Community Living St. Marys and Area

Guide to the Planning & Facilitation Process

The purpose of this guide is to:

- Provide a resource for planners that sets the tone and tempo of planning and ensures the person's voice is the loudest in the planning and facilitation process.

- Provide a resource for planners to ensure consistency where it is important in the planning and facilitation process.

- Show how planning and support services interact.

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Attachments:

Why Plan…

Everyone wants a good life.

We all need people – usually a combination of family, friends, acquaintances and professionals – to help us have that life. One of the things that some of these people do is help us to dream about our futures and where we want to be. We explore these things together over coffee, on the telephone, in short conversations or long, heartfelt discussions. Likely, we wouldn't consider many of these things "planning", but they are what help us to mentally map out what steps can happen to move toward what we really want in life, both in the future and today.

Often, people who are labeled with disabilities haven't had the opportunity in life to do this in the natural ways many people experience (due to lack of relationships, nontraditional forms of communication, etc). So, "planning" becomes a more formalized and intentional process; for example, there's often a paid facilitator involved. This "planning" is a powerful tool to capture someone's voice and to have a clear understanding of what they want. It also outlines the action steps of who will do what by when to get there.

Simply put, planning provides everyone – the person, family, friends and professionals – with the direction and the action plan needed to move toward what the person describes as their "good life".

Givens of Planning and Facilitation…

We believe that good planning facilitation…

- ✓ values the **person's voice first**, with input from family, friends, and paid people. Regardless of how a person communicates, good planning ensures that the person directs the planning because it is centered on them.

- ✓ is **different for each person**. There is not a single "format" that must be followed. Planning had room to grow and does not just happen in meetings but is updated over time and recognizes people's changing lives and needs.

- ✓ **reflects the person's interests, hopes, fears and dreams** and is not driven by where the funding might come from.

- ✓ **Believes that each person has unique gifts** and that planning should assist the person to discover their own gifts and also explore how and where to share them.

- ✓ acknowledges that **each person has a unique history** of experiences and stories that has shaped who we are.

- ✓ **leads to action** by having clear goals and ways that they will be achieved. Planning identifies obstacles and steps to overcome them.

- ✓ **explores resources** in the community that people can use.

- ✓ **uses respectful language** that avoids jargon and social service terms.

- ✓ creates **opportunities for service providers to be creative** in how someone will achieve the goals in their plan.

- ✓ recognizes that you will never have the time you really need and you will never have the money you really need. Therefore, **commitment** is the necessary ingredient. Time and money just make it easier.

- ✓ recognizes the **honourable and valued role** that both family/friends and paid people play in people's lives.

Our Beliefs about Planning Facilitators…

We believe good planning means that the role of the Planning Facilitator will include…

- developing a trust relationship with the person (it is an exception when this is not important).

- capturing someone's thoughts and feelings in a plan, not being a participant in the planning

- offering encouragement

- not necessarily doing the planning, but rather identifying and supporting the person or someone in their life to lead the planning process

- using a variety of planning tools and resources

- sometimes struggling between personal values and principles and what the person or family wants

- doing no harm

- being true to the values of planning, while not judging others for different ways of seeing the world

- regularly connecting with other planners to avoid getting "stale" and to ensure that the most and best contacts are being made for the person

- connecting, digging, connecting

Spending Time Together Getting to Know Each Other…

Giving Information…

- what we have to offer (different ways of planning)
- givens/ beliefs about planning
- we're funded to provide planning service to people with label of developmental disability
- we don't plan for 24 hour segregated services
- planning means a commitment to action
- natural supports, support circles
- set culture of who's at the meetings, ensuring the person's voice is the loudest
- possible referrals will be made
- information about all services, including Developmental Services Ontario
- funding process
- resources that may be helpful i.e.: videos
- "Our Story" booklet

Getting Information…

- Typically someone from planning is the first contact with the agency so the initial contact form is used.
- the basics such as birth date, phone number/address
- listening to the story and what the person is looking for, including:
  - what's important now
  - who's all involved in both paid and non-paid roles
  - sense of long term vs. immediate needs
- brief history
- how are you feeling?
- are you safe? The Risk Assessment tool is used if there are any concerns.
- interests
- release of information
- request for DSO application and Supports Intensity Scale (SIS) for the person's file

Principles to keep in mind while giving and getting information…

- you don't want to overwhelm people with information, so only give what's needed
- start thinking from the very beginning about which planning process/style makes sense for that person
- this time together is about relationship and building trust, comfort level. It's about listening and people feeling safe.
- stay away from lingo
- individual approach for each person
- be aware and respectful of the family and/or community's culture

Life Plan

There is a wide range of things that someone may want to explore in their life; the following is merely a sample of some areas that they may wish to be captured.

Who is the person?

- Who is the person? What are their gifts? What is their core gift?
- Values (stories indicating why a person believes something)
- History (stories that mark the journey in pictures, words)
- Likes/Dislikes
- Dreams/Nightmares
- Strengths
- How does the person communicate?

Goals

What the person wants in terms of…

- Dreams
- Relationships/Friends
- Emotional growth
- Health
- Sexuality
- Spirituality
- Education
- Material possessions
- Learning new things
- Finances
- Employment
- Volunteerism
- Where and with whom they live, etc.
- Augmentative communication

A Snapshot of Today…

- Present situation
- What is important to the person today and why (routine, decision making)
- How the person and their family feel about what's happening
- Roles in Community
- Places/community map

Anything Getting in the Way…

- Recognition of obstacles and ways to overcome them
- Unresolved Issues (things we don't know about the person or ways to overcome obstacles)
- Health issues?
- Decreasing formal supports.

People…

- Who loves this person?
- Who is important to the person?
- Relationship map
- How family and friends may be involved in offering/providing support

Other Topics

- Driving or driver's license
- Spending time alone and building skills.

Communication…

- When the person says/does this, we think it means…

✸ ***Note: All planning should include an action plan of how goals will be implemented. Who is responsible for helping, a timeline and follow-up on what has happened.***

Capturing the Plan on Paper

NOTE: THE PERSON DOES AS MUCH OF THIS ACTUAL CAPTURING STUFF AS POSSIBLE THROUGH THE USE OF SYMBOLS, PICTURES, VIDEO, ETC.

The main component of the plan is the **LIFE PLAN.**

The Planning Facilitator helps explore all community options and resources, including the involvement of family, friends, and neighbours to help the person get what they need.

Life Plans should reflect;

- Who the person invited to be involved in the process
- The person's wishes and permission for sharing their written plan.
- An action plan for making things happen that includes goals, who will help and a timeline. The planning facilitator helps the person and their family to review these action plans.
- A way to monitor the plan and any services needed to accomplish it.

Typically the planning facilitator is the first contact with Community Living St. Marys and Area. If there is a need for paid support after all community resources have been explored then the facilitator will

assist in looking at what funding is available to meet the person's needs. All access to Ministry of Community and Social Services support funding comes through Developmental Services Ontario (also known as the DSO) so the person needs to apply and prove eligibility. If this has already happened and the person is requesting additional funding then the DSO will want an update of the person's situation.

At times people with disabilities and their families need assistance in gathering written information to use as they request funding and the facilitator can support this in the following ways:

- Help the family think about the amount of support that is needed and the specifics of what it will be used for.
- Preferences for how service is to be delivered.
- A budget estimate of what the support would cost.

In high risk/emergency situations, there may be more immediate ways to help.

Support Plans

Principle #1 states that "We believe everything starts with the person" and the first step is by "helping people plan for their good life." This gives direction for how supports are tailor made for the person.

There is an important difference between a life plan and a support plan. The life plan is broad and a bigger picture of the person's lifestyle and dreams. It involves every aspect and is not limited in what to explore and the creative way it can be achieved. The support plan specifically looks at how paid service will be delivered considering the person's wishes and realities of funding and service limits.

Ongoing information about how service will be provided through the support plan is completed by support services/team leader in

conjunction with the person and their family. If there is no team leader, the facilitator or community resource coordinator helps. Any goals from the life plan that the person would like paid support to assist with should also appear on the support plan. See the support plan checklist for what needs to be included.

Developing Agreements

Agreements are important tools for people with disabilities and their families to get the support they need. The Planning Facilitator may help to ensure that a written agreement is developed for all new people connecting to the agency. This process includes assisting the person and their family to identify what is important to them and may include things like:

- Specific outline of the service being requested including goals to be met.
- Administration of funds
- Roles and expectations of service
- Funding portability
- How decisions will be made
- How conflicts will be resolved
- How communication will happen
- Accountability
- How the agreement will be reviewed in the future and how service will be monitored.

Ongoing, the agreement with the agency will be part of the annual development of a support plan and the person and their family will sign-off.

Ongoing Planning Facilitation

Planning is ongoing. It should be a process that is alive, growing and marked by accomplishments and action.

Some considerations for ongoing planning…

- At times planning activity could be intense such as during a transition, a crisis or a change in the person's life.
- At other times the facilitator is less involved and may simply check-in with the person.
- Requesting planning support can happen in different ways; the person or family might request it, the support services involved may recognize the need or the agency might request, for example when meeting someone new.

Evaluation of the Planning Process

Evaluation of the planning process will be regular and ongoing, and will include:

- The Plan Review tool.
- The Planning to Plan tool is a way for the facilitator to evaluate their own process and personal development.
- Monitoring the action plan to ensure that people are getting the support needed to implement goals.
- Feedback from person.
- Feedback from service providers (i.e. Does the plan give enough information in a clear way in order to develop and implement services?)
- Internal agency evaluation (i.e.: Are the givens of planning being followed, etc.)

- External agency evaluation (as part of agency reviews and strategic planning)

Files

NOTE: *Hard copy is kept in centralized files, and all copies go to the person first (not necessarily to the family). Electronic copies are saved in the person's file on Share Vision.*

Files to be organized in the following folders:

- Basic information – in the orange file kept at the front of the person's file. If there is no team leader involved, the planner is responsible for creating a file and gathering this info.
- Plan – all information relating to planning facilitation is kept in the purple file.
    1. Life plan
    2. Service Request
    3. History
    4. Community Maps
    5. Monitoring
    6. Evaluation
- Support Plan – ongoing support plans are kept regarding service. If there is no team leader involved, it is the responsibility of the planner to develop these.
- Release of Information
- Supports Intensity Scale and Application