

A Facilitator's Guide to Person Directed Planning

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We would also like to acknowledge the contributions of the experts in the field. There is a burgeoning body of international scholarship and ongoing research into promising practices in person directed planning that we have referenced throughout the guide. Yet it is the professionals in Ontario who have been leading innovators in person directed planning. Their work has informed the work of most others around the world. Therefore, we would be remiss in not mentioning the pioneers in this field: the late Marsha Forrest, Jack Pearpoint, Lynda Kahn and so many of their associates with Inclusion Network, Inclusion Press, and the Marsha Forrest Centre. Their work is referenced throughout this guide. The development of this particular guide has also been well-informed by the work of so many other developmental services agencies in Ontario that are leading the way in person directed planning. Their valuable resources have enhanced the quality of this guide. Thanks to all!

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PART ONE: SETTING THE CONTEXT

Introduction: Setting the context

Purpose of the guide

Guiding principles for effective facilitation

Guiding principles for person directed planning

Culturally responsive practice



PART ONE: SETTING THE CONTEXT

Introduction

In September, 2004, the Ministry of Community and Social Services in Ontario (MCSS) announced a process to transform developmental services for adults with a developmental disability. The intent was to create a more equitable, accessible, and sustainable system of community-based supports. Over the past several years there has been a growing emphasis on self-determination, community involvement, and overall quality of life. To this end, the fundamental goal is to enable people to live and participate in their communities as independently and fully as possible, and to make their own decisions to the fullest extent possible. Regulation 299/10 promotes the social inclusion of persons with a developmental disability and recognizes the critical importance of planning and support networks as essential components of this larger process.



Person directed planning is highly consistent with the emphasis on self-determination and the achievement of personal outcomes for people with developmental disabilities. Through an action-oriented approach to planning, people with disabilities are the architects and directors of their plan. Other people in their networks or circles of support participate in the planning, and assist these people to think about dreams, goals and supports needed.

There have been many approaches introduced over the past two decades that describe a person centered and more recently a person directed approach to planning. Many of the models share similar characteristics but each offers something unique in the designs for planning and learning. All approaches look at a person's place in the community and at his or her strengths and needs. The approaches or models encourage communities of practice that support people with developmental disabilities to identify their talents and skills and how best to apply them. Furthermore, there are a myriad of guides, resources, and planning

tools that support the different approaches to person directed planning. Several of these resources and tools will be referenced throughout the guide. Yet it is critically important that person directed planning is viewed as much more than a toolbox of techniques. This paradigm shift to person directed and individualized planning is accompanied by a shift in how we assess and evaluate whether or not the person is experiencing improvements in the quality of life. It is the person who determines the outcomes and assesses the growth.

Purpose of the Guide

This guide has been written to assist staff working in the developmental services sector and across other organizations in furthering their understanding of person directed planning and the role of the facilitator in the planning process. Guidance is provided on how to facilitate the development of a person directed plan and how to build capacity and commitment with a network of people supporting the person with the disability.

This facilitator's guide is divided into two parts. Part One provides the facilitator with an overview of the Ontario context, information on person directed planning, and the role of the facilitator in the planning process. Part Two addresses the elements of practice that are part of the person directed planning process. In this section, facilitators are provided with a variety of tips and tools to support them with each element of practice. It is important to note that person directed planning is not a linear process. Rather it is an iterative one. Therefore, this section is not organized by steps or modules, as is commonly found in many facilitator's guides. This was purposefully avoided to emphasize how individualized this planning must be. Each person with whom the facilitator is interacting will inform what element of practice should be addressed next.

Guiding Principles for Person Directed Planning

A person directed plan tells us about the person's hopes and dreams, the supports necessary for success, and the actions required for the desired outcomes. The person directs and owns the plan. Such an approach highlights the importance of the person taking the lead on the plan, deciding what is most important to the person, and what the future could look like.

The following principles underpin person directed planning:

Planning is Person Directed

- Person generated, directed and owned
- Strengths-based design outlining gifts, dreams, and hopes
- Defines what is meaningful in one's life

Planning is Organic and Dynamic

- A flexible, open-ended and on-going process
- On-going review of goals set, strategies used, actions required, and desired outcomes

Respects Individual Rights

- Respects individual rights, entitlements, and responsibilities
- Emphasizes choice and making decisions for self

Embraces Cultural Diversity

- Honours the dignity of the person
- Addresses all aspects of the person's identity (race, ethnicity, faith, language, disability, sexual orientation, etc.)

Builds Relationships

- Fosters meaningful and lasting relationships with family, friends, and community members
- Values and strengthens involvement of a personal support network
- Learning and planning is part of a social activity

Inclusion

- Facilitates participation in and contribution to community life (recreation, work, volunteering, relationships and other experiences)
- Develops relationships in the local community
- Explores creative options and resources to support desired outcomes

Guiding Principles for Effective Facilitation

The term facilitation refers to a process of supporting others to achieve self-growth. Simply put, facilitation is the process of helping others engage, learn, and achieve. This is accomplished through attending, responding, and understanding how best to build upon a person's strengths and gifts. The facilitator invests in the outcomes, and is knowledgeable about the process and content in person directed planning. For example, the role of the facilitator is to support the person and establish, grow and maintain a support network. The facilitator supports the person to direct planning to the greatest extent possible. An effective facilitator is an enabler and a connector who supports others in achieving goals. The facilitator supports others in doing their best thinking and practice by encouraging full participation, and by helping to define roles and responsibilities among the support network. The facilitator also provides structure and process to each meeting so that focused conversations and action planning can occur. Effective facilitators commit to a partnership with the person and his/her support network of family, friends, and community members.



The following principles underpin effective facilitation:

Person Directed

- Accommodates the person's style of interaction and preferences in the planning process
- Focuses on what is important to the person
- Respects the dignity and worth of each individual
- Explores natural supports in the community

Effective Communication

- Engages empathetically in deep and active listening
- Asks open- ended questions when exploring talents, skills, preferences, choices, and goals
- Acknowledges and affirms through frequent feedback

Embraces Diversity

- Recognizes and values person's cultural background in the planning and decision-making process
- Sensitive to the needs, fears, and goals of the person

Fosters Connections

- Facilitates connections and the development of healthy relationships in the community
- Connects to natural and more formal services to support desired outcomes
- Cultivates a climate of respect, acceptance, trust, and cohesion among participants

Effectiveness in Coordination

- Understands the process of coordination
- Approaches tasks in a creative and flexible manner
- Ensures plan remains current as SMART goals and preferences evolve
- Organizes time and resources, and administrative tasks
- Monitors and tracks progress

Culturally Responsive Practice

Being culturally aware during the planning process involves enhancing the facilitators' knowledge and skills to effectively work with people who are different from them. It is important to be familiar with the cultural characteristics, history, values, belief systems, and practices of the person at the centre of the plan. A good facilitator engages in various learning opportunities to gain this knowledge. This could be achieved through both informal and formal settings including conferences, professional development sessions and simple conversations with peers. Self-reflection and dialogue with others may help facilitators confront their own biases and assumptions about how someone else sees the world around them. Becoming culturally competent or proficient involves building capacity in self-assessment and managing the dynamics of difference.



PART TWO: ELEMENTS OF PRACTICE

Tips and Tools for the Facilitator:

Preparing for the Process

Getting to Know the Person

Learning What is Important to the Person

Mediating Differences of Opinion

Exploring Cultural Identity

Building Relationships

Exploring Natural Community Supports

Accessing Disability Supports and Services

Facilitating a Planning Meeting

Setting SMART Goals

Developing Strategies

Aligning Resources with Priorities

Determining Outcomes

Conclusion: Sustaining Commitment to Action



PART TWO: ELEMENTS OF PRACTICE

This section of the guide outlines the different elements of practice associated with person directed planning that are addressed throughout a planning process. Each facilitator will be focusing on different elements of practice while engaged with a person and his/her support network. The outcomes of those interactions will inform and drive what elements of practice the facilitator applies to the next session. The following elements of practice are reviewed in this guide:



- Preparing for the Process**
- Getting to Know the Person**
- Learning What is Important to the Person**
- Mediating Differences of Opinion**
- Exploring Cultural Identity**
- Building Relationships**
- Exploring Natural Community Supports**
- Accessing Disability Supports and Services**
- Facilitating a Planning Meeting**
- Setting SMART Goals**
- Developing Strategies**
- Aligning Resources with Priorities**
- Determining Outcomes**

Element of Practice: Preparing for the Process

Taking the time and effort to plan out what the process will look like is a great strategy for setting the stage for successful interactions and excellent outcomes. A facilitator will become more comfortable interacting with the person and his/her network if the necessary time has been taken to be well prepared. In the beginning, the facilitator guides the planning process and is then guided by the person and his/her network. Through this preparation, the facilitator will also learn how the person responds to the path the process is taking and makes any necessary adjustments. The facilitator wants the person and his/her network to participate in the process and must be skilled at posing questions to encourage creative problem solving and collaboration. A facilitator must repeatedly check that he/she is not imposing his/her own interpretations on what’s being communicated.

Tips	Tools
<p>The facilitator reflects upon some of the following:</p> <p>What is the best process to take with the person?</p> <p>If there is a formal meeting what is the focus of the meeting? (i.e., getting to know you, developing relationships, seeking employment, etc.)</p> <p>Where should the meeting be held?</p> <p>Who needs to be invited?</p> <p>What is the best time for the meeting?</p> <p>How long should the meeting be?</p>	<p>MAPS and PATH Activities: Path: Planning Possible Futures</p> <p>PATH Workbook</p> <p>The Path and Maps Handbook: Person-Centered Ways to Build Community</p> <p>Hints for Graphic Facilitators</p> <p>Implementing Person-Centered Planning</p> <p>DVD Packs for MAPS and PATHS</p> <p>Planned Lifetime Advocacy Network: Planning for a future where we all belong.</p>

Tips	Tools
<p>Do I know yet if the person can stay engaged in a longer meeting or should I be breaking the one meeting into a series of shorter meetings?</p> <p>Do I know if the person and his/her support network have a best time or day of the week to set aside for planning meetings?</p> <p>Does the person require some supports or accommodations in the meeting like built in breaks?</p> <p>Are there particular coping strategies that work for the person?</p> <p>What planning tools (visuals, etc.) will be appropriate for this particular meeting?</p> <p>What communication systems might need to be incorporated into the process?</p> <p>Am I allowing time and space for processing?</p> <p>How should I ask the participants to prepare for the meeting?</p>	<p>It’s My Choice, pages 5-23</p> <ul style="list-style-type: none"> – graphic records – captures key words and images as people speak – corrects misunderstandings, helps others visualize connections, possibilities, and encourages reflection <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – PCP Facilitator’s Doughnut – PCP Facilitator’s Be-Know-Do – Quality Evaluation Tool – Decision-Making Agreement <p>ELPNET Sample Plans</p> <p>My Choice, pages 15-23</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability</p> <p>LPW Associates Checklist – Appendix 6</p>

Element of Practice: Getting to Know the Person

For the facilitator, deciding how much information to find out about a person in any given planning session will depend on the type of planning you have been engaged to do. For example, learning about a person’s history when planning for support to access a community recreation program will look very different from planning for employment.

There may be one or several sessions devoted to Getting to Know You depending on the person and his/her directions in the planning process.

Tips	Tools
<p>Welcome the person.</p> <p>Introduce yourself and what your role is as facilitator.</p> <p>Give some background information on Person Directed Planning.</p> <p>Give some information on your organization.</p> <p>Explain what the next few hours might look like.</p> <p>Structure the conversation as a graduated exploration of getting to know the person, and the person getting to know you.</p> <p>Listen to the person - words, actions, engagement level.</p>	<p>Griffin Centre: My Person Directed Plan – Appendix 2</p> <p>Corbrook Awakening Abilities: Person Directed Plans – Appendix 1</p> <p>Montage Support Services: Getting to Know You - Appendix 3</p> <p>WordQ and Inspiration Software</p> <p>It’s My Choice, pages 7-22</p> <p>Learning Community Sample Plans</p> <p>Creating a Good Life in the Community: A Guide on Person directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 76-90</p>

Tips	Tools
<p>What is unique and special about the person that helps everyone to better understand how the person will make wonderful contributions to the community?</p> <p>Give space and time for input.</p> <p>Spend time with them in different situations and settings and at different times of the day and week.</p> <p>Focus on the person by probing:</p> <ul style="list-style-type: none"> ▪ What are the great things about you, your skills and gifts? ▪ What are your hopes and dreams and fears? ▪ Tell me about some of the things you think you are good at ▪ What do you like to do? <p>What achievements, interests, hobbies, and life events have been important?</p> <p>Together begin creating a portfolio of significant events, mementos, etc.</p>	<p>MAPS and PATH Activities: Path: Planning Possible Futures</p> <p>PATH Workbook</p> <p>The Path and Maps Handbook: Person-Centered Ways to Build Community</p> <p>Hints for Graphic Facilitators</p> <p>Implementing Person-Centered Planning</p> <p>DVD Packs for MAPS and PATHS</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – PCP Facilitator’s Doughnut and Be- Know- Do – Ground Rules – Team Purpose – Gift Sheets and Community Map – Pyramid of Success – Communication Tools

Element of Practice: Learning What is Important to the Person

For the facilitator to learn what is important to a person, an exploration of the experiences that the person enjoys may be necessary. For example, the facilitator might explore engagement in social activities of interest linked to developing friendships. Exploring things of importance *to* the person is a key component of person directed planning and forms the basis for setting meaningful goals linked directly to desired outcomes.

Tips	Tools
<p>Ask the person to talk about what it means to have a good day or a bad day.</p> <p>Is there an especially good day in the week or bad day in the week and why?</p> <p>What would you like to be doing to make a day a good day?</p> <p>What are the activities or experiences that make this a good day?</p> <p>What activities would you like to engage in that they have never tried before?</p> <p>What are your hopes and dreams?</p> <p>What are your fears?</p>	<p>Griffin Centre: My Person Directed Plan – Appendix 2</p> <p>Corbrook Awakening Abilities: Person Directed Plans – Appendix 1</p> <p>Getting to Know You (Montage Support Services): Appendix 3</p> <p>It’s My Choice, pages 5-23</p> <p>A Guide on Person Directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 76-90</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – Good Day/Bad Day – My Daily and Weekly Routines – Dreams and Nightmare Tool

Element of Practice: Mediating Differences of Opinion

Family members or others in a person’s support network may not always agree on all goals or activities identified by the person. They may see a potential health or safety risk, or identify a conflict with their own beliefs or practices. The facilitator may need to mediate some of these conflicting views about what the person should or should not do. The role of the facilitator is to support the person and his/her support network to work through these differences of opinion and arrive at some solutions.

Tips	Tools
<p>Encourage the person to identify and communicate the desired activities associated with the goal.</p> <p>Support the person in expressing why the activity is important to him/her.</p> <ul style="list-style-type: none"> ▪ Why would it be a good thing to do? ▪ Ask others how they see this activity as risky? ▪ What could go wrong? What harm might there be? <p>Encourage others to think about ways to reduce the risk.</p> <p>Facilitate the development of different strategies.</p> <p>Be mindful of preserving the healthy relationships while resolving the tensions.</p> <p>Be mindful about differences of opinion regarding goals and expectations.</p>	<p>It’s My Choice, pages – 5-23</p> <p>A Guide on Person Directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 76-90</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – 5 Conflict Questions – Decision-making Agreement – Lifeline – The 4 plus questions

Element of Practice: Exploring Cultural Identity

It is important for the facilitator to understand the person and the identity of the person as it relates to ethnicity, race, nationality, language, faith, disability, sexual orientation, etc. Recognizing and incorporating the diversity of that identity into the planning process is critical to the formation of a person directed plan. Moreover, including any cultural support networks is an essential part of assisting the person with supports to enhance meaningful and inclusive participation in communities.

Tips	Tools
<p>Asking the person if he/she belongs to any groups.</p> <p>Examples:</p> <ul style="list-style-type: none"> ▪ A particular faith community ▪ Attendance at any religious services ▪ Observance of religious holidays ▪ Ethnic community groups ▪ English language learning ▪ Special Olympics ▪ Special interest groups (sports, arts...) ▪ Gay/Straight alliances <p>Are friends or family involved with you in any cultural activities?</p> <p>Be mindful of cultural differences in beliefs, values and terminology used.</p>	<p>Cultural Competency: A Self Assessment Guide for Human Service Organizations</p> <p>Achieving Cultural Competence: A Diversity Tool Kit for Residential Care</p> <p>Equality and Diversity Digital Toolkit for Frontline Service Sector Workers</p> <p>LGBTQ Resources: www.egale.ca www.pinktriangle.org www.alterheros.org</p> <p>It’s My Choice, pages 5-24</p> <p>A Guide to Person Directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 76-90</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – Like and Admire – The For/To Sort – Learning Log <p>A Guide to Developing Community Connections</p>

Element of Practice: Building Relationships

Many people with disabilities have a significant imbalance in terms of paid and non-paid relationships. It is important to work towards a better balance. Everyone needs a sense of belonging and contact with others. Relationships are critical to our health and well-being. The role of the facilitator is to assist the person in thinking about with whom he/she spends time, how much time he/she would like to spend with them, and ways in which they can strengthen and expand the number of relationships.

- What relationships does the person want to nurture and explore?
- What things can happen now to strengthen the relationships already in his/her life?
- How can the person connect with others?
- What support does the person need to build more relationships in his/her life?

Tips	Tools
What relationships does the person have?	Griffin Centre: My Person Directed Plan – Appendix 2
Who would the person like to get to know?	Corbrook Awakening Abilities: Person Directed Plans – Appendix 1
How can the person meet new people?	It's My Choice , pages 5-17
Who is in his/her life now?	Person Centered Planning Tools
Who does the person want to spend more time with and get to know better?	<ul style="list-style-type: none"> – Like and Admire – Lifeline
How can the person increase social contact with others in the community or at work, etc?	A Guide to Person Directed Planning Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability A Guide to Developing Community Connections Best Buddies Canada

Element of Practice: Exploring Natural Community Supports

Person directed planning focuses on building informal supports and networks in addition to formal supports when appropriate. Natural supports can be identified through collaborative brainstorming and problem solving. Members of the support network look to what is available through family, co-workers, neighbours, and other community members. The overarching goal here is to assist the person in becoming better connected to his/her own community. Some people enter the planning process with a strong support network or circle of support already in place. Others have very few people as part of his/her support structure.

Tips	Tools
<p>Identify whom the person already knows and considers part of a circle of support.</p> <p>Discuss with the person who might share in his/her interests.</p> <p>Explore together how to build a circle of support or expand an existing one where needed.</p> <p>Connect with others who have been successful in creating strong circles of support.</p>	<p>Griffin Centre: My Person Directed Plan – Appendix 2</p> <p>Corbrook Awakening Abilities: Person Directed Plans – Appendix 1</p> <p>Montage Support Services: Getting to Know You - Appendix 3</p> <p>It's My Choice, pages 18-24</p> <p>A Guide to Person Directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability</p> <p>A Guide to Developing Community Connections</p> <p>Person Centered Planning Tools</p> <p>Community Resources and Information for Learning</p>

Element of Practice: Accessing Disability Supports and Services

Some people may want access to more formal disability supports and services. The role of the facilitator is to assist the person and the network to explore and access such services. This may be achieved through referral processes, and by connecting the person to a particular service provider. There are a variety of pathways to supports and services that a facilitator would explore with the person. The facilitator can also assist in brainstorming some new and creative opportunities for supports. It is important to make sure that the resources that are accessed are the most appropriate way to achieve a goal.

Tips	Tools
<p>Conduct an on-going review of the person’s goals.</p> <p>Consider whether that type of support will help the person achieve those goals.</p> <p>Continue to explore natural supports in the community.</p> <p>Become acquainted with the types of informal and more formal disability supports and services accessible to the individual and his/her support.</p> <p>Familiarize yourself with the different pathways to access necessary supports and services.</p>	<p>It’s My Choice</p> <p>A Guide to Developing Community Connections</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – Staff Matching – Gift Sheets and Community Map – Ideas Evaluation Tool – The 4 plus/questions – The For/To sort <p>Ontario Government Ministries:</p> <ul style="list-style-type: none"> – Children and Youth Services – Community and Social Services – Education – Training, Colleges and Universities <p>Developmental Services Toronto</p>

Element of Practice: Facilitating a Planning Meeting

A planning meeting is often a great way to engage a person and his/her support network. The facilitator supports the person to lead or direct the planning process to the greatest extent possible at each meeting. All invited participants are encouraged to fully engage in the process. The facilitator also assists everyone in arriving at an agreement about how the meeting will be conducted, how long the meeting will run, and what they hope to achieve within that time frame. Some find it helpful if the group develops some “ground rules” to keep the meeting respectful and person directed.

The plan of action includes the development of goals and strategies prioritized by the person, identifying the resources required, and the people responsible for assisting with the implementation of the plan. Timelines for completion are also important to set out in a plan.

Tips	Tools
<p>Identify the most suitable and convenient meeting place for all participants</p> <p>Ensure meeting starts on time.</p> <ul style="list-style-type: none"> ▪ welcome and introductions <p>Assist others in communicating why it is important for them to be part of the support circle.</p> <p>Ensure that there is a shared understanding about the purpose of the meeting.</p> <p>Listen respectfully and deeply.</p> <p>Review the person directed planning process.</p>	<p>It’s My Choice, pages 5-23</p> <p>MAP and PATH Activities</p> <p>ELPNET Sample Plans</p> <p>Creating a Good Life in the Community A Guide on Person directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability</p> <p>Person Centered Planning Tools</p> <p>Griffin Centre: My Person Directed Plan – Appendix 2</p>

Tips	Tools
<p>Develop ground rules together.</p> <p>Take the time to build relationships during the facilitation process.</p> <p>Seek agreement on what information needs recording, who is going to record it, and what the best format is.</p> <p>Outline how you will mediate any disagreements that arise during the meeting.</p> <p>Watch the time.</p> <p>Ensure enough time to review what was accomplished, what actions need to happen next, and who would be taking responsibility to support with those actions.</p>	<p>Corbrook Awakening Abilities: Person Directed Plans – Appendix 1</p> <p>Montage Support Services: Getting to Know You Guide - Appendix 3</p> <p>A Guide to Developing Community Connections</p>



Element of Practice: Setting SMART Goals

The facilitator assists the person, family, and network in setting goals that emphasize what is most important to the person. An understanding of what the person would like to achieve is critically important here. The language of the goal must capture what it is the person wants to have in his/her life now and into the future. It is important to understand that goals should never be restricted to what is currently available in both informal and formal supports. This thinking does not encourage creativity and innovation about what is possible for future growth and achievements. A good balance should be achieved in exploring both present and future resources and opportunities. This thinking will influence the setting of both short term and long term goals.

How to be SMART about it:

Setting goals involves creating a written plan that includes reasonable and measurable long-term and short-term objectives. The best goals are smart goals. SMART is an acronym for the five characteristics of well-designed goals. SMART goals are Specific, Measurable, Achievable, Relevant and Time Bound.

Start with some long-term objectives that the person might want to accomplish by the end of the year. Next, establish some shorter-term goals so that you can help set the person and the process up for success. There should be plenty of opportunities for celebration of short-term goal attainment as the individual and others work towards the longer-term goals. Short-term goals can include monthly, weekly or even daily targets that help move the person towards his/her long-term objectives. The goals become the roadmap!

Specific: When goals are specific, they tell us exactly what is expected, and when. It is much easier to measure progress towards goal attainment.

Measurable: It is necessary to have milestones that support in measuring progress towards goal attainment.

Attainable: Goals must be realistic and attainable. Good goals require the person to stretch a bit to achieve them. They are within reach but not below standard performance. Goals that are set too high or too low can easily become meaningless.



Relevant: Goals that are relevant are directly related to the vision of the future and a person’s hopes and dreams.

Time-bound: Goals must have starting and end points with fixed durations. However, it is necessary to take the person into account and adjust the timelines accordingly. There must be schedules for completion in order to sustain focus on the person and collective efforts required to achieve the goal.

Tips	Tools
<p>Ask questions that explore the hopes and dreams of the person.</p> <p>Ensure an understanding of what is meant by a dream or a nightmare as this can be taken literally.</p> <p>Explore what matters most to the person and family/network.</p>	<p>SMART Goal Checklist – Appendix 5</p> <p>It’s My Choice, pages 16-21</p> <p>Inspiration Software</p> <p>MAP and PATH Activities: PATHs: Planning Possible Futures</p>

Tips	Tools
<p>Assist the person in seeing how these hopes and dreams can be directly linked to strengths/needs and the setting of goals.</p> <p>Try to set both short and long term goals in the visioning process so small successes are celebrated often.</p> <p>Explore what is currently working or not working for the person.</p> <p>Support others in building capacity to make choices</p>	<p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability</p> <p>ELPNET Sample Plans</p> <p>Individualized Funding Coalition for Ontario</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> - Dreams and Nightmare Tool - Achievement Tool - Measuring Well-being - Pyramid of Success - Daily and Weekly Routines <p>Griffin Centre: My Person Directed Plan – Appendix 2</p> <p>Corbrook Awakening Abilities: Person Directed Plans – Appendix 1</p> <p>Montage Support Services: Getting to Know You - Appendix 3</p>

Long Term Objective:

I want a paid job where I can work with young children in a daycare centre.



Element of Practice: Developing Strategies

Once the facilitator has worked on developing the SMART goal with the person and others, the planning focuses on how the goal can be achieved. This is where strategies are introduced. They are specific actions that help the person achieve the goal. There may be a number of strategies required to achieve a single goal. Even within a particular strategy, there may be a need to break it into smaller steps. The number of strategies and how much rehearsal time is needed to achieve a particular goal is uniquely dependent upon the person and his/her support network. Strategies build upon a person’s strengths, level of independence, current relationships and other connections.

Tips	Tools
<p>Identify if the goal requires more than one strategy.</p> <p>Outline the timelines for implementing a strategy and achievement of the goal.</p> <p>Identify what role each person will play in supporting with the strategic interventions.</p> <p>Identify any other community supports that the person might need for successful implementation of a strategy and goal attainment.</p> <p>Honour other people’s thinking and ways of doing things that might differ considerably from your own.</p>	<p>SMART Goal Checklist – Appendix 5</p> <p>Person Directed Planning: Reviewing My Goals Template, pages 15, 22, 23</p> <p>MAP and PATH Activities</p> <p>ELPNET Sample Plans</p> <p>Individualized Funding Coalition of Ontario</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 82-90</p> <p>A Guide to Developing Community Connections</p> <p>Person Centered Planning Tools</p>

Long Term Objective	SMART Goals
<p>I want a paid job where I can work with young children in a daycare centre.</p>	<p>Will contact local service provider for possible skills building workshops or courses in which to enroll by next week</p>
	<p>Will look after my nieces one night a week</p>
	<p>Will explore volunteer opportunities at child care centres in the local community over the next month</p>
	<p>Will develop a resume and practise interview skills over the next few months</p>



Element of Practice: Aligning Resources with Priorities

Both human and material resources need to be identified at this stage in the planning process. The facilitator encourages the person and others to think beyond what is accessible today. Together the group engages in creative thinking about other supports that might change in even a small way what resources are actually needed at any given time. This might include an environmental accommodation or a piece of equipment that would enhance a person’s independence and quality of life over a particular period of time. During this stage the facilitator also assists in identifying who will be responsible for finding a particular resource. The person identifies any preferences for the ways they wish to be supported. For example, a person may want to be accompanied by a peer to a social event, yet be fine with having an older adult act as a reading tutor.

Tips	Tools
<p>Assist the person in identifying current supports and resources already being accessed.</p> <p>Assist the person in identifying any gaps in supports and resources.</p> <p>Consider informal supports already in place in the person’s life and how to expand any necessary supports by connecting with family, friends, neighbours, community members from the faith community, social recreation centre, etc.</p> <p>Develop a timetable that provides a good visual of a week at a glance and the different times the person requires some type of support.</p>	<p>It’s My Choice, pages 15-19</p> <p>MAP and PATH activities</p> <p>It’s My Choice, pages 5-23</p> <p>ELPNET Sample Plans</p> <p>Individualized Funding - PDP</p> <p>A Guide to Developing Community Connections</p> <p>Individualized Funding Coalition for Ontario</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 82-90</p>

Tips	Tools
<p>Brainstorm some community building strategies that could also support the person in accessing resources.</p> <p>Identify the ways in which the person can increase his/her own network of support.</p>	<p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> – One Page Profile – Quality Evaluation Tool – Team Purpose Tool – Achievement Tool

Long Term Objective	SMART Goals	Strategies/Resources
<p>I want a paid job where I can work with young children in a daycare centre.</p>	<p>Will contact local service provider for possible skills building workshops or courses in which to enroll by next week</p>	<p>Mother (by next week)</p>
	<p>Will look after my nieces one night a week</p>	<p>My sister and I (once a week in the evening)</p>
	<p>Will explore volunteer opportunities at child care centres in the local community over the next month</p>	<p>My support worker and I (2 hours a week)</p>
	<p>Will develop a resume and practise interview skills over the next few months</p>	<p>My employment counselor and I</p>

Element of Practice: Determining Outcomes

An outcome describes the change that is likely to take place for the person as a result of implementing strategies to achieve a goal. Discussing outcomes right at the beginning of the planning process enables all members to develop a better understanding about what achievements and success actually look like for the person. Outcomes also assist with assigning roles and responsibilities for tracking, monitoring and reviewing the plan on a regular basis.

Tips	Tools
<p>Work with the person to ensure a good understanding of what life could look like once the goal has been achieved.</p> <p>Ask the person how he or she would feel.</p> <p>Ask the person why it matters.</p> <p>After achieving the goal, ask the person what has changed for the better in his/her life.</p>	<p>MAP and PATH Activities</p> <p>It's My Choice, pages 18-22</p> <p>ELPNET Sample Plans</p> <p>Creating a Good Life in the Community A Guide on Person Directed Planning</p> <p>Connections: A Guide to Transition Planning for Parents of Children with a Developmental Disability, pages 82-90</p> <p>Person Centered Planning Tools</p> <ul style="list-style-type: none"> - Quality Evaluation Tool - Achievement Tool

Long Term Objective	SMART Goals	Strategies/Resources	Measureable Outcomes
I want a paid job where I can work with young children in a daycare centre.	Will contact local service provider for possible skills building workshops or courses in which to enroll by next week	Mother (by next week)	<p>I have enrolled in a few skills building workshops to be completed over the next three months.</p> <p>I am applying this month to a one-year college certification program to be an Early Childhood Educator Assistant.</p>
	Will look after my nieces one night a week	My sister and I (once a week in the evening)	I am spending two hours a week looking after my nieces.
	Will explore volunteer opportunities at child care centres in the local community over the next month	My support worker and I (2 hours a week)	<p>I have visited five places where I could volunteer.</p> <p>I have chosen one I like.</p> <p>I have arranged a follow-up visit to discuss possibilities of volunteering there.</p>
	Will develop a resume and practise interview skills over the next few months	My employment counselor and I	I have completed my resume and rehearsed several times for an interview.

Sustaining Commitment to Action

It is important that the facilitator models a commitment to sustaining the person directed planning process with the person and his/her support network. Some planning circles might need to meet more frequently than others to keep the momentum going. The facilitator may also need to check in with the network members to ensure follow-through with assigned actions and possible outcomes in between meeting times. The role of the facilitator is to support the person and his/her family/network in staying invested and engaged in the planning process. In order to do this, the focus must always remain on helping others make connections to the ways in which their actions are enriching the quality of life of the person and enriching the contributions the person can make to his/her community. Celebrating and building upon short-term successes is critically important for sustaining commitment. Person directed planning should be viewed as an organic journey. Such a perspective allows for some inevitable ups and downs and ins and outs with all participants who have invested their time and efforts to the planning process. Yet this also invites the integration of new experiences and fresh perspectives and ideas, which can further motivate everyone and help sustain their commitment to the individual and the PDP process.



PART THREE: RESOURCES

Websites

References

List of Appendices



PART THREE: RESOURCES

Websites

A Guide to Developing Community Connections:
www.allenshea.com/CIRCL/connections.pdf

Achieving. Cultural. Competence. A Diversity Tool Kit For Residential Care:
http://www.children.gov.on.ca/htdocs/English/documents/topics/specialneeds/residential/achieving_cultural_competence.pdf

Connections: A Guide To Transition Planning for Parents of Children With a Developmental Disability:
www.dsto.com/resource/resource-11.html

Cultural Competency: A Self-Assessment Guide for Human Service Organizations:
http://www.calgary.ca/docgallery/bu/cns/fcss/cultural_competency_self_assesment_guide.pdf

Developmental Services Toronto
www.dsto.com

John Lord: The New Story
www.johnlord.net

Individualized Funding Coalition for Ontario:
www.individualizedfunding.ca/resources.html

Inclusion Press MAPS and PATH Activities:
www.inclusionpress.com

It's My Choice Document:
www.mncdd.org/extra/publications/choice/Its_My_Choice.pdf

Planned Lifetime Advocacy Network:
www.plan.ca

Person Centred Planning in Lancaster:
www.csrpcp.net/default.aspx?page=16600

The Learning Community for Person Centered Practices:
www.elpnet.net

UK Department of Health "Valuing People Now"

www.valuingpeoplenow.dh.gov.uk/content/personalisation-resources

"What is Person Directed Planning?" Document:

[www.modelingcommunitychange.com/PDF/What Is Persondirected Planning.pdf](http://www.modelingcommunitychange.com/PDF/What%20Is%20Persondirected%20Planning.pdf)

WordQ and Inspiration Software:

www.strategictransitions.com

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List of Appendices¹

Appendix 1 – Corbrook Awakening Abilities: Person Directed Plans

Appendix 2 – Griffin Centre: My Person Directed Plan

Appendix 3 – Montage Support Services: Getting to Know You

Appendix 4 – Operation Springboard: Person Directed Planning Tools

Appendix 5 – SMART Goals Checklist

Appendix 6 – LPW Associates Checklist

¹ Each of these documents was created through the collaborative efforts of individuals and teams at the various agencies. We would like to thank all those who participated in the development of these resources.

Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

Date of the 1st plan

Dates the plan was changed

What do I hope that this plan will help me accomplish?

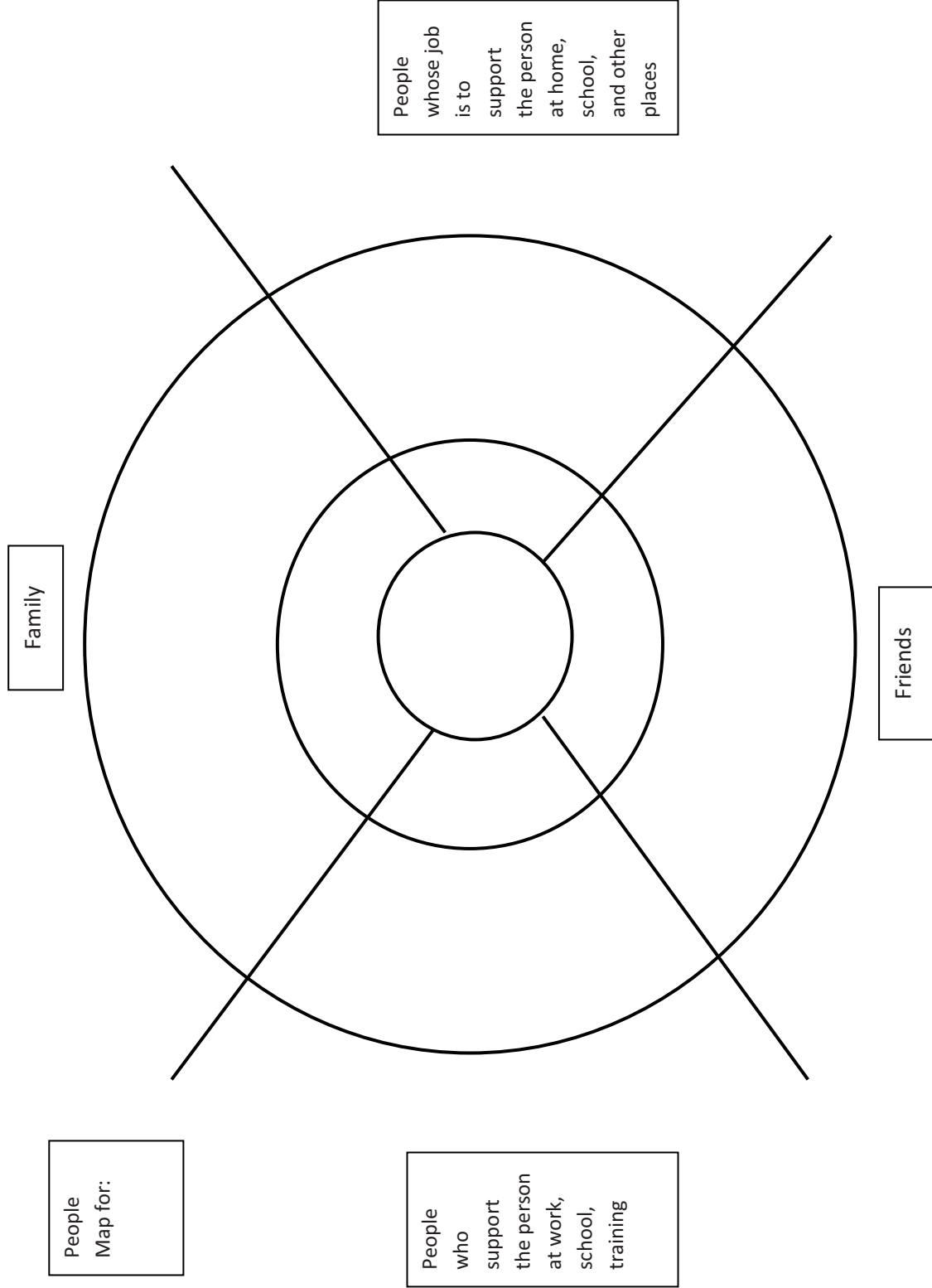
Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

Who helped me with this plan? (Who gave me information?)	

Who do I still need to talk to? (Others who can help me get more information)	

My Story
Born May 15, 1985 with a hole in the back of my head. My visual cortex was protruding out the hole was surgically removed. I was told that I would not see.
I'm now using other parts of my brain to see now I have 30% radius peripheral no lower field below eye level.
I have no depth perception. I use a cane. I went to school and I graduated age 21. Cognitive and mature, skills are a barrier for me today.
I have to sing, have fun with everyone. I listen to music, watch T.V., play Wii. I look at car reviews, talk to family on MSN.
I am a member of the special need bowling league. I go to church and sing at the choir. I volunteer at YMCA – Oakville, swiping card and giving. Volunteer at Sunday school, deliver program and monitor kids, do D.J., help out with announcement.



Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

My Introduction – Great

What do people like and admire about me? What are the good things they say about me? How would I like to be introduced?

Things About Me

<ul style="list-style-type: none"> • Good sense of humour • Great smile • Awesome • Enthusiastic • Positive “can do it” attitude • Like to laugh • Very helpful • Active kindness (believes) • Great memory • Talent for voice recognition • Very clever 	<p align="center">New Things I have Learned About Myself</p> <ul style="list-style-type: none"> • Great speller • Nact for words
---	---

The Dream	
<ul style="list-style-type: none"> • Leave a presence of enthusiasm, like to be remembered • Learn hoe to cook • Variety village member of special Olympics • To live with my sister • Travel to England, around the U.K., Ireland 	<ul style="list-style-type: none"> • Train travel • Be part of a bowling league • Volunteer work • •

Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

--

What is Important to Me

What do I want other people to know about the things that are important to me? Who are the people that are most important to me? What do I do with them? What are the things that I have to do (and things I need to have) if I am going to be happy?

	New Things I have learned About Myself
<ul style="list-style-type: none"> • Family • Making connection • Random act of kindness • Going to Church • Singing in the • Making voice announce • Seeing everyone on special occasions • My sister • 	

My Own Plan

Appendix I – Corbrook Awakening Abilities: Person Directed Plan

What are the Characteristics of people Who support me best? If I was going to pick a new person to work with me (e.g. case manager, staff in a home) what would I look for? What do the people that I like to work with have in common? Have there been people that I couldn't work with? What do they have in common?

	New Things I have Learned About Myself
• Understands my needs	
• Someone who is pleasant, easy going, patient	
• Someone who is respectful	
• Someone who like to try new things	
• Very social and good listening skills	
• Good sense of humour	
• Someone that could motivate and inspire me	
• Someone to encourage	
• Ongoing support	
• Very caring	
• Take under wings and take an interest	

Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

What Others Need to Know

If I am going to have the things that are important to me, and stay healthy and

Or Do to Support Me

safe, what do people need to know about me? What do they need to do? How do I
Need to be supported at home, at work, and when I am out in my community?

	New Things I have Learned About Myself
<ul style="list-style-type: none"> • Tripping hazards 	
<ul style="list-style-type: none"> • Depth perception, tunnel vision 	
<ul style="list-style-type: none"> • Understanding my vision impairment (lower field peripheral) 	
<ul style="list-style-type: none"> • Coming down stairs 	
<ul style="list-style-type: none"> • Balance sometimes difficult 	
<ul style="list-style-type: none"> • Limited fine motor skills and manual dexterity 	
<ul style="list-style-type: none"> • Hole in head with titanium mesh 	
<ul style="list-style-type: none"> • Avoid blunt force injury to head 	
<ul style="list-style-type: none"> • 8:00 riser will get up earlier if needed • Anything new requires step by step introduction • Get upset stomach if upset about something 	

Appendix I – Corbrook Awakening Abilities: Person Directed Plan

My Own Plan

**What Other People Need to Know
Or Do to Help Me Stay Healthy and
Safe**

Do I have medical conditions or mental health issues that other people should know about? Are there times when I need help in managing my medical or mental health?

	New Things I Have Learned About Myself
•	
•	
•	
•	
•	
•	
•	
•	

Things to Figure Out

What are the things that I am still trying to “figure out?” What are the things about me, my condition, or the supports that I get that I don’t understand or where I need more information? What are the things that are getting in my way?

	New Things I Have Learned About Myself
<ul style="list-style-type: none"> • Apply for wheel trans 	
<ul style="list-style-type: none"> • Back into Value Village membership 	
<ul style="list-style-type: none"> • R.D.S.P. 	
<ul style="list-style-type: none"> • Options for housing 	
<ul style="list-style-type: none"> • Life skill type training (readiness for independent living) 	
<ul style="list-style-type: none"> • Volunteer / P.T. look 	
<ul style="list-style-type: none"> • {Anxiety/Head/Spine} Dr. 	
<ul style="list-style-type: none"> • 	
<ul style="list-style-type: none"> • 	
<ul style="list-style-type: none"> • 	

How Do I Communicate

What is happening	What I do	What I think it means	What others should do

My Own Plan

The Nightmare	
• Travelling in the dark	• Anticipation of the unknown
• Getting close to helicopters	•
• Anxiety attack	•

My Own Plan

What is Happening in Your Life – The Upside and Downside

	What I think – my perspective
<p>Look at what is working and not working, makes sense and doesn't make sense in your life right now. Think about...</p> <ul style="list-style-type: none"> • Where you live • What you do during the day • Who you spend time with • The services that you receive to help you stay healthy/safe • Issues with medication – how it works, side effects • What you do for fun • Other parts of your life 	<p>What works, makes sense, the upside</p> <ul style="list-style-type: none"> • Volunteer work • Friends smile • Mom and dad • Support • Living in Toronto, access to services • Caring people • Friends (Francine/Heather) • Being able to help others • <p>What doesn't work, doesn't make sense, the downside</p> <ul style="list-style-type: none"> • Being away from mom and dad for a long time • Commuting in bad weather • No access to bus stop • When bus driver drive by • When someone is rude • • • •

My Own Plan

What is Happening in _____'s Life – The Upside and Downside

	What Others think – their perspective	
	What works, makes sense, the upside	What doesn't work, doesn't make sense, the downside
<p>Look at what is working and not working, makes sense and doesn't make sense in _____'s life right now. Think about...</p> <ul style="list-style-type: none"> • Where you live • What you do during the day • Who you spend time with • The services that you receive to help you stay healthy/safe • Issues with medication – how it works, side effects • What you do for fun • Other parts of your life 	<ul style="list-style-type: none"> • • • • • • • • 	<ul style="list-style-type: none"> • • • • • • • •

My Person Directed Plan



Name:

Making a Person Directed Plan will help me:



Get ready for transitions !



Connect me to my community and help me build relationships !

Support me with finding volunteering work or take classes in areas I like !



How do you make a plan?

There are lots of pieces in a plan. For each piece, I might need help to do something, that's why it's important to think about people in my life who are already helping me and how to find community people to support me with my plan.



Make the Plan

The first step is to invite anyone that is important to you and who you want to help you make your plan.

In that plan will be your dreams, goals and how to make your plan happen!



Action

After your plan is made, everyone will help you to do the different pieces of your plan.

We will meet regularly to make sure all the pieces are getting done or find out if you need more help.

You will review your goals to make sure you still like your plan or make changes



You did it !

Your plan will be complete when you have reached your goals.

While putting together all the pieces of your plan, you will build community relationships to help you in the future! When you are ready, they can help you start a new plan with new goals!



About me!



How do you like to communicate? (talking on phone, email, in person, with help from someone, sign language, letters, etc)

How do you get around the city?

Do you go anywhere by yourself?

Do you have any hobbies?

Do you have any collections?

Do you like to read books or magazines? What kind?

Do you like animals?

What is your favourite store at the mall?

Do you go on the internet? What are your favourite websites?

Do you do any budgeting? (banking, taking care of money, etc)

Appendix 2- Griffin Centre

What are your favourite movies?

What shows do you watch on TV?

Do you like sports? Do you play or watch?

Do you like music? What kind? Do you watch music videos?

Do you like to play instruments or sing?

Do you like the outdoors? Have you ever gone camping?

What types of classes do you like?

Do you like cooking?



Is there a chore you like doing?

Do you speak another language?

Are you a morning person or do you stay up late?

Do you like to attend religious services?

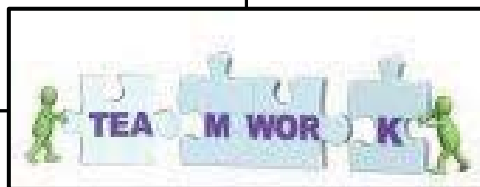
These are relationships that are important to ME!



Family I see often, like my parents and family that lives far away like cousins.

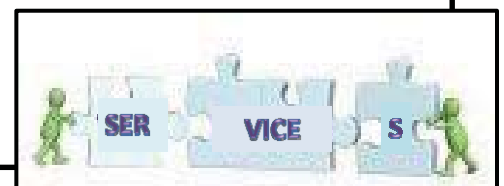
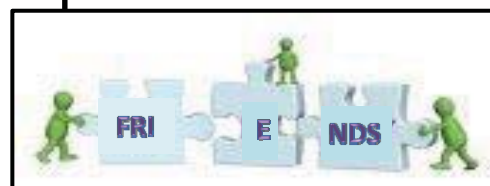


People I see in the community for example doctors, employer, pastor



People I like to hang out with and some that I don't see often.

People who provide me with service like an APSW, social worker, therapist, case worker, one to one worker, staff.



A Snapshot of Me in My Home!

Draw or write about things you do at home (ex. chores, hobbies, things you do in your spare time)



A Snapshot of Me in the Community!

Draw or write about things you do in your neighbourhood or the community (ex. clubs, work, volunteer, drop-ins, schools/classes, shopping, library, sports, etc)





My Weekly Schedule Right Now!

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

My Talents - My Interests - My Challenges

Things I am good at:

List your talents, skills and what people like about you!



Things I like:

List things you find interesting and are important to you.



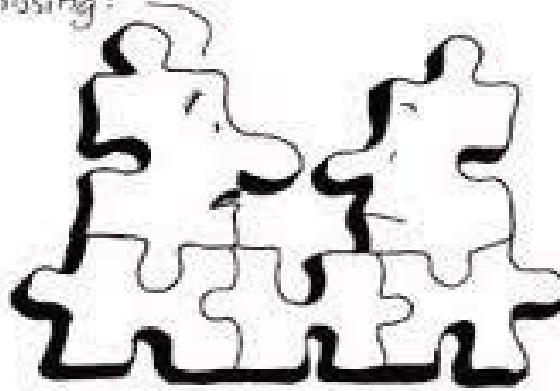
Things I don't like

List some things you find challenging, things that might upset you or things you don't like to do.



Why do Person Directed Planning?

Ever get the feeling something's missing?



Person Directed Planning can help you figure out what might be missing in your life, and help you to find it!



The missing piece might be for you:



a job



volunteering



a safe comfortable place to meet people



classes



sports



anything you want to do!

My Dream - My Team

My Dream

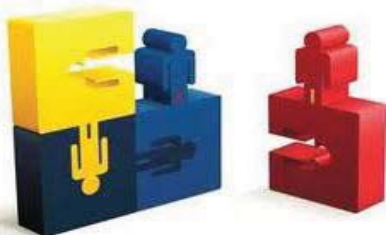


Write or draw things you would like to happen in your life.

My Team



What types of community connections would you like to make?



What are Goals?

Goals are things that point you to where you want to be, not where you are today.

What are your goals?



Your team will help you find a way to make your dream fit for you!



What are the steps?



What do you need to do to reach your goal?



You can't do it all by yourself, get help!



Learn about community connections and places to go

What are some obstacles or roadblocks?



What could stop you from reaching your goal?



Build on your skills and get experience!

Track your progress and review your plan.



Take time to check-in with your team and review your plan to make sure there's action in your plan!



Keep working on the next steps!



Celebrate when you reach your goal!



Use your new skills and community connections to make more changes in your life!

My Goals



Now we are going to talk about what goals you want to work on in your plan.
 When you finish a step, check it off and move on to the next step!
 If you didn't get something done, talk to your team about why it didn't happen to
 decide if you need more help or to change the steps if you need to.

Goal

I want to _____

First steps to reaching my goal	Who will help me with this step	Do the step by this day	Result

What community resources can I use? What community connections can I make?

Reviewing My Goals



It is a good idea to review your goals to make sure everyone is doing the piece they said they would do, and find out if there are any obstacles. Your goals might change in your plan as things change in your life.

Goal #

I want to _____

Next steps to reaching my goal	Who will help me with this step	Do the step by this day	Result

What community resources can I use? What community connections can I make?

Person Directed Planning - My Next Meeting

Date



Time



Place





To Do List for next meeting

Goal #1

Goal:

Step:

If I need help

I can ask:

Goal #2

Goal:

Step:

If I need help

I can ask:

Goal #3

Goal:

Step:

If I need help

I can ask:

You Did it!



Celebrate! You earned it!

When you reach your goals, you have completed your Person Directed Plan! But

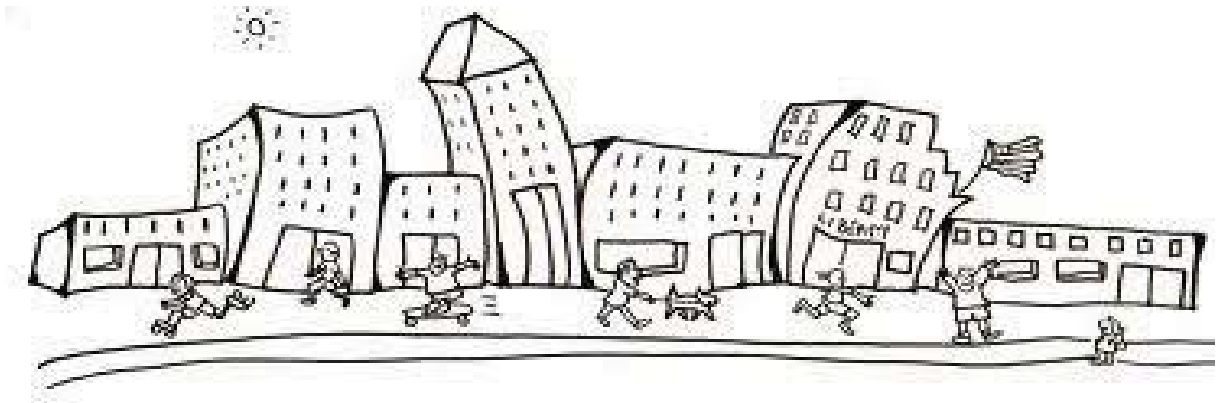
the journey doesn't end here. You now have the experience and tools to continue and choose new goals to work on!



You have new community connections, resources and successes to build on!



My Community Toolkit



My toolkit has information about places and people who I have connected with while I worked on my Person Directed Plan.

My toolkit has been made just for me! It has community connections for areas I like, places I feel safe and comfortable and information I might need for future goals.

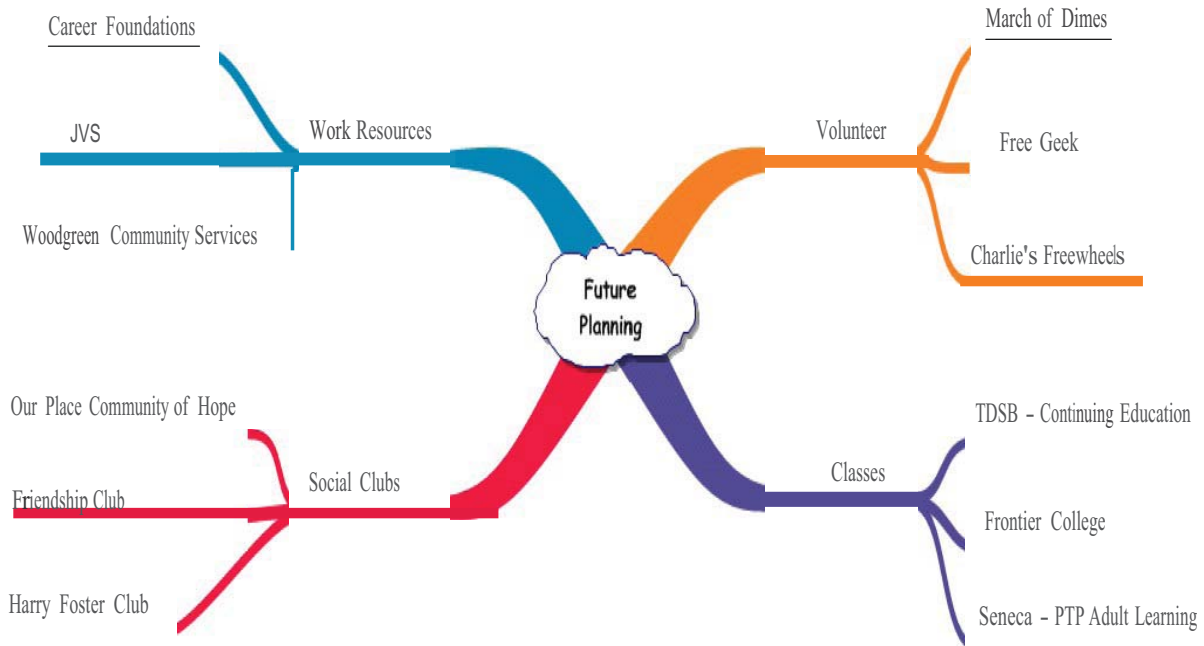
I can visit these places when I need help with a situation.

I can call when I need information.

I can email when I need help.

Appendix 2- Griffin Centre

The following is an example of an Inspiration Software map. A map is created for each client to display their resources that are included in their Community Resource Toolkit.



Library



Closest Library to me:

Address:

Phone Number:

Website: www.torontopubliclibrary.ca

How can the librarians help me?

The librarian can help me with : Research, library information, career information,
homework help.

What kinds of program do the libraries have?

I can ask the librarian at the information desk to help me find programs like:

Literacy
Homework clubs
Social Clubs
Writing groups
Computer classes
Crafts clubs (example knitting, drawing)

Employment



Where:
Address:
Website:
Phone Number:

How can they help me?

What can I do there?

Where:
Address:
Website:
Phone Number:

How can they help me?

What can I do there?

Where:
Address:
Website:
Phone Number:

How can they help me?

What can I do there?

Classes



Where:

Address:

Website:

Phone Number:

How can they help me?

What can I do there?

Where:

Address:

Website:

Phone Number:

How can they help me?

What can I do there?

Where:

Address:

Website:

Phone Number:

How can they help me?

What can I do there?

Volunteering



Where:
Address:
Website:
Phone Number:
How can they help me?

What can I do there?

Where:
Address:
Website:
Phone Number:
How can they help me?

What can I do there?

Where:
Address:
Website:
Phone Number:
How can they help me?

What can I do there?

Social Groups



Where:
Address:
Website:
Phone Number:

How can they help me? What can I do there?

Where:
Address:
Website:
Phone Number:

How can they help me?

What can I do there?

Where:
Address:
Website:
Phone Number:

How can they help me?

What can I do there?

Getting to Know You!

Person-Directed Planning is a process that connects you to a trained Facilitator who will help link you to the things you want in life. By partnering with Montage in planning, we will need to spend a significant amount of time getting to know you.

We'd like to begin this process with a few details that will help guide our future conversations and will identify what types of support you already have in place.

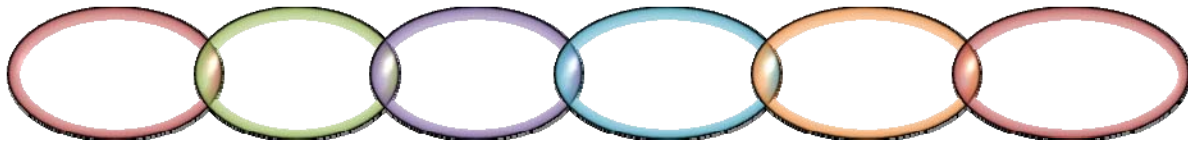
Do your best to fill out the following pages.

What's your full name? _____

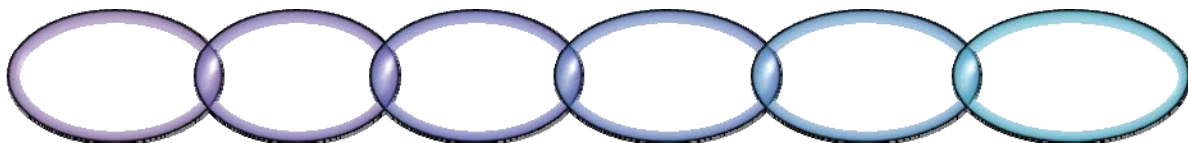
What's your birth date? Year _____ Month _____ Day _____

What is your address? _____

Who are the important people in your life? (this can include family, friends, co-workers, etc.)



Are you connected to any places in your community?



Appendix 3- Montage Support Services

Do you currently receive any type of financial support? (ODSP, Passport, Special Services at Home)

How do you communicate your preferences?

Name three things that you like to do?



Name three things you do not like to do?



Where's your favorite place to hang out?

How do you get around the city?

TTC ___ Walking ___ WheelTrans ___ Car ___ Taxi ___ Bike ___

Do you go places by yourself? Yes ___ No ___

Are you a morning person? Yes ___ No ___

Tell us about some of your important routines?

Appendix 3- Montage Support Services

What are things I'd need to know to support you the best way possible?

- *
*
*
*

Person Directed Plan

My G

IT:



Step 4

Who:

When:

Step 3

Who:

When:

Step 2

Who:

When:

Step 1

Who:

When:





Person Directed Planning- Getting Started

Name: _____

Address: _____

Telephone Number: _____

Date of Birth: _____

Diagnosis: _____

Lead Agency: _____

(If no lead agency, discuss DSTO interim support visit)

Does individual receive support from the following agencies?

- | | |
|---|--|
| <input type="checkbox"/> Community Living Toronto | <input type="checkbox"/> Family Services Association |
| <input type="checkbox"/> Geneva Centre for Autism | <input type="checkbox"/> Griffin Centre |
| <input type="checkbox"/> Surrey Place | <input type="checkbox"/> Other _____ |

List services currently receiving:

Individuals involved in life of Participant:

Family members: _____

Respite worker: _____

Peers: _____

Other: _____

Notes: _____



Person Directed Planning- Getting Started

1. HEALTH/ RECREATION:

Does the participant have a gym/community centre membership? (name and location)

List type of exercise(s) participant enjoys most:

Strengths: _____

Needs: _____

Goals: _____

2. NUTRITION:

Does participant prepare any snacks or meals independently? If yes, please list.

List any cooking instruction or class participant has received or is currently receiving.

Strengths: _____

Needs: _____

Goals: _____

3. ACCOMMODATION/RESPITE:

Is participant currently on Residential /Day Waiting list for housing? _____

Participant currently resides:

home w/ family group home SIL independently other _____

Does the participant receive Special Services at Home funding (amount)? _____

Does the participant access over night respite or have a respite worker? _____

Strengths: _____

Needs: _____

Goals: _____



Person Directed Planning- Getting Started

4. BUDGETING/FINANCIAL:

Is participant currently receiving ODSP? _____

Is the participant currently receiving Passport funding (amount)? _____

Strengths: _____

Needs: _____

Goals: _____

5. EMPLOYMENT:

Vocational History (including school co-ops): _____

Has participant completed any Training Programs (please list)? _____

List area(s) of interest participant has in a volunteer or paid placement: _____

Strengths: _____

Needs: _____

Goals: _____

6. COMMUNITY:

What is the main form of transportation for the individual?

TTC-independent TTC-escorted Rides / Private Transportation Other _____

Strengths: _____

Needs: _____

Goals: _____



Person Directed Planning- Getting Started

7. RECREATION:

Is participant part of any community programs or activities? If yes explain: _____

What recreational activities does the participant enjoy: _____

List other activities the participant would like to do: _____

Strengths: _____

Needs: _____

Goals: _____

8. SOCIALIZATION:

Participant is communicative towards (choose all that apply):

family members peers counselors strangers other _____

List social groups participant has attended or is currently attending:

Strengths: _____

Needs: _____

Goals: _____

9. LITERACY

Does the participant: read words or sentences write own name/ address?

Does the participant use a computer independently? Yes No Somewhat

Strengths: _____

Needs: _____

Goals: _____



Person Directed Planning- Getting Started

10. EDUCATION

Has the individual completed high school?

Yes Currently in School No

Does participant have interest in education? If so, what program?

No Yes (list areas of interest) _____

Strengths: _____

Needs: _____

Goals: _____

Additional Comments/Notes:

Next Meeting Checklist



Date: _____



Time: _____



Location: _____

Who I want at my next meeting:



Topics I want to discuss at my next meeting: (eg. nutrition, recreation)



What I need to do for the next meeting:



People that can help me prepare for my next meeting:



Planner's Name

Planner's Phone Number

Planner's Email



What the planner needs to do for my next meeting:



Appendix 5

SMART Goals



S – specific and strategic identifying an action that answers Who

M - measurable, meaningful, motivational with measurements used to determine that outcomes have been achieved – Answers the How

A - agreed upon, attainable, achievable, acceptable, action-oriented – challenges the individual to do his/her best

R - realistic, relevant, reasonable, rewarding, results-oriented

T - time-bound, timely, tangible, trackable – answers the question When

When you have successfully articulated a SMART goal, you should be able to answer each of the questions below affirmatively. If you cannot, it means more work is required to articulate your SMART goal.

Question	YES\NO
1. Is the goal clearly future oriented?	
2. Is the goal realistic?	
3. Will the goal challenge me?	
4. Will this goal help me become more independent?	
5. Will this goal require me to make a personal investment of time, energy and effort?	
6. Will this goal contribute to my growth and development?	
7. Is this goal achievable within the time frame set out in the plan?	
8. Will I feel a sense of pride and satisfaction in accomplishing this goal?	
9. Is achieving this goal in my best interests?	

The overall impression...

Does the plan...

- show that the person was involved and contributed? (ie: includes quotes from the person and "I" statements if the person uses verbal language, includes descriptions of gestures etc. if the person uses body language to communicate, includes responses from communications systems if the person uses technology to communicate)

Yes

No

Comments...

- show that family and friends were involved and contributed?

Yes

No

Comments...

- show separately what is important to the person from what is important to all of the other people in the person's life? (ie: it is clear which statements are from the person and which are from others)

Yes

No

Comments...

- respect the person's privacy while making certain that those who need to know have the needed information? Does the plan clearly say who cannot have access to information in the plan? (ie: private information is kept in a brown envelope with a note on front about who has access)

Yes

No

Comments...

- read positively about the person?

Yes

No

Comments...

- use respectful language?

Yes

No

Comments...

Does the plan...

- avoid jargon and 'human service lingo'?

Yes

No

Comments...

- use plain language that the person and/or family and friends, and those implementing the plan understand?

Yes

No

Comments...

- make it easy and inviting to read?

Yes

No

Comments...

- reflect the culture of the person?

Yes

No

Comments...

- give enough detail to understand what is meant?

Yes

No

Comments...

- make you feel like you have met the person even if you have not?

Yes

No

Comments...

- tell you what the person said when the plan was written up and then reviewed with them to make sure it's right?

Yes

No

Comments...

What's covered in the plan

Does the plan...

- review the person's current situation?

Yes

No

Comments...

- review what has happened since the previous plan?

Yes

No

Comments...

- clearly outline the person's goals?

Yes

No

Comments...

- identify any barriers to reaching the goals?

Yes

No

Comments...

- identify options to explore or a way to develop options to reach goals?

Yes

No

Comments...

The person's voice...

Does the plan...

- describe what the person wants in terms of their relationship with family?

Yes

No

Comments...

- describe what the person wants in terms of keeping their friends and making new friends?

Yes

No

Comments...

- describe what the person wants in terms of where they live and who they live with

Yes

No

Comments...

- describe what the person likes to do and things they'd like to try in their community:

- **job**
- **spirituality**
- **fun**
- **vacations**
- **sexuality**
- **education**
- **learning new things**
- **new experiences**
- **material things**
- **volunteer work**
-

Does the plan...

- describe what is important to the person in terms of their routines

Yes

No

Comments...

- describe what is important to the person about the decisions they make and would like to make about both the big and little things in life

Yes

No

Comments...

- describe what the person likes and dislikes

Yes

No

Comments...

- describe the person's dreams

Yes

No

Comments...

- describe how the person communicates

Yes

No

Comments...

- describe what is important to the person about their health

Yes

No

Comments...

- describe what is important to the person about their safety

Yes

No

Comments...

What other people say...

Does the plan...

• describe what others want for the person in terms of their relationship with their family?

Yes

No

Comments...

• describe what others want for the person in terms of keeping friends and making new ones?

Yes

No

Comments...

• describe what others want for the person in terms of where they live and who they live with

Yes

No

Comments...

• describe what others feel the person likes to do and things they'd like to see them try in their community:

- **job**
- **volunteer work**
- **spirituality**
- **fun**
- **vacations**
- **education**
- **learning new things**
- **new experiences**
- **material things**
-

Does the plan...

- describe what is important to others in terms of the person's routines

Yes

No

Comments...

- describe what is important to others about the decisions the person makes and feel they would like to make about both the big and little things in life

Yes

No

Comments...

- describe what others feel the person likes and dislikes

Yes

No

Comments...

- describe what others dream for the person

Yes

No

Comments...

- describe what is important to others about how the person communicates

Yes

No

Comments...

- describe what is important to the others about the person's health

Yes

No

Comments...

- describe what is important to the others about the person's safety

Yes

No

Comments...

How service is provided

Does the plan...

- include options and opportunities for support other than paid services?

Yes

No

Comments...

- include options the person has in choosing a service provider?

Yes

No

Comments...

- clearly outline how goals will be achieved? (ie: who's going to do what by when)

Yes

No

Comments...

- outline what the person said they want staff to do?

Yes

No

Comments...

- say what qualities the person wants in support workers who will be providing the service? (ie: "someone who likes to get out and do things", "not bossy or loud", "quiet and won't push me to do things I don't want to do", etc.)

Yes

No

Comments...

Does the plan...

- outline anything else services need to know in order to support the person successfully?

Yes

No

Comments...

- cover any history that is relevant to providing current supports?

Yes

No

Comments...

- outline any issues to be resolved or questions to be answered?

Yes

No

Comments...

Reviewing the plan...

The following questions are designed to help ensure that the plan created by people, their family, friends and service providers is written in a way that clearly says what people want and how services will respond. It is intended as a self-evaluation tool to be used by planning facilitators to consider the way they write plans.

There are five sections:

- The overall impression
- What's covered in the plan
- The person's voice
- What others say
- How services will be provided

It is recommended that if the No box is checked off in any question, comments be added to explain why that element is missing (ie: it may not be relevant, it may have been forgotten or missed in the planning process etc.)