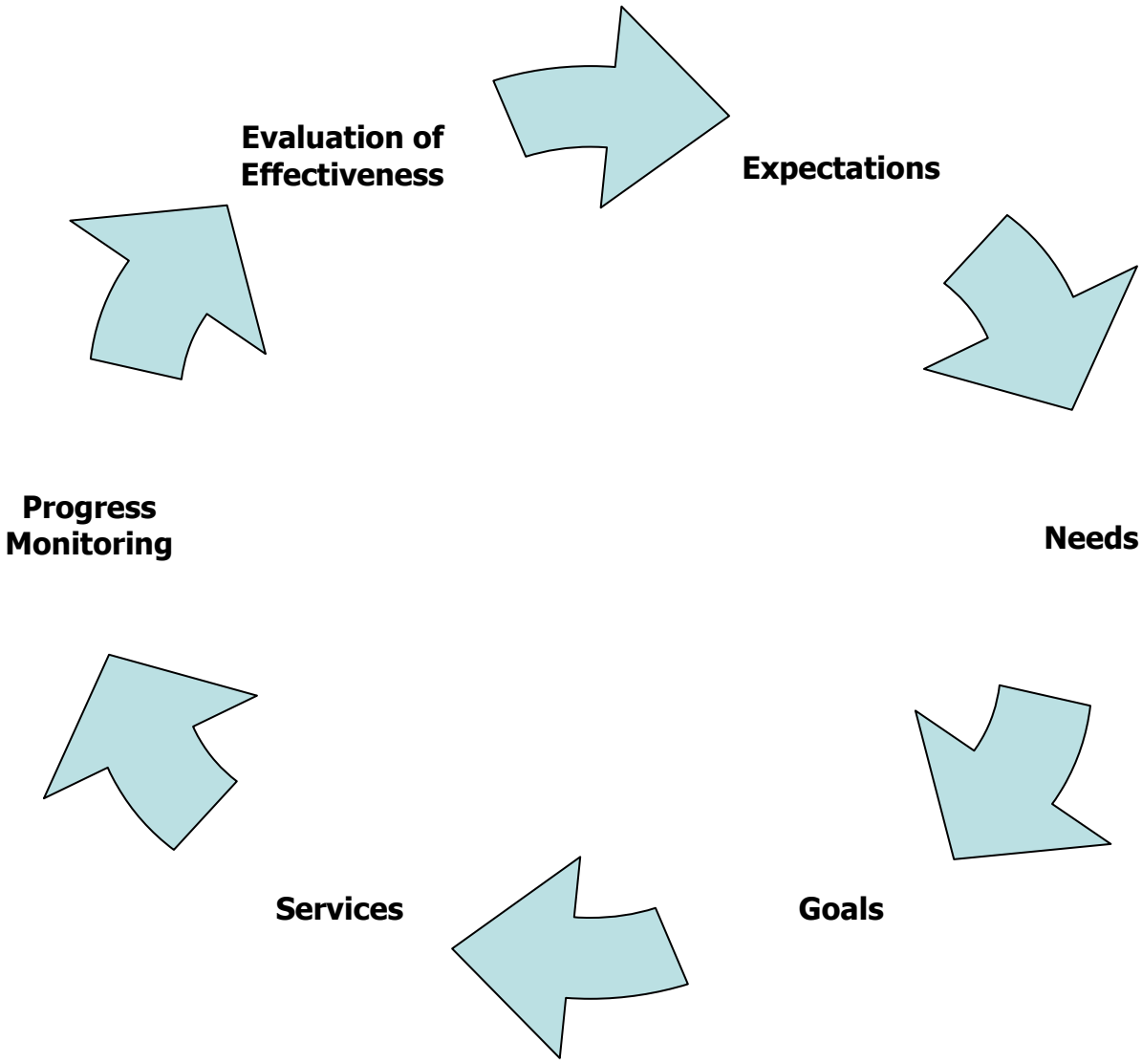
Each Individual Habilitation Plan is tailored to the individual. Therefore, not all service plans contain all of these components. Some plans may have additional information not listed here.

Additional Information: Service Plans are developed and signed by the individual or guardian, the QIDP, and all service providers. Service Plans explain significant changes in services or providers and indicate that the individual, family members and Service Facilitator participated in the decision process regarding these changes.

Service Plans contain formal (e.g., ICAP) and informal assessment information, including an indication that individual preferences were considered.

Service Plans contain at least one measurable goal. Service Plans contain an explanation of instructional methods for assisting the individual in moving toward accomplishment of his/her goal(s) and a way to monitor the individual's progress in achieving the goal. It also contains the name(s) or role(s) of the person(s) responsible for assisting the individual in achieving the goal.

GOALS/SERVICES PLANNING MODEL



What is a Rights Restriction?

"Restriction" means anything that limits or prevents an individual from freely exercising his/her rights and privileges.

Something is usually considered restrictive if it impedes the enjoyment of general liberties that are available to all citizens.

With any program that causes a restriction of rights, it is implied that:

- The restriction is **temporary**
- The restriction is defined with **specific criteria** (under exactly what circumstances will it be used)
- The program is **paired with learning/training components** to assist the person in the eventual removal of the restriction
- The restriction is **removed** upon reaching clearly defined objectives
- **Reviewed** regularly by HRC

Rights of Individuals

The **US Constitution** guarantees these rights to each citizen, **regardless of ability**:

- Access to the courts and legal representation
- Free association
- Right to contract, own and dispose of property
- Equal educational opportunity
- Equal employment opportunity
- Equal protection and due process
- Fair and equal treatment by public agencies
- Freedom from cruel and unusual punishment
- Freedom of religion
- Freedom of speech and expression
- Right to marry procreate and raise children
- Privacy
- Right to vote

Rights of people receiving supports in the Illinois DD Support System include:

- Right to services in the least restrictive environment
- Right to normalized living conditions
- Right to dignity and respect
- Right to freedom from discomfort and deprivation
- Right to appropriate clinical, medical and therapeutic services
- Right to religious worship
- Right to physical exercise
- Right to manage personal funds
- Right to adequate nutrition
- Freedom from involuntary servitude
- Freedom from unnecessary medication and mechanical, chemical, or physical restraints

With any program that causes a restriction of rights, it is implied that:

- The restriction is **temporary**;
- The restriction is defined with **specific criteria** (under exactly what circumstances will it be used);
- The program is **paired with learning/training components** to assist the person in the eventual removal of the restriction;
- The restriction is **removed** upon reaching clearly defined objectives;
- **Reviewed** regularly by the Human Rights Committee.

Some examples of rights restrictions include:

- Locks on refrigerators
- Locked kitchen
- Areas off limits in home
- Loss of activity due to behavior
- Limiting who the person may socialize with
- No food/drink in room
- Restitution
- Limiting use of phone
- Making someone go to bed at a certain time
- Alarms on doors
- Limiting opportunity to learn
- Limiting access to personal property

PEOPLE FIRST LANGUAGE

People first language is using language that puts the person first and the disability last. Using people first language is important so that we portray as positive a message as possible about people with disabilities.

Who should use People First Language? Everyone!!!

- Staff
- Media
- Family members
- Politicians
- People with disabilities

Following is a set of guidelines, adapted from guidelines prepared by the Research and Training Center on Independent Living at the University of Kansas. The guidelines explain preferred terminology and offer suggestions for appropriate ways to describe people with disabilities. They reflect input from over 100 national disability organizations and have been reviewed and endorsed by media and disability experts.

1. **Do not focus on a disability** unless it is crucial to a situation. Avoid tear-jerking human interest stories about incurable diseases, congenital impairments, or severe injury. Focus instead on issues that affect the quality of life for those same individuals, such as accessible transportation, housing, affordable health care, employment opportunities, and discrimination.

2. **Do not portray successful people with disabilities as superhuman.** Even though the public may admire super-achievers, portraying people with disabilities as superstars raises false expectations that all people with disabilities should achieve at this level.

3. **Do not sensationalize a disability** by saying afflicted with, crippled with, suffers from, victim of, and so on. Instead say, "*Person who has multiple sclerosis or a man who had polio.*"

4. **Do not use generic labels** for disability groups, such as "the retarded", "the deaf". Emphasize people, not labels. Say, "*people with intellectual disability, or people who are deaf.*"

5. **Put people first**, not their disability. Say, "*woman with arthritis, children who are deaf or people with disabilities."* This puts the focus on the individuals, not the particular functional limitation. Do not say "crippled," "deformed," "suffers from," "victim of," "the retarded," "infirm," "the developmentally disabled," "the autistic," "the mentally ill," etc. This is NEVER acceptable under any circumstances.

6. **Emphasize abilities**, not limitations. For example: *Uses a wheelchair/braces, walks with crutches*, rather than confined to a wheelchair, wheelchair-bound or is crippled. Similarly, do not use emotional descriptors such as unfortunate, pitiful, and so forth. Disability groups also strongly object to using euphemisms to describe disabilities. Some advocates, who have a visual impairment, dislike partially sighted because it implies avoiding acceptance of blindness. Terms such as handicapped, mentally different, physically inconvenienced, and physically challenged are considered condescending. They reinforce the idea that disabilities cannot be dealt with upfront.

7. **Do not imply disease** when discussing disabilities that result from a prior disease episode. People who had polio and experience after effects years later have a *post-polio disability*. They are not currently experiencing the disease. Do not imply disease with people whose disability has resulted from anatomical or physiological damage (e.g., person with spina bifida or cerebral palsy). Reference to disease associated with a disability is acceptable only with chronic diseases, such as arthritis, Parkinson's disease, or multiple sclerosis. People with disabilities should **never** be referred to as patients or cases unless their relationship with their doctor is under discussion.

8. **Promote that people with disabilities are active** participants of society. We know that persons with disabilities interacting with non-disabled people in social and work environments helps break down barriers and open lines of communication.