

RichmondPRA
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Good Practice Guidelines for Person-Centred Planning and Goal Setting for People with Psychosocial Disability

A Project Report for DisabilityCare Australia
May, 2013



Contents

1. Project Report.....	3
1.1 Introduction	3
1.2 The Methodology.....	4
1.3 The Key Findings of the Project	5
1.4 Some Outstanding Issues to Consider	7
2. Literature and Research Review	8
2.1 Introduction	8
2.2 The Terminology	8
2.3 The Literature on Person-Centred Planning and Recovery	9
2.4 The Research.....	15
2.5 The challenges/barriers/blocks to person-centred planning.....	19
2.6 The Good Practices	21
2.7 Planning Tools	29
3. Good Practice Guidelines	33
3.1 Introduction	33
3.2 Principles of a Person-Centred Plan.....	33
3.3 The Difference with Person-Centred Planning	35
3.4 The Process of Person-Centred Planning.....	36
3.5 An NDIS Person Centred Plan	40
3.6 The Role of a Facilitator/Planner	45
4. Evaluation Framework and Approach to Testing.....	55
4.1 Introduction	55
4.2 The Methodology.....	55
4.3 The Evaluation Framework and Approach to Testing.....	55
5: Appendices.....	62
Appendix 5. 1 Consultations	62
Appendix 5. 2 References.....	63

1. Project Report

1.1 Introduction

RichmondPRA was commissioned through the Practical Design Project Fund to undertake the following project:

‘Good Practice Guidelines for Person-Centred Planning and Goal Setting for People with Psychosocial Disability’

The **‘Purpose’** of the project was to identify good practice approaches to assisting people living with psychosocial disability to exercise choice and control in an NDIS environment, and was to particularly focus on identifying –

- person-centred planning and goal setting;
- management and co-ordination of a package of supports; and,
- models which integrated planning and on-going support co-ordination.

Its **‘Objectives’** were to identify and document good practice elements or approaches to –

- person-centred planning and goal setting;
- working with and assisting people living with a psychosocial disability to manage and co-ordinate a package of supports and to monitor their progress in achieving their goals; and,
- to identify the benefits and challenges of integrated planning and on-going support co-ordination and how the benefits can be achieved in an NDIS environment and the challenges overcome.

The **‘Outcomes or Deliverables’** involved -

- a set of **‘Guidelines’** which outlined how people living with a psychosocial disability could be supported to exercise choice and control in an NDIS environment, including guidance on good practice approaches to the development of person-centred plans and co-ordination of supports and services; and,
- an **‘Evaluation framework and an approach to testing’** that would enable the guidelines to be appropriately reviewed and evaluated from 2013.

The **‘Project Completion Date’** was 31 May, 2013.

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1.2 The Methodology

The Project was undertaken in 'Stages' which included:

1.2.1 A Literature and Research Review:

This entailed –

- an extensive process of identification and examination of books, periodicals and articles pertaining to person-centred planning; and
- documents and resources available through internet search engines including those held in Australian and International Libraries.

The majority of the information and data considered was sourced from those countries where person-centred approaches and planning was well advanced, such as in the UK and USA. In Australia such an approach is still in its infancy, although the term 'person-centred' shows up regularly in legislation, strategic and policy plans of Governments.

The 'literature' available on 'person-centred planning' was considerable. The actual 'research' available concerning its 'evidence-base' was less so. Even though a lot of such research has been qualitative rather than quantitative, the person-centred planning approach appears to have much to commend it.

'Good Practices' have often had to be discerned from the considerable readings of the literature and research. 'Best Practices' are yet to be fully determined even though person-centred planning has been in evidence for well over three decades in the USA and mandated in the UK for over a decade in its social services.

1.2.2 The Development of Guidelines for Person-Centred Planning and Goal Setting:

This entailed –

- the knowledge gained from the Literature and Research Review being applied to the development of a set of 'Guidelines' based on a 'person-centred' approach to planning and 'Good Practices';
- the outcome of consultations with a wide range of experts, peak bodies and academia along with focus groups and interviews with people living with a psychosocial disability, their families and carers during the development and drafting of the Guidelines;
- consideration of the NDIS environment that any such Guidelines would need to be adapted to; and
- understanding of what would be needed in terms of a Plan in such an NDIS environment.

The Guidelines explain the origin of person-centred planning; the concept, philosophy, values and beliefs underpinning it; and what its major or essential elements are. The Guidelines set out a 'framework' for person-centred planning and then adapt that 'framework' to the planning requirements of the NDIS Act 2013 and the Draft Rules.

Potential barriers and blocks to person-centred planning are identified. Although known and envisaged 'good practices' are incorporated in the Guidelines, a separate description of 'good practices' concerning a participant; a service that seeks to provide person-centred services to one or more of its clients or consumers; and for an organisation that fully wants to become a person-centred one by effective consultations about its strategic, service planning and development, are also provided.

1.2.3 The Evaluation Framework and Approach to Testing:

This entailed –

- building on the Literature and Evaluation Review and Guidelines developed to determine a means by which the Guidelines could be appropriately evaluated and tested at a 'high level';
- incorporating the feedback and comments on the Guidelines from consultations conducted on them to inform such a framework for the evaluation and testing of them.

The approach taken has been to evaluate and test how well the guidelines were implemented; the quality of the plans developed; the achievement of the participant's goals, objectives and aspirations; and, the contribution of the 'Plans' developed to the strategic, service planning and development objectives of the NDIS Launch Transition Agency or DisabilityCare Australia.

The focus was therefore on whether the planning was done well, and if so, then on 'personal goals' and 'policy goals' facilitated or achieved. It sought to do these multiple tasks through a series of questions (which could be described as checklists) requiring answers.

The proposed 'Framework' although in some ways 'high level' as intended, has morphed somewhat by drilling down as well into issues about 'what happened'; 'how it happened'; 'what resulted'; 'what personal gains or benefits were there for the participant'; and 'what benefit the Plans developed could have for NDIS policy goals'.

1.3 The Key Findings of the Project

- 1.3.1 'Person-Centred Planning' is both efficacious and effective and although the quantitative or evidence-based practice for it is limited, the qualitative research base for it is substantial;
- 1.3.2 the principles and underpinning values and beliefs set out in the NDIS Act 2013, of 'person-centred planning' and of 'recovery planning' are similar even though slightly different terminology is used for each of them;
- 1.3.3 the adaptation required to a 'person-centred plan' to meet the specific requirements of the NDIS Act 2013 and the Draft Rules is readily achievable;
- 1.3.4 'person-centred planning' appears simple but is actually complex. Its success depends primarily on the characteristics of its facilitator/planner; the selection of appropriate planning team members; the quality of the 'Plan' then produced; and the 'Plan's' ongoing review and the learning of lessons involved;
- 1.3.5 'person-centred planning' has other dependencies for its successful implementation and these include the availability of informal and other supports for the participant; the participant's geographic isolation; and the services and support available whether they be informal, specialist or mainstream;
- 1.3.6 there are barriers and blocks to 'person-centred planning' which can be overcome;

- 1.3.7 the best means of evaluating how well or otherwise a 'Plan' is developed and implemented under an NDIS environment relates to how well it was developed and its quality; its implementation and outcomes achieved in terms of the goals, objectives and aspirations of the participant; the extent to which the NDIS planning principles were achieved; and whether the 'Plans' developed contributed to the strategic, service planning and development goals of the NDIS.

1.4 Some Outstanding Issues to Consider

- 1.4.1 The 'Agency' (whether known as the NDIS Launch Transition Agency or DisabilityCare Australia) is responsible for 'facilitating' the Plan development of 'participants' and 'prospective participants'. It is understood that the Agency has employed a number of staff to do that during the 'Pilot Stage' of the NDIS.

The Guidelines make clear what is expected of such facilitators/planners and the participant's or prospective participant's self-identified supporters or team members.

A training or other manual needs to be developed to ensure that such facilitators/planners and a participant's or prospective participant's supporters or team members actually have the skills, knowledge and ability to assist the person with their planning of their goals, objectives and aspirations and the support and assistance that they may require.

- 1.3.8 Neither the NDIS Act 2013 nor the Draft Rules impose a minimum review date for a 'Plan'. This is clearly of concern as it makes possible a 'Plan' being approved and not implemented. An 'outcome-focussed review' of each 'Plan' should occur at least annually.
- 1.3.9 The 'Agency' can only use (if it is the 'Plan Manager') those service providers for 'Plan Management' or 'Provider of Participant Supports' that is registered with it. The criteria for registration is not made clear either in the Act or the Draft Rules.

As the 'Principles' of the NDIS Act and the Draft Rules clearly centre on the 'person-centredness' then that may be a problem for many existing services and organisations.

'Good Practice Guidelines' should be developed by the Agency to help such services and organisations become registered.

- 1.4.4 A participant or prospective participant may seek to submit a 'management request' to the Agency concerning how they wish their plan to be managed. No 'guidance' is currently available to such persons as to the 'pros and cons' of the available options. Such guidance needs to be developed and made available to enable an informed decision to be made.

2. Literature and Research Review

2.1 Introduction

This review of the literature and research concerning 'person-centred planning' is based on an extensive reading of:

- a) books, periodicals and articles devoted to the topic; and,
- b) documents and resources available through the web.

The majority of the information and data considered comes from those countries where person-centred approaches and planning are well advanced, such as in the UK and USA.

The key purpose of this literature and research review is to inform the development of 'Guidelines' for person-centred planning and an 'Evaluation and Testing Framework' for such Guidelines.

This literature and research review acknowledges the NDIS (National Disability Insurance Scheme) environment as a side issue at this stage as the brief/purpose of this paper is as stated above.

2.2 The Terminology

The literature abounds with instances of different terminology for what essentially means the same thing. These guidelines will simply and mainly refer to 'person-centred planning' and explain what that means. However, as the focus of this paper is people with a mental illness, the concept of recovery is all important. Terms that the reader will encounter include:

NDIA (National Disability Insurance Agency), **NDIS** Launch Transition Agency and **DisabilityCare Australia** which will be taken to mean the same thing under different names in these Guidelines. The term **Agency** when used alone means the NDIS Launch Transition Agency established by the NDIS Act provisions.

'**Focus Person**' is the person with a disability who is at the centre of the planning process and who is referred to under the NDIS as a 'participant'.

'**Person-centredness**', '**person-centred thinking**', '**person-centred support**', '**person-centred planning**', '**personalisation**', '**person-centred care**', '**family-centred planning or care**' are just some of the terms used in the literature and in policy and planning documents. In general the terms are reasonably synonymous, or at least have significantly shared meanings, although some fundamental distinctions can be made.

'Person-centredness' and 'person-centred thinking' can be thought of as a philosophy, a way of thinking or mindset which involves viewing, listening to and supporting a person with a disability based on their strengths, abilities, aspirations and preferences to make decisions to maintain a life which is meaningful to them. Such a mindset or way of thinking is essential to the development of a 'person-centred plan' and the provision of 'person-centred support'.

'**Personalisation**' which is the dominant term used in United Kingdom social policy documents, seems to be used to mean the tailoring of services and support to the individual citizen or service user and hence is very similar to what 'person-centred support' seeks to do.

'Psychiatric disability' is the disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement, or that results in disturbed behaviour. It is the impact of a mental illness on a person's functioning in different aspects of a person's life such as the ability to live independently, maintain friendships, maintain employment and to participate meaningfully in the community. It involves clinically recognisable symptoms and behaviour patterns frequently associated with distress that may impair personal functioning in normal social activity. Impairments of global or specific mental functions may be experienced, with associated activity limitations and participation restrictions in a range of areas. Supports needed may vary in range, and may be required with intermittent intensity during the course of the condition. Change in level of supports tends to be related to changes in the extent of impairment and the environment. Psychiatric disability may be associated with schizophrenias, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.

'Psychosocial disability' is the accepted term to describe disability of people with impairments and participation restrictions arising from mental health conditions. These impairments and participation restrictions include loss of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives. The experiences can involve unemployment, homelessness, social and community isolation or exclusion and many other difficulties. The experiences can often be episodic. A psychosocial disability is not just a result of a diagnosable illness but comes about through the interaction between the person, society and the environment and the experience of systemic and cultural problems including stigma and discrimination, exclusion and social disadvantage.

'Recovery' is the concept in contemporary mental health services to describe the personal journey to empowerment and citizenship. There are many definitions of recovery. RichmondPRA, a community managed mental health service which provides recovery focussed support to over 3,000 people a year, has adopted the following: "It involves making sense of and finding meaning in what has happened; becoming an expert in your own self care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you to pursue your aspirations and goals. (Repper J and Perkins R, 2012)

2.3 The Literature on Person-Centred Planning and Recovery

2.3.1 What is 'person-centred planning'?

"...it is at the heart of much recent policy relating to the provision of social care services. It refers to a family of approaches aimed at enabling people who use services to plan their own futures and get the services that they need." (Dowling et al, 2007 pvi)

"...(it is) a process of continual listening, and learning; focused on what is important to someone now, and for the future; and acting upon this in alliance with their family and friends. It is not simply a set of new techniques to replace Individual Program Planning. It is based on a different way of seeing and working with people with disabilities, which is fundamentally about sharing power and community inclusion." (Sanderson 2000, p2)

"...(it is) a process that finds out what an individual wants to do with his/her life, helps the person decide on goals and then plans what action needs to be taken to achieve those goals. It is an ongoing process which means that the person can regularly set new goals as his/her skills and experience grow and ambitions change. The core principle in all these methods (of

person-centred planning such as PATH, ELP etc) is to look at the whole person, rather than viewing them as a series of 'needs'- such as for residential, day or leisure services – and to consider all aspects of a person's life including friendships and relationships. The focus (is) on each person as a unique individual....” (Cole et al, 2000 p30)

“...(the) listening and learning (in person-centred planning) is used to understand a person's capacities and choices (and) is a basis for problem-solving and negotiation to mobilise the resources to pursue a person's aspirations. These resources may come from a person's personal network, from service agencies or from a range of non-specialist and non-service sources.” (Dept of Health 'Valuing People Guidance', 2002 p2)

“ it provides a way to understand the experiences of people with disabilities and, with the help of allies, to expand those experiences through reducing social isolation and segregation, facilitating the establishment of friendships, increasing opportunities to engage in preferred activities, developing competence and promoting respect” (Holburn 2002 as cited in DADHC 2008, p5)

2.3.2 The origin of person-centred planning

The literature generally attributes the development of 'person-centred planning' approaches to the independent living movement generated by people with disabilities and their advocates during the 1980's in North America. (O'Brien and Mount 1989; Mount 1992; Garner and Dietz 1996; O'Brien and O'Brien 2000).

This movement had as its core beliefs that –

- all human life is of value;
- anyone, whatever their impairment, is capable of exerting choices;
- people who are disabled by society's reaction to physical, intellectual and sensory impairment and to emotional distress have the right to exert control over their lives;
- people with a disability have the right to participate fully in society (Morris 1993, p21)

The Productivity Commission noted that –

“The concept of so-called 'person-centred' and 'independent living' approaches...is based on the view that people with a disability should be recognised as active participants in the community, needing support to achieve their lifetime goals based on their strengths.” (Productivity Commission 2011, p344)

The 'independence' sought was however, never about limited notions of personal autonomy or self-determination; rather it was about removing barriers (attitudinal, physical and communication) to as full participation in the community as possible with the tailored support necessary to do so.

It was and continues to be a 'rights-based' philosophy seeking to ensure that each person with a disability receives the support that they need and have control over that support so as to enable them to live their lives as fully and on terms as equal as possible as those of other members of the community.

'Independence' means –

“people have control over their lives, not that they perform every task themselves. Independence is not linked to the physical or intellectual capacity to care for oneself without assistance; independence is created by having assistance when and how one requires it.”
(Brisenden 1989, p9)

The ‘Human Rights Movement’ has also made a marked contribution to policies and procedures embracing ‘person-centred approaches. Of particular importance is the United Nations Convention on the Rights of Persons with Disabilities. The Convention which entered into force on 3 May, 2008 and which has been ratified by Australia provides the following guiding principles -

- respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- non-discrimination
- full and effective participation and inclusion in society
- respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- equality of opportunity
- accessibility
- equality between men and women
- respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

“The convention states that persons with disabilities enjoy the same human rights as everyone. Without being exhaustive, these rights include equality before the law without discrimination, the right to live in the community, and the right to education and work. The convention entails certain obligations on parties ratifying it, such as adopting legislation and administrative measures to promote the human rights of persons with disabilities, eliminating discrimination in workplaces and society; providing information to people with disabilities, undertaking disability-relevant R&D and appropriate consultation with people with disabilities in developing and implementing legislation and policies and in decision-making processes that concern them.” (United Nations Convention on the Rights of Persons with Disabilities 2008)

2.3.3 The Person-centred planning approach

A range of slightly different approaches to ‘Person-centred planning’ have developed and are continuing to evolve as knowledge about it and its efficacy and effectiveness is progressively established by evidenced-based practice.

One reason for the advocacy for a more ‘person-centred’ approach was dissatisfaction with the Individual Programme Planning approach which limited ‘choice’ to effectively ‘no choice’ as individuals with a disability were invariably fitted into ‘take-it or leave-it’ services. (Greasley P. 1995 and Mount B. 1987)

The same applied to earlier theories associated with ‘Normalisation’ and ‘Social Role Valorisation’ which heralded a new vision at that time. (Nirje B. 1969; Nirje B. 1980; Wolfensberger 1972; Wolfensberger 1983A; Wolfensberger 1983B)

The main approaches to ‘Person-centred planning’ involve –

- Essential Lifestyle Planning; (Smull & Burke-Harrison 1992)

- Personal Futures Planning; (Mount & Swernik 1988)
- MAPs; (Vandercook et al 1989) and,
- PATH. (Pearpoint et al 1993)

There are other approaches such as 'Circles of Support' (Barrett 2007) and Outcome Based Planning (Callicott 2003; Robertson et al 2005), Individual Service Design (Sanderson et al 1997) which are often found in the literature.

According to Sanderson et al –

"The different styles of PCP are used to answer the questions, 'Who are you and who are we in your life?' and 'What can we do together to achieve a better life for you now and in the future?' They differ in the way in which information is gathered and whether the primary emphasis is placed on the detail of day-to-day life or on developing longer-term plans for the future." (Sanderson et al 1997)

Each of the approaches has benefits or is 'appropriate' for different individuals at different points in time. Essential Lifestyle Planning was developed for those individuals whom Stalker and Campbell (1998) describe as people with 'severe reputations'. It is commonly used to plan for those who are moving out of institutions. Personal Futures Planning focuses less on services and tends towards building relationships with family, friends and the wider community. The McGill Action Planning System (MAPs) brings together a group of people who help to identify the focus on service users' talents and needs, and to negotiate changes to their routines based on their desires and aspirations. This process is useful for gathering information and is often used at an early stage of planning. Planning Alternative Tomorrows and Hope (PATH) can be used in the development of individual action plans.

Although each planning method has different features, common characteristics pertain. They all adopt a perspective that sees the whole person rather than seeing them merely from a medical or clinical point of view. Each strategy is orientated towards the future; it focuses on a person's strengths, investigates their hopes and desires, and advocates creativity in planning and implementation. (Stalker and Campbell, 1998)

The essential ingredients of 'person-centred' planning involve:

- first and foremost – an understanding and commitment to the philosophy, approach, mindset of 'person-centredness' by all of the concerned individuals;
- the bringing together (by the person with a disability or a family member, friend, facilitator) of a group of those individuals who are committed to the person and who will openly share their information and views and fully participate in the action planning or goal setting process;
- a plan of action which articulates a view of the future based on the needs, strengths, capacities, even dreams of the person;
- a willingness to strive to take steps to see that that plan is implemented (whatever its simplicity or complexity and level of difficulty to implement) and to constantly review progress or outcomes and revise and change the plan as needed;
- an ability of all individuals to 'think outside of the square' and look broadly to both informal, mainstream and specialist services as well as services or support not currently available but possible to develop, create or change; and,
- an acknowledgement that 'person-centred' planning isn't simple and may be much harder than simply choosing to accept the 'status quo' but its participants have the willingness to

strive for 'person-centred' outcomes. (adapted from Kilbane & Thompson 2004b, Kim & Turnbull 2004, Medora & Ledger 2005)

Central to the approach therefore, is that:

- the person (ie the person with a disability) is at the centre or is the 'focus' of the process;
- individuals (such as family, friends, neighbours, service provider representatives, advocates, guardians, clinicians etc) chosen by the person are participants and partners in the planning process;
- the plan looks at what is possible and just not only at what is currently available and hence is creative and innovative;
- the plan concerns itself with what the person wants, seeks, dreams of, and not just the person's assessed/professed needs;
- the plan results in actions and identifies the timeframes and responsible individuals to work towards inclusion, dignity, respect, relationships which provides the person with greater choice and control over their situation and circumstances; and,
- the plan is subject to on-going review and adjustment.

Beresford has described 'person-centred' support as having the following key components or elements:

- putting the person at the centre;
- treating service users as individuals;
- choice and control for service users;
- setting goals;
- the importance of the relationship of service users with practitioners;
- listening to service users;
- up-to-date, accessible information about appropriate services;
- flexibility; and,
- appropriate services. (Beresford et al 2011 p50)

'Person-centred' planning can be a 'tall ask' as it requires:

- not only actions and change at an individual level (inclusive of the person and their attitude and approach) but also service or organisational and systemic changes of major significance. (adapted from O'Brien & Mount 1987; Duffy 2004; Mansell & Beadle Brown 2004; Beadle Brown 2005; Cambridge & Carnaby 2005 cited in DADHC 2008 p6);
- those involved in human services to radically re-examine assumptions, commitments and investments, and to change the way that they relate to people with disabilities, each other and their organisations. (It involves) a broad collection of practices that requires widespread and fundamental system and organisational change...(Parley 2001; Kendrick 2004; Michaels & Ferrara 2005; Robertson et al 2007a; Robertson et al 2007b; Kilbane, Thompson & Sanderson 2008 cited in DADHC 2008)

The United Kingdom policy endorsement of 'person-centred planning' in its 2001 'Valuing People' (Dept of Health 2001) announced strategy for social policy was quickly followed by a "Good Practice Guidance" (Dept of Health 2002). That 'guidance' made clear that –

"When we use the term 'person centred', we mean activities which are based upon what is important to a person from their own perspective and which contribute to their full inclusion in society. Person centred planning discovers and acts on what is important to a person.

Person centred approaches design and deliver services and supports based on what is important to a person."

2.3.4 Recovery

'Recovery' is now at the very core of services provided for persons with a psychiatric or psychosocial disability. Its roots are, as with 'person-centred approaches' for persons with other disabilities, based on the actions of the consumer and self-advocacy movements, particularly from the 1950s. Another description is as follows: "recovery is a self-determined holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope; empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members." (OMHSAS 2005 p7)

The central or fundamental elements of a 'recovery approach' have been variously described as involving:

- **Self-direction:** the person leads, controls, exercises choices, and determines their own path to recovery through maximum autonomy, independence and control of resources to achieve a self-determined life. The person defines their own goals and designs their own path to achieving them.
- **Individualised and Person-Centred:** the pathway or journey to 'recovery' is based on the individual person's unique strengths, needs, circumstances, preferences, experiences, and cultural background.
- **Empowerment:** the person has the authority to exercise choices and make decisions that impact on their lives and are educated and supported as required to do that. This involves effectively speaking for themselves about their needs, wants, desires and aspirations. It involves the person gaining control over their own destiny and influencing changes in the organisational and societal structures in their life.
- **Holistic:** it encompasses the person's whole life and embraces all aspects of that life including special as well as mainstream services that they may use; the support of family and friends; social networks, community involvement and participation; housing; education; income; employment and creating and maintaining meaningful opportunities for the person to access these supports.
- **Non-linear:** it is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from the experiences. Recovery starts once the person becomes aware that positive change is possible.
- **Strengths-based:** it focuses on valuing and building on the person's multiple strengths, resiliency, coping abilities, inherent worth, and capabilities.
- **Peer Support:** it views the mutual support of a person's peers in recovery as being invaluable and the need for valued roles and community inclusion to be recognised and promoted.
- **Respect:** community, service system, family and friends acceptance of the person as a person first and foremost, elimination of discrimination and stigma, are seen as being crucial to recovery as is the self-acceptance of the person and the regaining of self-belief along with respect for others. Respect ensures the inclusion and full participation of the person in all aspects of their lives.
- **Responsibility:** it entails the person taking personal responsibility for their own self-care and journey of recovery and taking the often difficult steps to achieve their own goals.
- **Hope:** believing in themselves and that they can overcome any barriers and obstacles that are in their path. Hope is the catalyst for recovery. It is internalised and needs to be fostered and promoted by the person's family, peers, friends and services. (adapted from OMHSAS 2005, MHCOC 2005 and Onken et al 2007))

'Person-centred care planning' involves a collaborative process between the person and his or her supporters (including the clinical practitioner) that results in the development and implementation of an action plan to assist the person in achieving his or her unique, personal goals along the journey of recovery. Such a 'plan' is always 'goal oriented' and needs to:

- promote recovery rather than only try to minimize illness;
- be based on the person's own goals and aspirations;
- articulate the person's own role and the role of both paid and natural supports in assisting the person to achieve his or her own goals;
- focus and build on the person's capacities, strengths, and interests;
- emphasize the use of natural community settings rather than segregated program settings; and,
- allow for uncertainty, setbacks, and disagreements as inevitable steps on the path to greater self-determination.

2.4 The Research

The rhetoric of 'person-centred' planning and approaches abounds in the literature and in many legislative, Government policy and strategic planning initiatives/announced directions for change both within Australia and Internationally. 'Person-centred' planning if however, fully embraced and actioned means many changes over time to the thinking of persons with a disability, their families, friends and circles of support; to clinicians and practitioners and their roles; to service organisations and their structures and their flexibility and responsive to the needs and aspirations of their customers.

Although 'person-centred' planning doesn't yet appear to have an extensively robust basis in evidentiary practice, it certainly does have evidence that it can be effective, is both evolutionary and revolutionary in some ways and that it clearly makes sense to the 'person-in-the-street' who wants choice and control over the services that they receive and over the nature and quality of those services.

Cambridge & Carnaby have expressed concern that the reported good outcomes associated with person-centred planning may be of short duration as there appears to be no research into the longer term outcomes or the sustainability and enhancement of such planning outcomes. (Cambridge & Carnaby 2005)

Many of the studies admittedly, have been qualitative in nature (ie. being descriptive, providing a depth or richness of data, indicating differences but more open to interpretation) rather than quantitative (ie more concerned with measurement of change, more able to test hypothesis such as 'without person-centred planning' where would this individual be? and so forth). Research on quality of life outcomes associated with person-centred planning have mainly employed qualitative research designs. (Holburn et al 2004)

Often the sample sizes in the studies appear to be quiet small.

Very few studies have actually sought to formally evaluate the impact or outcomes associated with person-centred planning. (Holburn et al 2004; Malette et al 1992; Rea et al 2002; Holburn & Vietz 2002) Rather than attempting to evaluate the efficacy or person-centred planning approaches per

se, the qualitative studies have sought to evaluate elements of the process of person-centred planning such as satisfaction with meetings, effectiveness of the training etc). (Miner & Bates 1997; Everson & Zhang 2000; Heller et al 1996; Whitney-Thomas et al 1998) As a result there are a number of studies which can only support the possible impacts of person-centred planning approaches. (Mount 1987; Malette et al 1992; Hagner et al 1996)

A number of studies have found difficulties in implementing person-centred planning including:

- goals remaining unmet (Hagner et al 1996; Coyle & Moloney 1999; Dumas et al 2002)
- goals being limited to options previously available to service users (Coyle & Moloney 1999; Dumas et al 2002)
- failure to address goals in more ambitious or contentious areas such as sexuality (Moloney 1999; Dumas et al 2002)
- goals not corresponding to individual preferences assessed by other means (Reid et al 1999)
- few planned outcomes being achieved in a timely manner; outcome not achieved because of no viable service or solution; participants felt that they were limited to an existing services (Hagner et al 1996)

26 Individuals with differing disabilities/support needs were researched by Medora & Ledger (2005) and found that they enjoyed the 'person-centred' approach to planning and achieved increased involvement of family and friends as a result. The person and their family and friends felt more attuned to what that person actually wanted in terms of their aspirations and hopes and that the planning process was beneficial in key transition areas such as 'leaving school', 'getting a job'.

Holburn et al looked at 38 individuals in institutional settings, 19 of whom were subject to person-centred planning approaches and 18 of whom were subject to the more conventional individual service planning. The study found that person-centred planning approaches hastened the move to community settings for the concerned individuals with 18 relocating as against only 5 individuals relocating from the contrast group. Other increased outcomes for the person-centred approach individuals were in the areas of autonomy, choice making, daily activities and satisfaction compared with the contrast individuals. (cited in Robertson et al 2007a p9)

The largest (thus far) international study of the outcomes of person-centred planning was conducted in England by Robertson et al. This 2 year study involved 4 different locations, 93 individuals with learning disabilities, and resulted in 65 of those individuals actually having person-centred plans developed and maintained throughout the study period. (Robertson et al 2005)

This study found that the introduction of person-centred planning resulted in **positive** changes to the person's lives in the following areas:

- social networks;
- contact with family;
- contact with friends;
- community based activities/involvement;
- scheduled day activities; and,
- choice (p33 & 44)

Negative changes were however found in the following areas following implementation of person-centred planning:

- risk (or perception of risk at home or in the community);
- health problems identified; and,

- emotional/behavioural problems increased.

Possible reasons for these 'negative' changes could include:

- more active involvement in the community and in its opportunities and activities increased perceived risk (from traffic, from other people etc);
- knowing much more about someone and being much more involved with them can lead to a better appreciation and identification of existing health issues that they may have. Studies have demonstrated that people with disabilities often have unidentified and unmet health care needs (Alborz et al 2003; Horwitz et al 2000; NHS Scotland Health 2000; Oulette-Kuntz and cited in Robertson et al 2005); and,
- possibly pre-existing behavioural issues are more manifest due to increased activity and community involvement and hence more opportunity to be expressed or the result of stress due to this extra activity and involvement. Similar issues have been found with 'deinstitutionalised' individuals during their early days following moving to the community. (Emerson & Hatton 1996; Kim et al 2001; Young et al 1998)

This study also found that person-centred planning had greater impact for some individuals than for others:

- people with mental health or emotional or behavioural problems were less likely to receive a plan and less likely to benefit if they did receive a plan in the areas of size of social networks, contact with friends, contact with family, choice, hours per week of scheduled activity and (depending on the measure used) number of community activities;
- people with Autism were less likely to receive a plan;
- women were more likely to benefit in the areas of number of community activities and choice. Men were more likely to benefit in the areas of number of hours per week of scheduled activity and contact with friends;
- people with more health problems were unlikely to receive a plan, but if they did they were more likely to benefit in the area of contact with friends;
- people with restricted mobility were less likely to receive a plan, but if they did were more likely to benefit in the areas of contact with family, hours per week of scheduled activity and number of community activities.

Robertson et al notes that:

"these results, and in particular those relating to mental health and Autism, indicate some powerful inequalities in the extent to which people are likely to receive a person-centred plan, and if they do, the level of benefits that they can expect. Similar inequalities have previously been reported in a wide range of studies on supported accommodation and on general life experiences of people with learning disabilities in England". (Robertson et al 2005 p106 but see also Emerson et al 2001; Emerson et al 2000; Emerson et al 2005)

Some key variables were identified in the study as extremely influential to the success of the person-centred planning process:

- the **commitment of the facilitators** to the planning process was the most powerful predictor of whether a person would get a plan and to their increased chances of benefitting in the areas of: choice, contact with friends, hours per week of scheduled activity; and size of social networks. The higher the level of commitment the better the outcomes for the person;

- the **direct involvement of the person** with a disability (eg. directing their own meetings) was associated with increased benefits in the areas of: size of social network, contact with friends and with choice;
- the **identity and role of the facilitator** was associated with benefits in a number of areas. First, facilitators for whom facilitation was part of their formal job role were more likely to deliver plans and appeared to deliver greater benefits in the areas of size of social networks; hours per week of scheduled activity. Facilitators who were managers within services were associated with greater benefits in the areas of: size of social networks; choice; and community activities. Having a facilitator who was a member of support staff, however, was associated with benefits in one area (size of social networks), but disadvantages in three (community activities, contact with friends, contact with families). (Robertson et al 2005 p107)

The most surprising finding of the Robertson et al study was that the introduction of person-centred planning (inclusive of training and costs) did not significantly increase the average weekly cost of the packages of services for each person with a plan. (Robertson et al 2005 p110 see also Sanderson, Thompson & Kilbane 2006 p20)

The formal evaluation of person-centred planning conducted by Robertson et al demonstrated that this approach was both efficacious and effective in delivering improved life outcomes for people with disabilities.

“Person-centred planning also reflects the core values of empowerment and personalisation which underlie contemporary approaches to health and social care in England. Indeed, there can be little doubt that the continued evolution of procedures to improve the ways in which supports can be tailored to the needs and aspirations of people with disabilities will constitute a core task for those commissioning and providing services and support”.
(Robertson et al p110 see also Dept of Health: *Valuing People* 2001; Greig 2005; Cabinet Office – *Improving the Life Chances of Disabled People* 2005; Dept of Health – *Independence, Well-being and Choice* 2005; Dept of Health – *Disabled Child Standard* 2004)

‘Person-centredness’ is equally the underlying approach to health and social care services in Australia.

Many of Robertson et al 2005 findings have also reinforced that considerable work needs to be done to ensure equality of access to person-centred planning and that all individuals receive good outcomes. Everson and Zhang et al found that plans for people with behaviour, communication or social skills difficulties were less likely to achieve goals. (cited in Robertson et al 2007a DADC 2008 p16)

Other researchers such as Medora & Ledger (2005) have found that person-centred planning approaches produced good outcomes for people with complex needs, dual diagnosis and people with communication difficulties as long as appropriate training in communication skills was provided to support the process. (cited in DADHC 2008 p17)

Much of the research remains equivocal and qualitative in nature. Participation in person-centred planning was found to achieve significant improvements for the concerned persons in the areas of respect, choice and involvement in everyday activities but no real measureable gains in power-sharing, participation in major life decisions and family involvement. (Parley 2008) Care managers in England found person-centred planning to be a ‘good way’ to better get to know each individual,

provided some greater structure to their work and tasks, and that the plans provided stronger and clearer evidence to support requests for funding and resources. (Johnson et al 2007).

Some researchers/writers see the introduction of person-centred planning as a 'fight for change' where allies to the cause need to be recruited. Towell & Anderson see the person-centred planning, philosophy and methods as an effective way of engaging the hearts, minds and skills of potential allies in service reform. (cited in DADHC 2008 p18)

O'Brien talks about the process of person-centred planning, when well implemented, as aligning the person and their allies around a common understanding of what is desirable for the person now and in the future; which clearly articulates choices that are made about how the person wants to live and be supported as a valued community member; generates creative solutions to overcome constraints and barriers; and defines locally relevant strategies to negotiate for required mainstream and specialist resources; results in occasions for the participants to get together to update and revise their shared understandings. (cited in DAHC 2008 p18-19)

2.5 The challenges/barriers/blocks to person-centred planning

"It sounds so simple. Read logically, it makes sense to us. When we first explore what (person-centred planning) means, it has a visceral 'rightness'. It feels as though the concept expresses all we have ever aspired to in our professional practice....we like to think that we are warm, caring individuals who would not dream of putting someone we work with anywhere else than in the centre of their life planning....only by constantly exploring and revisiting the (person-centred planning) approach will we truly be able to practice in a person-centred way and understand the implications of our actions". (Kilbane & Thompson 2004b pp28-29)

Person-centred planning is much more complex than it seems to be on the surface. The rhetoric is easily mastered but its wider implications and complexity need to be understood if it is to be implemented successfully. (see Medora & Ledger 2005 p150; Parley 2001; Mount 2002; Holburn 2002; Kendrick 2004; Michaels & Ferrara 2005; Robertson et al 2007a & 2007b; Kilbane, Thompson & Sanderson 2008 and DADHC 2008)

Person-centred planning offers challenges across-the-board to people with disabilities; their families, friends and supporters; to services both mainstream and specialist and their staff; to clinicians and practitioners; to funding bodies such as Governments and non-government organisations.

The decade of English experience where person-centred planning is now mandated highlights some, but by no means all, of the difficulties and complexities:

- failure by organisations to really change how people are listened to and responded to resulting in superficial changes;
- focus on staff training to the exclusion of families and self-advocates;
- failure to pay attention to the implementation of plans;
- disconnection between seeing what is important to people in the process of person-centred planning and how resources are allocated and used;
- focus on technical training and failure to pay attention to follow up support, management action, and embedding person-centred values in organisational cultures;
- implementation of person-centred planning without good connections to other plans and strategies;
- failure to get person-centred plans developed for the main target groups; and,

- failure of organisations to work effectively together. (Routledge & Gitsham 2004 cited in DADHC 2008 p22)

For person-centred planning to be efficient and effective requires fundamental change to organisational structures (Dowling et al 2007), practices and service funding arrangements. The task is extremely complex and the challenges, possibly monumental (but surmountable over time) for many service organisations. The timeframe will not be short. As noted by Robertson et al, after 10 years following the introduction of Individual Programme Planning (IPP) in England, a study of 13 local authorities found that 75% of individuals with a disability did not have an IPP recorded in their files. (Robertson et al 2005 p13)

Medora & Ledger have noted that existing organisational policies will often conflict with person-centred planning approaches and philosophy and that:

“it requires a radical and complex review and redesign of service delivery..(policies, processes, decision-making, resource allocation)....if real shifts in power are to occur”
(adapted from Medora & Ledger 2005 p168)

Some of the barriers or blocks to fully implementing person-centred planning that have been identified include:

- a failure to fully understand the person-centred planning process and its full impact, complexity and wider implications; (Medora & Ledger 2005; Holburn 2002; Parley 2001; Kendrick 2004; Robertson et al 2007a and 2007b; Kilbane et al 2008)
- the culture shift in services not happening resulting in the language of person-centred planning being adopted but not the actual practice of person-centred planning; (Routledge & Gitsham 2004; Gregson 2007; Holburn 2002; Medora & Ledger 2005)
- a non-appreciation of what is possible by the person with a disability and their families resulting in choice being constrained by a fixed menu of existing options based on their past experience; (Ramsey 2007)
- the difficulty of changing organisational practices, procedures, processes and addressing the conflicts with these that person-centred planning results in; (Dowling et al 2007)
- the difficulty for organisations to devolve authority and the more lateral management and resource allocation systems required; (Cambridge & Carnaby 2005b; Mansell & Beadman 2004)
- the difficulty of marrying person-centred planning goals with organisational goals; (Kilbane et al 2008)
- producing high quality and meaningful person-centred plans given the time, energy and resources needed; (Robertson et al 2007b)
- the potential competing priorities of the stakeholders about what ‘they’ want for the person; (Holburn 2002)
- tensions concerning risk, person safety and health, duty of care, role and responsibilities; (Kilbane & Thompson 2004a; Medora & Ledger 2005)
- tensions between organisational planning and planning for an individual as what a single individual wants may be very different to what other service user’s desire. (Duffy 2004)

The English experience over the past decade has highlighted difficulties including:

- bureaucratic processes and systems that stifle creativity and innovation;
- priority being placed on targets and statistics rather than on outcomes for the individual;
- the conflict between roles such as gatekeeper of resources;

- limited resources to properly implement person-centred planning (such as training, mentoring and support for staff, each individual and their families, and for service redesign, development and review);
- eligibility criteria;
- confusion over whether service managers should lead planning, assist in planning or whether planning should be separate from services;
- conflicts between duty of care and person-centred approaches;
- pressure between producing good and meaningful plans against ensuring everyone simply has some sort of plan. (adapted from Johnson 2006 as cited in DADHC 2008)

Person-centred outcomes thus far found in the research however, suggest that organisational and system barriers and blocks can be overcome; that the process of change will be slow and necessarily needs to be slow; and, that there is no need to wait for the whole system to change to create small pockets of innovation. (Robertson et al 2005, 2007a & 2007b; Parley 2008; Rouget 2003; Mendora and Ledger 2005)

To do this still requires changes to resource allocation and management; restructure of funding arrangements and of contracting and financing support for individuals. (Rouledge & Gitsham 2004; Mansell & Beadle-Brown 2004; Dowling et al 2007.

The goals of person-centred planning concern choice, control and social inclusion of people with a disability. Simply listening and understanding to their views as to what would meaningfully change their lives and what is really important to them won't help those goals be achieved without having person-centred plans directly linked to how resources are allocated and used. To do this in many cases, will require existing funding to be 'un-bundled' to enable the resources to be used in new and different ways.

2.6 The Good Practices

There is a difference between 'good' practices and 'best' practices and even a more marked difference with 'poor' practices. For the most part, this section will describe 'good' practices and occasionally err into 'best' practice territory. 'Poor' practices are simply the reverse or inverse of what is stated below. The 'good' practices are not in any hierarchical order and in some cases focus on the individual and in others focus on the facilitator/planner or service/organisation.

2.6.1 For the Individual

- **putting the person at the centre.**

This requires "*starting with the person rather than the service.*" (Carr 2008 pv) It means always being focussed on the individual and on:

- where they are at now, their journey, dreams and goals;
- matching the services or support with their needs rather than the other way round;
- the opposite of 'one-size-fits-all' and to personalise services as far as is possible;
- not fitting the person into various boxes;
- looking at a person's capacities and strengths.

- **treating service users as individuals.**

This requires *“starting with the person and not the service system”* -

- a focus on each person’s individual requirements;
- organising services around each person;
- treating each person as you would like to be treated yourself.

- **enabling choice and control to service users.**

This requires *“the person being in control”* -

- the person deciding what they need or want to do rather than some other person doing it for them;
- allowing the person to make choices and decisions;
- the person determining if it is what they want;
- being listened to and able to say *“this isn’t what I want or need”*.

- **the person setting their own goals.**

This requires the *“person identifying what they want to achieve”* –

- the person’s interests, priorities and aspirations and dreams are paramount;
- changes in a person’s life and circumstances are encouraged and made possible;
- the emphasis is on the person’s rights, decision-making and active participation in the community;

- **acknowledgment of the importance of the relationship between the person and the services that they may use.**

This requires a *“trusting relationship to be established”* –

- listening carefully, understanding where the person has come from, what their current situation is and the changes that they would like to make. It is a ‘getting-to-know-you’;
- establishing a real foundation for a relationship.

- **actually listening to the person.**

This requires hearing and understanding *“what the person actually says and means or intends”* -

- the person is listened to and respected;
- encouraging and supporting the person to ‘open-up’.

- **providing information.**

This requires *“accurate and full information”* -

- the person is provided with up-to-date, accurate, accessible and relevant information at all times.

- **services provided are flexible and adaptable.**

This requires *“responding to different needs”* -

- the person is recognised as having his/her own individual needs and is responded to accordingly;
- services are tailored and responsive to changing needs, situations and circumstances of the person.

- **always adopting a ‘positive approach’.**

This requires *“focussing on the positives”* -

- the person’s capacities, abilities and not the impairment/disability or the negatives;
- providing the person with every possible opportunity to achieve their goals or desires;
- recognising the person’s value;
- helping the person to make choices and work towards what they want in their lives;
- recognising the person’s talents and strengths and building up the person’s confidence to strive for their goals;
- not focussing solely on a person’s needs.

- **providing assistance and support to the person to as far as possible enable them to take control, make choices and their own decisions.**

This requires *“an acceptance and adherence to ‘assisted decision-making’ and as needed, ‘supported decision-making’ approaches”*

- in those situations where a person simply does not know or cannot decide what to do, other persons such as peers, mentors, family members, friends etc provide assistance to them by providing and researching any additional information required, any other options for the person to then consider, ensure that communication styles and approaches are appropriate, discuss the possible positives and negatives and then leave the person to make the decision/s in front of them that need to be made. *“Assisted decision-making’ is about ensuring that the person has the information needed for them to make informed choices; (Assisted Decision-making)*
- with *‘supported decision-making’* the role of others is much the same, however, the other person or persons are formally authorised by the individual to help them decide. *(Supported Decision-making)*
- in some cases, another person or authority may be authorised by a Court or Tribunal to actually make one or more major life area decisions (eg. where a person lives), or financial decisions (what they can spend their money or how much they can spend) for the person. This unfortunately can happen irrespective of the actual ability, capacity, wishes of the person to make the decision/s themselves or with *‘assistance’* and *‘support’*. *(Substitute Decision-making)*

2.6.2 For the Facilitator/Planner

- the 'person' is the focus.

This requires *"the person to be at the centre"*

- the person is involved in all decision-making concerning them;
- the person decides when to meet to develop an initial plan, where that meeting will take place, what time etc;
- the facilitator/planner may provide advice (along with that of other participants) about any cultural or communication aids or accommodations/considerations that are necessary;
- the initial plan will be revisited and reviewed/changed as needed by the person.

- the participants.

This involves *"a mixture of supporters and allies committed to enhancing the life of the person"*

- other than for an NDIS appointed facilitator/planner if their presence is mandated, the person determines all other persons to invite to each 'planning meeting';
- such other persons will generally be partners, family, friends, neighbours, service representatives (including clinicians) etc. who know the person well and support them and who will help the person bring about the changes in their life, situation and circumstances that they desire.

- the role of participants.

This requires *"openness, honesty, full participation and commitment"*

- enabling the person to fully express their needs, wishes, desires, preferences, and to make choices;
- providing whatever 'accurate' and full information and advice that they can give to the person;
- focussing on the person's strengths, capabilities and not 'weaknesses' or clinical label or past perceived behaviours or 'indiscretions';
- challenging stereotypes and 'clinician to patient' treatment methodologies and approaches when appropriate;
- understanding and believing in 'person-centred planning' and 'recovery' approaches;
- a willingness to take on whatever actions/tasks/goals that they agree to take on and to
- consistently advocating for the person;
- looking 'outside-of-the square' to create and innovate different options with specialist and generic services and natural supports (such as family and friends) which will assist in meeting the person's goals and desires and enable full membership and community inclusion;
- assisting and as necessary supporting the individual to make their own decisions and challenging (as necessary) the views of other participants

when needed and the inputs and decisions of any 'guardians/financial managers' appointed as 'substitute decision-makers' for the person by a Court or Tribunal.

2.6.3 For the specialist service provider

- **culture and other changes.**

This requires "*committing to meet differing needs of each individual client*" –

- management and staff having the same commitment to respond to the individual needs of each consumer;
- responsiveness, flexibility, adaptability in service provision;
- a vision, a mission, policies, procedures and processes that reflect and give effect to 'person-centred planning' and 'recovery' approaches;
- appropriate on-going training and support for staff and consumers and their families so that all partners in change understand 'person-centred' planning and 'recovery' and learn from their experiences;
- written and verbal communication that is at all times uses person-first language and which is culturally and linguistically appropriate;
- open, transparent and full information is always available and provided;
- staff, consumers and their families, friends, advocates are always respectfully treated, listened to and responded to;
- treating each person as an equal partner in their treatment or service programme;
- focusing on each person's strengths, capacities, desires and goals and putting aside the negatives;
- encourage the involvement of each person's family and friends as well as advocates and independent others to help plan, monitor and review the services provided;
- deliver what you say that you will deliver (ie. keep your promises and if you can't, carefully and fully explain why that wasn't possible);
- always be holistic in focus and link your services with other services aimed at better meeting the needs, desires and goals of each person;
- have clear and easy to navigate grievance and complaints resolution systems and fully inform consumers and their families of alternative options that they can pursue if dissatisfied.

- **involving consumers and their families in decision-making.**

This requires "*determining how to do that and then doing it effectively*" –

- on-going examination and review of the outcomes of previous methods to engage consumers and their families and building on what was done before and learning from past experience;
- implementing planning systems which tap into the knowledge, skills, experience and ideas of consumers and their families;
- working out how consumers and their families want to be involved and when and how;
- having a realistic timetable for their involvement and the necessary financial and physical resources available for them to do so;

- involving consumers and their families from the outset or from 'day-one' and not after everything is all but decided;
- making clear that involvement is voluntary and that there will be no come back;
- identifying other organisations/services/groups (including advocacy and peer support) that could/should be involved or invited to participate;
- working out how to involve consumers and their families who don't have any other external means of support;
- determining whether whatever is to be discussed and considered involves a single individual or collective of individuals and if so, who;
- making sure any written or visual materials are appropriate;
- providing enough notice so that service users and their families can attend any meetings;
- providing information in different and appropriate formats and interpreters as needed;
- giving sufficient notice to consumers and their families of proposed meetings;
- ensuring that consumers have the necessary supports to attend such as personal care and transport;
- ensuring that if not all then at least a sample of consumers and their families participate and that such a sample represents the cultural, gender, linguistic, age, disability etc. diversity of the consumer group you are consulting with;
- making sure that the 'seldom-heard-voices' of consumers and their families who face particular barriers to participation (such as leaving their homes, are homeless, who communicate differently, etc) are in fact heard;
- inviting consumer and staff representatives from other services to input to discussions and decisions;
- determining whether each consumer's and their families' costs incurred (such as transport, personal care assistance, time) in meeting attendance will be met by the service/organisation;
- allowing consumers and their families to contribute 'anonymously' if they wish to do so;
- making meetings 'small' as they are often less intimidating and using plain and simple to understand language which is free of jargon and 'in-house' talk;
- ensuring privacy and confidentiality of discussions;
- making it clear from the outset why each consumer and their family is invited to participate in the discussions and decision-making concerning planning;
- making clear what their involvement is (ie. what their input actually means in terms of any decision-making or is it just for information or to 'tick-a-box' that the funder requires be ticked);
- making sure that each participant has equal and full information about whatever the issue to be discussed is;
- noting whether the discussion/decision is a 'one-off' event or part of a larger and on-going programme/attempt at change;
- providing support for any consumer or their family member or even staff member who finds the meeting/discussions painful and challenging;
- providing feedback as to what happened, what was/has been decided and what that means, when it will happen and who is responsible for doing it or making sure that it occurs;

- what to do if you are unhappy/dissatisfied with the outcome and how to appeal or challenge it;
- advice as to how the outcome of any changes will be evaluated and assessed and of the next steps in the process of change.

Involving consumers and their families in the process of change is not simply about often 'one-off' and 'tokenistic' consultation events. Such events are relatively meaningless 'consultations' if an organisation or service doesn't listen and act on the advice and guidance of its consumers and their families and supporters. Involvement should be an on-going process which enables consumers and their representatives a place in service planning, development and management groups and an active role in day-to-day decision-making. To meaningfully involve consumers means:

- Before even starting –
 - identifying whether previous attempts have been made to enable such involvement, what has been learnt from those attempts and why this new approach will be different, better and build on any previous attempts and lessons learnt;
 - working out how consumers can be involved in actually planning their involvement to enable the organisation to benefit from their ideas and experience;
 - asking consumers how they want to be involved including when and where the consultation/s should take place;
 - working out a realistic timetable to enable consumer involvement the resources needed and available to enable this to occur;
 - making clear that participation is voluntary and that there will be no 'come-back' for consumers who choose to participate or not to participate;
 - recognising that consumers should be involved from the outset;
- Determining Who to Involve:
 - identifying any existing consumer, family, forum and organisations that should/could be approached to be involved;
 - then inviting them to participate after clearly understanding why you want these consumers and their supporters involved and what value they will be adding;
 - working out how many consumers and their supporters should be involved;
 - determining whether consumers will be involved individually or collectively (e.g. inviting this group of persons who use this specific service or programme);
 - determining what different ways consumers want to be involved and how to facilitate this happening (eg. actual attendance, written input, commenting on proposed actions etc.);
- Communicating:
 - determining if any written materials proposed to be used are actually accessible and appropriate for each of the consumers and their supporters proposed to be involved;

- taking steps to provide information in the needed form such as in plain English, the languages or audio or other formats that individual consumers and their supporters may require;
- Access and Meeting Attendance:
 - providing sufficient notice for consumers and their supporters to organise themselves and make arrangements to attend;
 - identifying which consumers may require physical or other assistance (such as transport) to attend or to prepare (such as preliminary training and support to actually participate in a meaningful and confident way);
 - identifying what communication aids would be required such as language interpreters, signers etc;
 - working out how to identify and respond to individual consumer needs in terms of access and communication;
- Culture and Diversity:
 - seeking to ensure inclusion and diversity of involvement;
 - making sure that consumers can get involved on an equal basis, regardless of gender, sexuality, ethnicity, financial, culture, beliefs, age, disability etc.;
 - taking steps to ensure the involvement of consumers who face particular difficulties associated with homelessness, refugee status, penal system involvement, culture etc.;
 - involving users who both are and are not regular consumers (ie. those persons who use other but related services);
- Bringing Participants Together:
 - making sure that when meetings are appropriate that all participants feel welcome and comfortable to contribute;
 - taking steps to ensure participants who may feel 'intimidated' or 'unsure' about their involvement are supported (this would possibly be case when a large forum/meeting is proposed and smaller groups reporting back may be appropriate in such a case);
 - ensuring minimal use of jargon and that the language used is plain and understandable;
 - ensuring adequate and timely breaks from discussions if the timeframe is great (eg. more than a couple of hours) are provided for with refreshments/food available;
- Confidentiality:
 - ensuring that the views/comments of individual consumers and their supporters can remain anonymous if they so desire but nevertheless fully considered;
 - guaranteeing that no matter what consumers and their supporters say that there will absolutely no repercussions for them;
- Scope of Involvement:

- making clear to participants why they are being involved and exactly what they are being asked to be involved with/in;
- stating clearly what is being proposed/planned and the scope for influence/change by the result/outcome of the forum/meeting;
- making clear whether the purpose of the forum/meeting is just meeting is just 'information gathering', to meet some formal "yes we have consulted" 'tick-a-box' requirement, or to actually inform or determine service directions and make possible changes to existing directions and services;
- making clear to participants the specific aims of involving them;
- ensuring all participants have the information that they need (and in the appropriate formats);
- advising participants about whether this is a 'one-off' or 'on-going' event/forum/meeting;
- irrespective of the primary purpose of the consultation, making clear whether any other related and/or non-directly related issues will be taken on-board and responded to and how this will be done and supported;
- providing support for consumers and their families/supporters if the issues raised are 'painful' to them;

○ Feedback:

- providing feedback to participants on the outcome of their input;
- providing feedback in an appropriate and suitable way;
- letting participants know the timeframe for providing feedback;
- identifying who is responsible for providing the feedback and by when and how;

● Next Steps:

- advising participants of the level of commitment of the organisation to actually take action/implement the actions determined/under consideration;
- advising how different views, interests, proposals, ideas will be considered and negotiated;
- stating how service users will be involved in deciding and taking action following their involvement;
- determining what funding and other resources are to be allocated to follow-up what service users want;
- evaluating service user involvement in terms of 'how well it went', 'what participants thought about it' and 'how could the process be improved';

● Involvement Outcomes:

- determining how the outcomes/achievements of service user involvement are to be evaluated; and,
- examining what has been achieved by such involvement.

2.7 Planning Tools

There is a range of tools that can be described as person –centred planning tools. They are all sensitive, reflective, forward thinking tools in terms of the Focus person’s situation and circumstances and aspirations. The major tools generally advocated include:

- PATH (Planning Alternative Tomorrows With Hope);
- MAPS (McGill Action Planning System aka Making Action Plans);
- Personal Futures Planning;
- Essential Life Planning; and,
- Person Centred Thinking Tools.
- Collaborative Goal Technology

There are many other tools that could be used. They are almost all thinking and planning tools which aim to enable a better appreciation of where a Focus person:

- is at in terms of his/her history and current situation and circumstances;
- what his/her goals, objectives and aspirations are both in the short and longer term;
- who his/her supporters are;
- what actions he/she and his supporters will take to get him/her there;
- what needs to change in his/her life and what doesn’t.

Person-Centred Thinking Tools can be helpful in informing issues involving ‘What’s not working’ such as:

- those involving relationships as the Focus person is losing touch with family and friends and others important in his/her life, or finds that he/she doesn’t have enough friendships; (**Relationship Map**)
- other people feel that they don’t really understand how the person communicates with them, or they feel that they can’t rely on what is being said or indicated; (**Communication Charts**)
- other team members/participants to the planning process feeling that they don’t know enough about what is really important to the Focus person and their family. (**Learning Log**)

Whatever, if any tool or tools is used, the key outcome is a ‘person-centred’ description that the Focus person creates which can and must of necessity change and be subject to constant review.

2.7.1 PATH (Planning Alternative Tomorrows With Hope)

Jack Pearpoint, Marsha Forest and John O’Brien developed PATH. It can be used as a planning style with individuals and with organisations. PATH is a very strongly focused planning style. It helps a group of people with a basic commitment to the person to sharpen their sense of a desirable future and to plan how to make progress. It assumes that the people present know and care about the individual and they are committed enough to support the person towards her desirable future over the next year. PATH is not a way of gathering information about a person, but a way of planning direct and immediate action. PATH focuses first on the dream and works back from a positive and possible future, mapping out the actions required along the way. It is very good for refocusing an existing team who are encountering problems or feeling stuck, and mapping out a change in direction. It requires either that the person can clearly describe their dream or, if the person does not use words to speak, that the others present know the person well enough to describe it for the person. PATH needs a skilled facilitator to ensure that the dreams are those of the individual rather than those of the team.

O'Brien J, Pearpoint J, Kahn L, The PATH and MAPS Handbook: Person-Centered Ways to Build Community (2010), Inclusion Press.

2.7.2 MAPS (McGill Action Planning Systems aka. Making Action Plans)

MAPs is a planning style developed by Judith Snow, Jack Pearpoint and Marsha Forest with support from John O'Brien and others. It was used first as a tool for helping children with disabilities integrate into mainstream schools, but is now used more widely in person centred planning with children and adults. Maps is more of a picture building style than PATH. It can be used in a meeting or it is possible to use the individual components separately. For some people there are more important lessons to be learnt from looking at their past. Maps has a specific section at the beginning of the process for going over the history of an individual. It goes on to ask the question 'who is the person?' and 'what are their gifts?'. Focusing on the gifts often provides the key to unlocking the community so Maps is a useful process when looking for ways of helping an individual to make connections. The Maps process allows people to express both their hopes for the future, in the dreaming section, and their fears about the future, in the nightmares section. The action plan is about working towards the dream and away from the nightmare. It treads a middle way between PATH and Essential Lifestyle Planning, allowing people to dream and including some 'getting to know you' in the process. It is neither as focused as PATH nor as detailed as Essential Lifestyle Planning.

O'Brien J, Pearpoint J, Kahn L, The PATH and MAPS Handbook: Person-Centered Ways to Build Community (2010), Inclusion Press.

2.7.3 Personal Futures Planning

Personal Futures Planning was developed by Beth Mount and John O'Brien. Personal Futures Planning provides a way of helping to describe the person's life now and look at what they would like in the future. It helps people to build on areas of their life that are working well now and to move towards their desirable future.

It is therefore useful when people need to learn more about the person's life (unlike PATH, which assumes this knowledge) and to create a vision for the future (unlike Essential Lifestyle Planning that focuses on getting a lifestyle which works for the person now). It will not provide the detail about what the person requires on a day to day basis in the way that Essential Lifestyle Planning does, but provides an excellent overview from which areas of concern can be considered. The quality of the planning depends more on the skill of the facilitator than on choosing the 'right' style.

Mount B, Capacity Works: Finding Windows for Change Using Personal Future Planning (1995), Communitas, Inc.

2.7.4 Essential Lifestyle Planning

Michael Smull and Susan Burke-Harrison developed Essential Lifestyle Planning in the context of helping people move from long-stay institutions which were closing. Essential Lifestyle Planning is a very detailed planning style that focuses on the individual's life now and how that can be improved. It can help people find out who and what is important to the person and what support the person needs to have a good quality of life. It helps identify what is not working at present and the individual's desirable future or dream.

Smull M, Sanderson H, Sweeney C, Skelhorn L, George A, Steinbruck M, Essential Lifestyle Planning for Everyone (2005), HSA Press.

2.7.5 Person-Centred Thinking Tools

This set of 'tools' which can assist in working out 'what a good day/bad day' for a person is; 'what is important to and for a person'; 'what's working/not working'; 'the roles, responsibilities and possibilities of supporting staff'; 'positive and negative staff and person relationships'; 'identifying important people in the person's life'; 'how the person communicates and the trips and traps of what someone thinks a person said/meant and what the person really meant'; and, a 'learning log' to capture changes required'.

Bailey G, George A, Sanderson H, Watson D Person-Centred Thinking (2005) Inclusion Press.

2.7.6 Collaborative Goal Technology

The objective of Collaborative Goal Technology (CGT) is to assist people with a psychosocial disability to progress with their individual recovery process. CGT was designed to facilitate collaboration between a person in recovery and his/her mental health worker in relation to developing and monitoring individualised recovery goals and an overall recovery vision. CGT is an adaptation of other widely used goal setting interventions. It is established that better outcomes are associated with the degree to which people in recovery are active participants in treatment and goal setting.

Oades, L.G., Deane, F.P., Crowe, T.P., Lambert, W.G., Lloyd, C., & Kavanagh, D Collaborative recovery: An integrative model for working with individuals that experience chronic or recurring mental illness, *Australasian Psychiatry*, 13 (3) (2005)

3. Good Practice Guidelines

3.1 Introduction

The Guidelines that have been developed and presented below do not specifically credit the authors/researchers/ academics, nor the persons consulted and the others relied upon in the project, as their work has been extensively adapted to fit the requirements of the NDIS system. The good practice we have sought out inevitably becomes part of the terminology of the sector. We also acknowledge persons with a psychosocial disability, their families, carers and supporters consulted in the preparation of these Guidelines.

‘Recovery’ and ‘Person-Centred Planning’, are terms or concepts now common in mental health literature, legislation and strategic plans of Governments. For the purposes of these guidelines, the term or concept of ‘Person-Centred Planning’ will mainly be used.

The main objectives of these guidelines are to:

- explain the terms or concepts of Person-Centred Planning and Recovery;
- outline the key principles and elements of Person-Centred Planning and Recovery; and,
- describe what needs to be done to develop a Person-Centred Plan under the NDIS.

The guidelines do not try to elaborate on how an existing or possibly newly created specialist or mainstream organisation or service can move to become a ‘person-centred’ one, although some comments and good practice suggestions are provided. Nor do these guidelines provide, what is equally essential, and that is a manual detailing what the NDIS Launch Transition Agency should do in fulfilling its responsibilities to facilitate a participant’s or prospective participant’s plan.

Implementing or trying to implement person-centred planning, will however have limited effect if any effect if the service providers (as either or both manager of funding supports or provider of funded supports) registered with the Agency, are not ‘Person-Centred’ and if the staff of the Agency itself don’t have adequate training, knowledge, skills, attitude and a framework to work within.

The NDIS provides many possible innovations in approach to disability services and in particular for those individuals with a psychosocial disability arising from the effects of psychiatric disability and mental illhealth. The possibility of greater autonomy, choice and control of persons with disability is of immense significance under the NDIS.

3.2 Principles of a Person-Centred Plan

The ‘person-centred planning’ approach is characterised by:

- not being assessment or individual service (ISP) or programme planning (IPP). Assessment as ISPs and IPPs are usually about questions such as ‘eligibility’ and ‘how to fit’ a person into a particular service or programme or service system. The focus is mainly on ‘what’s on offer’. ‘Person-Centred Planning’ is about the goals and aspirations of the person; flexibility and responsiveness to their individual needs and circumstances; crafting or helping them to develop a vision of a life of greater opportunity and participation in the broader community and mainstream life; describing what actions or tasks need to be completed to do that, or at

least make positive changes in that direction along with allocating responsibilities for doing that; and, a 'focus' on the person and their goals, aspirations, capacities, strengths and concerns;

- listening, understanding, exploring and addressing what the person sees as 'core' issues for them; how they would like their life, situation and circumstances to change; and what is needed to do that and identifying who will support them;
- identifying and exploring options with the person inclusive of not only 'what currently' exists as specialist or mainstream services but what 'could exist' or be created;
- mobilising and drawing on those 'key' allies - family, carer, friend, service representatives that are willing to help and support the person, advocate and facilitate changes for them;
- the person and their 'key' allies committing to the process of 'person-centred planning', to take the actions agreed, to constantly review and monitor progress and outcomes;
- a recording system so that on an on-going basis:
 - changes to what is important to the person can be recorded along with the lessons learnt;
 - what balance has been worked out between 'important to' and 'important for' the person can be noted when they are in conflict and reconciled where possible;
 - what others are expected to know or come to appreciate about what is important to and for the person and are expected or have agreed to do how and by when can be captured;
 - what needs to change and what doesn't and whether the changes made are positive and making a real difference can be considered.

A truly 'person-centred plan' is a unified plan, embodying services and supports (natural/informal, specialist and general or mainstream). It comes from a process of determining real-life outcomes for a Focus person and their families which involve the development and implementation of strategies to achieve the outcomes and goals identified. The process supports the Focus person's strengths, capacities, abilities and recovery objectives. Person-centred planning can and should help to provide the person with the ability and capacity to be 'in-command', to exercise informed choices and control, enjoy social and community inclusion, be self-determining, and at the same time enjoy wellness and health.

The Plan is based on what is most important to the person as identified by the person, and as necessary, seeks to provide an appropriate balance when conflict occurs. The Plan captures the self-identified goals, objectives and aspirations of the person and sets out the role and responsibilities of his/her circle of team members who participate in the planning process and offer their support.

The Plan captures long term and short term goals and objectives, including information regarding continuation, modification or termination of a goal, objective or aspiration due to changing situations and circumstances. The Plan covers natural (eg. family/ friend) supports as well as specialist and mainstream support.

The Plan considers what is working and not working – what can stay the same and what needs to change. It can also include a section on 'personal situation support'.

The Plan itself, once developed, is not an **outcome**. The outcome is implementing the Plan to help the Focus person achieve a contributing life.

There are a number of 'key' values and 'principles' that form the foundation of a person-centred planning approach. These include that person-centred planning:

- 3.2.1 builds on the person's strengths, gifts, skills and abilities, goals, objectives and aspirations;
- 3.2.2 supports personal empowerment through choice and control, and provides meaningful options for the person to express preferences and make informed choices (assisted and supported as needed to do this) in order to identify and achieve their hopes, goals and aspirations;
- 3.2.3 is a framework for providing services, supports and interventions that meets the person's needs, and that honours the person's goals and aspirations for a lifestyle that promotes dignity, respect, independence, mastery and competence;
- 3.2.4 supports a fair and equitable distribution of financial and system resources;
- 3.2.5 aims at creating community connections (ie. social inclusion and citizenship) and hence encourages the use of all natural/informal supports as well as those from specialist and mainstream services to assist in ending isolation, disconnection and disenfranchisement by better engaging the person with their community and their community with the person;
- 3.2.6 sees the person in the context of their culture, ethnicity, language, religion, sexuality, gender identity and all of the elements that compose the person's individuality and their family's uniqueness is acknowledged, respected and valued in the planning process; and,
- 3.2.7 supports mutually respectful partnerships between the person, their family/friends and service providers/professionals and recognises the legitimate contributions of all parties involved.

3.3 The Difference with Person-Centred Planning

There are many ways to describe the difference of well-executed and implemented person-centred planning approaches from those often assigned or ascribed to traditional approaches. The comparisons will always appear to shed a negative light on the traditional practices. That is a wrong interpretation as practices are always evolving and changing.

'Person-Centred Planning' provides some things that other approaches do not provide the person:

- a chance to take stock of their lives, their situation and circumstances, their quality of life;
- an opportunity to explore their strengths, capacities, achievements in life thus far and their current goals and aspirations for the future and the possibilities open to them;
- a chance to identify what is working for them, what isn't working for them, what needs to change and how they might need to change;
- a chance to identify and recognize who are the people that are most important to them;
- an opportunity to bring those important people together with them to assist and support them as needed to make decisions about 'where to go from here to achieve what is important to them and for them';
- a chance to set their own goals and offer the opportunity to their family, friends and supporters to assist them;
- explore opportunities, identify choices, make decisions for themselves; and,
- it is an opportunity to advocate, seek and pursue the provision of services and support that they have greater choice and control over and which will improve their life.

With support for people with psychosocial disability the differences could be described as follows:

Traditional Approaches	Person-Centred Approaches
Self-determination comes <i>after</i> individuals have successfully used treatment to achieve clinical stability	Self-determination and community inclusion are viewed as fundamental civil rights of all people
Compliance with practitioner’s instructions and recommendations is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have access to the same information and information is shared readily between them
Disabilities, deficits, dysfunction, and problems drive treatment. Focus is on illness.	Interests, abilities, and personal choices define supports. Focus is on promoting health.
Lower expectations of patient.	High expectations of person.
Clinical stability is valued	Quality of life is valued
Linear progress and movement through an established continuum of services is expected	Person chooses from a flexible array of supports and/or creates new support options with team
Primary emphasis is on professional services	Diverse supports (professional services, non-traditional services, and natural supports)
Facility-based settings and professional supporters	Integrated settings and natural supporters are also valued

3.4 The Process of Person-Centred Planning

3.4.1 Person-Centred Thinking

‘Person-centredness’ and ‘person-centred thinking’ can be thought of as a philosophy, a way of thinking or mindset which involves viewing, listening to and supporting a person with a disability based on their strengths, abilities, aspirations and preferences as they seek to make decisions to pursue a life which is meaningful to them. Such a mindset or way of thinking is essential to the development of a ‘person-centred plan’ and the provision of ‘person-centred support’. If a ‘facilitator/planner’ or a service provider or the Focus person’s family, friends and supporters haven’t got that mindset and the necessary values and beliefs then don’t bother trying to do ‘person-centred planning’. Such a mindset and commitment can require a lot of training and support before even starting the process below.

Person-centred planning’ is a process and the Plan is not an outcome. It enables the Focus person, (and others) to identify what is important to them, and the ‘who, what, how and when’ actions to be taken to better the person’s life, situation and circumstances.

The important thing is that the Focus person is surrounded by a team of allies, family members, his/her friends, service providers/professionals and other supporters who know the person well and are sufficiently concerned to assist the person in their future life. The Focus person should choose their allies and be assisted and supported as necessary to do so.

Depending on the communication strategies and needs of the Focus Person, documentation of a person-centred plan should be meaningful to the Focus person. It could involve drawings, a video, or something more formal. It could set out who the participants were (ie. the person, his/her family members and friends, neighbours, service provider representatives and professionals, advocates, guardians and financial managers etc.). The Plan could have a 'signature' page attesting to the support of any Facilitator/Planner involved and the Focus person and meeting participants.

3.4.2 Documenting the Plan

The following is a minimalist 'Formal' example of what Person-Centred Plan would generally look like or contain. Its focus is on what the person aspires to in life and what those who know him/her best may contribute. Its concerns itself with what is working and not working, what is important to the person and for them, what needs to change, and the person's goals and aspirations.

Such a plan includes a One Page Profile and an Action Plan. Together they provide:

- a great description of how the person wants to live their day-to-day life both now and in the future;
- what that person's goals, aspirations, desires and even dreams are;
- what is working and what isn't working or is absent from their life;
- who will assist them, what they will do, how they will do it and by when.

3.4.2.1 The One Page Profile:

Building a One-Page Profile of the Focus person is the starting point. It involves the Focus person and his/her supporters discussing and articulating **what their capacities and strengths are**. It focuses on the person's attributes and abilities rather than deficits. It presents the person in a way that they would like to be seen and hence is a 'capacity' view. Such a view is essential to guiding the person in overcoming barriers to social inclusion, choice and control, self-determination and community participation. The profile needs to begin with a positive focus on the person – his/her gifts and skills, not focusing on his/her perceived deficits or shortcomings. The approach is to take a 'capacity' view in a planning process that belongs to the person.

What is 'great' about the person is central. The person could/should be asked "what is great about you?", "what are you especially good at?" "What do people who know you say what is special or great about you?"

The same questions about the person could/should be canvassed with the team's/meeting's participants along with other questions such as "what makes the person who he/she is?".

What is important to and for the person is about what the Focus person discusses through words or actions, is what matters to them. This is a listing of what the person tells by words or actions is important to him/her or what really matters to him/her. This may be balanced by or need to be balanced by what objectively and critically is important for the person. What is important to the person should however, generally out-weigh what is important for them

Identifying what's working and what's not working for the person is a collection of issues, events, or matters that have been identified by the person, their family and supporters. Here, the considerations include what needs to change for the person and what can remain the same, as they pursue their 'Recovery' goals, objectives and aspirations.

This is the crucial part as it identifies what the person and his/her team members/participants see as what is working but possibly could be enhanced or stay the same; what is not working in the person's life and needs to be changed; and, what is missing in terms of the person's goals, desires and aspirations and should be put into place or aspired to in the short or longer term.

How best to support the person follows and this is a collection of ways to support the person in staying in a healthy and well state while accessing the community and friends in a way that makes sense to them as well as doing so in a way that stays in balance with the things most important to them. This is a balance between what is important to a person and what is important for them. This is a statement about how the Focus person believes they can be best supported. It is what is agreed with the person will work, keep them healthy and well, in a way that makes sense to the person and in a way that will balance what is important to them and what is important for them.

3.4.2.2 The Action Plan:

The One-Page Profile is then turned into a plan of action focused on:

- what is working and needs to remain the same or be enhanced; and,
- what is not working and needs to change or which is not happening and needs to be created/developed.

The Action Plan identifies potential services (natural/informal and specialist/professional as well as mainstream that the person may draw on, plus services and support that may not yet exist and need to be created, plus any other support and assistance or options to meet the goals, desires and aspirations of the person).

The Action Plan needs to consider but not necessarily place primacy on views of specialists/professionals. Any concerns about health and safety expressed by family members and others in terms of perceived 'risk' of greater social inclusion, community participation, self-determination and choice and control by the person need to be discussed.

The goals, objectives and aspirations in an Action Plan are however, those of the Focus person and not of any others.

Long Term Outcome: This is what the person aspires to achieve within a 12 month period or beyond as noted in the One-Page Profile.

Where the Person is at Now in terms of achieving/reaching the Long Range Outcome: This is where the person is at now, what his/her situation and circumstances are, how he/she wants things changed and how he/she can be assisted with others to do that.

What needs to be done now, how it is going to done, by when and who (which person/s) is/are responsible: This builds on "what is Important to and for the person" and "what is working, not working or is missing" and the "How Best to support the Person" in the One-Page Profile. This is about what needs to done, who is going to do it, how they are going to do it and by when. It is

about the tasks/steps/actions needed to be taken to assist and support the person to attain his/her Long Range Outcome.

It can identify small steps and short term goals to build confidence and provide positive feedback. It specifies what the person themselves are going to take full responsibility for doing and what each other team member/participants is asked by the person and agrees to do. It sets out timeframes for action and progress review dates.

3.4.2.3 Personal Situation Support Plan:

The path to recovery for a person with a psychosocial disability that can arise from a psychiatric disability or mental illness is often described as being 'non-linear' (ie. the person may take 2 steps forward and then 1 step back and need to regroup). Sometimes additional supports may be required. The person will usually be able to identify what additional supports they need and when they need it.

This Plan aims to prevent health and wellness issues from arising. It considers what may occur, what makes such an occasion important to address, what such an event would look like, the likely impact/s on the person and others in terms of severity and how it should best be managed or responded to and who should do that.

Significant Events: Health and wellness issues should be identified and listed along with any physical or psychological issues that could increase or give rise to a person's vulnerability to them. The person's description (if appropriate) of their behaviours which may lead or give rise to a personal situation arising should be given, inclusive of any particular social, situational, environmental or other factors which contribute and of actions which can be taken to ameliorate or calm (de-escalate) the situation for the person.

What has worked previously: This involves a listing of the skills that the person has previously used during the lead-up to any similar events and what has worked or not worked. The strategies and the learning from them need to be identified to enable appropriate supports to be provided.

Supports for personal situation response: Based on the knowledge of the person and their family and supporters this involves a description of the supports required during periods of personal situation and problem resolution.

Back-up Supports/Protocols: This includes a listing of who/what services or persons should be contacted in the event of a personal situation for the person. They could be particular family members, friends, neighbours, service providers etc. Advice should be provided about what has been learned by from previous personal situations experienced by the person, their resolution and the actions that should be avoided.

Any Specific Recommendations: This includes information for any additional support or service persons that may be required as such persons may have had no previous contact with the person. Specific detailed information should be listed about the supports that have proven effective or helpful in working through any previous events. If there are things that should be done immediately, then they should be outlined.

3.4.3 Review, Reflection and Revision

This is an essential component. What has been learned; what strategies and agreed actions aren't working out as anticipated; what needs to be reconsidered; what is causing the failings to achieve

the changes/services aimed for; what could/should have been done better; how could/should it have been done better etc.

Updating of a 'person-centred plan' can be done whenever is needed due to changes in the situation and circumstances of the Focus person, problems with implementation of the agreed actions and strategies. Such revision then feeds back into 'on-going Learning, Review and Reflection'.

A person-centred plan is a living document which needs to be reviewed and updated due to changing situation and circumstances and goals and objectives of the Focus person plus any problems arising with the agreed tasks and actions allocated to themselves or other team members/participants.

Times of 'transition' (eg. from school, to employment, to living somewhere else etc.) may necessitate changes in team members/participants and changes in strategies or directions.

3.4.4 Privacy and Confidentiality

It needs to be recognised that the Plan is the Focus person's Plan and not anyone else's. Clear rules about who can access the 'person-centred plan'; whether it can be copied or distributed in any way to specifically identified persons or organisations and the reasons for that need to be established and agreed with the Focus person. In some circumstances however, the law may permit certain disclosures and sharing of information. The NDIS Act details some permissible uses of Plan information by the Agency.

3.5 An NDIS Person Centred Plan

The NDIS environment as demonstrated by its principles closely reflects person-centred planning and recovery approaches. Such an environment has however, its own requirements. To meet those, some changes are needed to the more standard approaches and documentation. Aspects of the NDIS considered relevant to the planning exercise are presented in Appendices 4 and 5 below.

What follows here is a 'One Page Profile' of a person-centred plan that could serve as a Statement of Goals and Aspirations preceded by some introductory information. The headings below are provided as prompts for information, as these guidelines do not attempt to provide any proforma for Planning. They do however, seek to provide an outline of the information that the NDIS Launch Transition Agency would require in a Participant's or Prospective Participant's Plan.

Depending on the communication needs of a person, his/her Plan could involve drawings, diagrams, pictures, a video, a nicely typed and signed document or whatever is needed. The NDIS Launch Transition Agency will however, require a written Plan which could be transcribed and interpreted from the original format.

The following is of necessity focussed on the NDIS Act requirements but it is not exclusively focussed on those. Person-Centred and Recovery Planning is about the person and their path or journey to achieving their goals, objectives and aspirations.

Note: The words in small print next to headings are those items specifically required by the NDIS Act to be included in a Plan.

Introduction

Your Details:

This would include your identifying details such as who you are, your date of birth and your contact details such as address, phone etc.

Your Facilitator/Planner:

This would be the name and position of the NDIS Launch Transition Agency facilitator/planner who has assisted you to develop your Plan.

Your Nominee if Applicable:

This would be the person either appointed by the NDIS Launch Transition Agency at its own discretion or following a request from you to have someone represent you at a planning meeting/s.

Who are the members of your Planning Team?

This could include family members, friends, advocates, service provider representatives etc. They would be persons important to you and who know you well.

The Planning Meeting/s:

This would include the date/s of your planning meeting/s.

Additional Information:

This would include any relevant assessment reports or other information that you have to support your Plan request for assistance under the NDIS(or Disability Care Australia) and to demonstrate that such assistance or funding is reasonable and necessary to be provided.

Statement of Goals and Aspirations (required)**What are your strengths, the things you do well?**

This is a chance for you and your supporters to express what you and they think is great about you, what your strengths are, what you bring to their lives and what they initially think could add to your life and build on your capacities.

Where are you now? (Your living arrangements)

What are your living situation and circumstances? Are you living with family or friends, on-the-street, in public or social housing, private rental, boarding house, home-alone or sharing etc.

What support and assistance do you receive? (Informal community supports and other community supports)

What assistance and support do you receive? Is it from family and friends? If there are other persons/organisations then who are they and what do they help you with and how often?

Do you go out, see friends and family, go to work? (Social and Economic Participation)

Do you see the same people every day? Do you see friends and family? Do you go to work or volunteer? Are you a member of a social or sporting club? What exactly do you do each day, each week or each year? How would you describe your life?

What do you want to do? Where do you want to go with your life? What are the most important things to you and for you? (Goals and aspirations)

This is about what is good or bad about your life and what you want to change as something is either not working or is missing in your life. It is about where you want to go, what your goals, objectives and aspirations are, what is important to you and for you (ie. what you need as well as what you want). It is about 'I want a job; I want to get out and about in the community more; I want to see more of my friends and make new ones; I want to see more of my family; I want to go here and there; I want to choose what I eat and when'. None of what you want to do each day, each week or in your lifetime needs to involve really BIG things (but it can involve those), as often the smaller things may be really important to you. It is also about what you need to survive (ie. personal care assistance, help with transport, a roof-over-your-head, people to talk to, your medication adjusted etc. Where do you want to be in 6 months, 12 months, 5 years time? What is most important to you now and in the future.

Can we help?

This is a collective statement of the ideas of both you and your Planning Team members about what is needed to help you to achieve your goals, objectives and aspirations.

The 'Action Plan' of a 'person-centred' would in part be substituted for a **Statement of Participant Supports**.

Statement of Participant Supports (required)

Where do you want to go?

This specifies more clearly and specifically your goals, objectives and aspirations. It establishes the pathway or road to doing so and the helpers you want to have with you along the way. It includes, or could include where you would hope to be in 6 months, 12 months or a few years time and what your life, situation and circumstances would then be or look like.

Where are you at now?

This is about what you have tried or not tried yet to achieve your goals, objectives and aspirations. Are you getting somewhere or just starting? What hasn't been tried or done yet? It is about how you want things to change and how you can be assisted and supported to do that.

What needs to be done:

What are the things that need to be done? What support and or assistance, services or support do you need to get there? Such supports could come from your family and friends, advocates and others as well as from funding under DisabilityCare Australia. These actions or things that need to be done must be SMART (ie. sensible, manageable, achievable, realistic and time-framed).

Who is going to assist you?

This is about who among your Planning Team Members is going to do what, when, how and by when to take the needed actions that lead towards you achieving your goals, objectives and aspirations.

What assistance and support would not require funding? (required)

This is about what services and assistance for you would be provided by family, friends and others without funding under DisabilityCare Australia.

What is the assistance and support that you want the NDIS/DisabilityCare Australia to fund? (required)

This identifies what you actually need funded as reasonable and necessary supports to meet what you need to survive each day and what you need to help you meet your goals, objectives and aspirations. It is about what is important both for you and to you. It is not a 'wish-list'. The NDIS current Draft Rules concerning 'mental health' provide the following examples of what may be funded/supported:

- *support for community (re)integration and day-to-day living including assistance with planning, decision-making, personal hygiene, household chores, financial management, tenancy support, transport and non-clinical residential accommodation;*
- *allied health and other therapy directly related to managing or reducing the functional impact of a person's psychiatric condition on undertaking activities of daily living or social and economic participation, including social and communication skills development, and behavioural and cognitive interventions;*
- *support in helping a person to independently access and maintain participation in mainstream community resources, including recreation, education, training and employment, and primary health care, where the support is needed to address barriers relating directly to functional impacts of a participant's condition;*
- *community supports aimed at increasing a person's ability to live independently in the community or to participate in social and economic activities, including in-home and centre-based care, recreational activities, day centre services and holiday care, and community access (including life skills and social skills day programs).*

Other Information:

Do you have any other information such as assessment reports about the 'reasonableness and necessity' of the supports that you want funded and why they will assist you to meet what is important for you (to live your life) and important to you (to achieve your goals, objectives and aspirations)?

You may want to manage your Plan yourself, use a registered plan management provider, or nominate a 'plan nominee' (ie. some other person that you feel confident in) or request that the NDIS Launch Transition Agency do it for you. You don't have to make any request but if you don't, the Agency will manage your approved and funded supports for you or possibly appoint a 'plan nominee' for you or use a registered plan management provider. Making such a request requires you to have enough information available to you to make an informed decision. The Agency should ensure that you can make an informed decision.

Personal Situation Support Plan

Although not required under the NDIS Act or the Draft NDIS Rules it seems to make sense for persons with a psychosocial disability undergoing the often difficult process of recovery to have provision in their Plan that seeks to prevent or mitigate any personal situation event that may arise. The NDIS Act and the NDIS Draft Rules mention 'risk' on a number of occasions. A fuller explanation is given at 3.4.3.3 above.

Significant Events:

You should identify and list any potential health and wellness issues along with any physical or psychological issues that could increase or give rise to your vulnerability to them. A description (if appropriate) of any actions which may lead or give rise to a 'personal situation for you' should be given, inclusive of any particular social, situational, environmental or other factors which contribute and of actions which can be taken to support you. It may mean that at certain times you may want additional support.

What has worked previously:

This involves a listing of the things you have previously used, and what has worked or not worked. The strategies and the learning from them need to be identified to enable a personal situation for you to be prevented.

Strategies for Personal Situation Response:

Based on your knowledge and that of your family and supporters this involves a description of the strategies supports used during periods of personal situation and problem resolution.

Back-up Supports/Protocols:

This includes a listing of who/what services should be contacted if you need extra support. They could be particular family members, friends, neighbours, service providers etc. Advice should be provided about what has been learned by from any previous personal situations and their resolution and the actions that should be avoided or are not helpful to you.

Any Specific Recommendations:

This includes information for any additional support or service persons that may be required as such persons may have had no previous contact with the person. Specific detailed information should be listed about the type of approaches, interaction and involvement that has proven effective or helpful in working through any previous events. If there are things that should be done immediately, then they should be recommended.

Review, Reflection and Revision

There is no point of having a Plan if you don't learn and reflect on its outcomes. What has been learned; what strategies and agreed actions aren't working out as anticipated; what needs to be reconsidered; what is causing the failings to achieve the changes/services aimed for; what could/should have been done better; how could/should it have been done better etc are essential matters to consider. Your Plan needs to be a 'living document'.

Updating your Plan can be done whenever is needed due to changes in your situation and circumstances; goals, objectives and aspirations; problems with implementation of the agreed actions/strategies; changes to your Team Members. Such revision then feeds back into 'On-Going Learning, Review and Reflection'.

*The NDIS Act and the Draft NDIS Rules don't as yet specify when your Plan should be reviewed. You can change your **goals and aspirations** at any time, however, doing so means that you will have to replace your Plan with a new one which will involve your changed goals and aspirations and with the existing **statement of participant supports**. You can request at any time that the CEO of the Agency review your Plan but there is currently no annual or other required timeframe for such a review to be done.*

3.6 The Role of a Facilitator/Planner

The role of such a person, irrespective of whether they are called a 'Facilitator' or a 'Planner' is that of simply 'Facilitator' of a Plan of action developed by the Focus person with his/her family and supporters (ie. a 'person-centred plan').

3.6.1 The Characteristics Required

To that end, the 'Facilitator' needs a range of skills, abilities and the appropriate mindset, values and beliefs associated with 'person-centred planning'. The facilitator is one who:

- has an understanding of and commitment to recovery oriented practice;
- is totally objective;
- is trained to have a good understanding of 'person-centred planning' approaches and is committed to them;
- is committed to and fully supports 'person-centred planning';
- understands and can implement the techniques of 'person-centred planning':
 - being able to support the Focus person;
 - help the Focus person identify and invite appropriate group/team members;
 - can create a welcoming and supportive environment;
 - has good graphic and group facilitation skills.
 - can foster commitment and support from the participants for the Focus person and the process and action plan
 - is non-judgemental, a good listener, self-confident, flexible, genuine and hospitable.

The facilitator must assist the Focus person to lead a process. Therefore the facilitator:

- knows how to facilitate a 'person-centred plan';
- can actually 'pace' a meeting and its progress to suit the needs of the Focus person and the participants;
- uses good listening skills;
- uses 'team work' to achieve progress;
- can resolve conflicts as they arise;
- uses consensus building;
- fosters self-determination by the Focus person and ensures that the Plan is focussed on them, is their Plan and created **with them and not for them**;

- can build relationships with participants/team members so that they will be open, honest, forthright, and really participate in the process and in the action plan's development and implementation;
- can help the Focus person and participants work through the necessary on-going learning, review and reflection process to see the successes and accomplishments and possible failures of action/s in positive terms.

3.6.2 Practitioner Concerns

Although there has been an increasing involvement of consumers and their support people in shaping developments in disability service practice such as recovery and person-centred planning approaches, obstacles have been encountered in achieving this. A number of professionals/practitioners have frequently questioned the ability of people whose insight has been affected by illness or disability to play a role in planning their own care and support, and in exercising greater choice and control over their lives.

Person centred (and recovery) approaches to psychosocial disability are however, at the forefront of behavioural transformation of professionals and service providers, yet how to implement these approaches raises questions for them. The following are ten concerns (with rebuttals) frequently raised by those professionals and service providers in the context of the provision of recovery and person-centred planning approaches. The terms 'professional' and 'practitioner' are not mutually exclusive and can in some cases include staff members of specialist disability services, psychologists, medical practitioners and psychiatrists.

3.6.2.1. Does emphasizing person choice inevitably devalue professional/clinical knowledge and expertise?

Person-centred care planning for any person with a disability does not require professionals/practitioners or service providers to do whatever the person wants. Ideally, person-centred care planning evolves within a collaborative relationship in which decision-making is viewed as shared between the person with disability and professionals/practitioners and service providers. Within the context of such a partnership, each party has its respective role to play.

Professionals/practitioners assess, evaluate, diagnose, educate, inform, and advise the person and his or her supporters about the possible courses of treatment and rehabilitation available for whatever ails or is disabling the person, including the relative benefits and drawbacks of each approach. Professionals/practitioners then provide and even deliver what they are competent to provide based on the nature of the person's situation and circumstances. The person, in conjunction with his or her supporters (to whatever degree he or she wishes) makes decisions about what treatments, interventions, services, and supports make the most sense within his or her life context, given his or her values, needs, preferences, and goals. It is no more appropriate for the person to assume the role of professional/practitioner than it is for the professional/practitioner to assume the authority to make the person's decisions for him or her. It is the right, and ethical responsibility, of professionals/practitioners to offer the best assistance and support that they can. Yet it is also the person's right, except in few exceptional circumstances to make his or her own decisions about what recommendations, interventions, services, or supports he or she will use in his or her recovery.

3.6.2.2. Should person-centred care planning be the responsibility of non-clinical professionals/practitioners?

It is certainly true that not every disability/mental health professional/practitioner can or should be proficient in every aspect of the care or lived experience of persons mental illness and the

psychosocial disabilities that can arise from it. Some professionals/practitioners were trained to diagnose disease and treat illness, while others may have been trained in job and community resource development or in cognitive-behavioural psychotherapy. The question is not so much one of what any given professional/practitioner was trained in, however, as much as what the person receiving care and support needs, wants, and can benefit from. Person-centred planning provides the overarching framework within which any of these specific interventions or treatments becomes relevant to the person's life. Otherwise, the professional/practitioner is trying to provide services to someone who may have no interest in, or reason for, receiving them.

Offering people services they do not want has often occurred in mental health where the attainment of "clinical stability" has been framed as the ultimate goal rather than as a means to an end. The concept of recovery is the antithesis of that approach. For example, a person living with bipolar disorder may wish to be the best parent that they can be, yet symptoms of mania may have led them to behave in a manner that frightened their children and alienated their partner. A traditional care plan might focus exclusively on the clinical goal (e.g., compliance with medications and reduction of mania) with little, or no, mention of the person's ultimate goal of reunification with their family. This lack of connection between treatment and personally valued life goals is one reason why attrition and drop-out rates are so high in outpatient mental health care.

For professionals/practitioners to offer more responsive and individualized care, the planning process needs to be shaped by the person's life goals rather than by the professional's/practitioner's specific training or professional discipline. Simply put, in a person-centred system, we no longer have a clinical or treatment goal that exists independent of a meaningful outcome in a person's life. The goal on the treatment plan – whether one is a supported employment specialist or a psychiatrist – is the same, e.g., the person wants to get a job. Each professional then assists the person based on his or her unique skills and training, with a supported employment specialist offering job development and coaching and the psychiatrist prescribing effective medications at a suitable dosage to control the psychotic symptoms that interfere with the person's job performance without making it impossible for them to get out of bed in the morning.

In order to create these types of person-centred care plans, clinical and medical and other professionals will need to know more about the person's overall life context and everyday experiences, and will need to place treatment and other interventions within this context. For a psychiatrist, for example, to expect a patient to accept being diagnosed with a psychotic disorder, it will be incumbent upon the psychiatrist to explain how this diagnosis helps the person to make sense of his or her own experience and how it accounts for some of what has gone wrong in the person's life. Similarly, to expect a patient to take prescribed medication, it will be useful for the prescriber to connect the taking of these medications to potential improvements in his or her daily life. Failing to address the person's everyday life concerns, and continuing to treat the illness as if it took place in a vacuum, perpetuates the narrowly defined, professional/practitioner-driven model of care that people with mental illnesses (and the psychosocial disabilities that can result), routinely identify as a major barrier in their recovery and their ability to benefit from the services being offered.

3.6.2.3. Isn't care and services planning already person-centred?

"We already take the person into consideration". This is not the same, however, as offering person-centred planning. In addition to listening empathically to the person and tailoring the support one provides to each individual, person-centred planning involves the use of new tools and strategies that professionals/practitioners may have some familiarity with, but which generally are not employed routinely in practice.

These include comprehensive and structured interests and strengths assessments; the inclusion of the person's natural supporters and legal representatives (eg. guardians and financial managers) in the planning process; articulation of clearly defined short- and long-term personal goals with measurable objectives; assignment of responsibility for different tasks and action steps to different members of the team, including the person in recovery; prioritization of natural, integrated settings over those designed solely for persons labelled with serious mental illnesses leading to psychosocial disability; assisted or supported decision-making aids, and supported employment, housing, socialization, and education coaches.

Thus, while many professionals/practitioners strive to attend to each person as a unique individual, there are many strategies and tools (some new, some long-standing) that are under-utilized and whose consistent use in practice could significantly advance the implementation of a more person-centred model of planning. Examples of this model are implied in such questions as: How do you determine what interests the person has that he or she might like to pursue? Does the person have the option of running the planning meeting? Do you automatically offer a copy of the plan to the person you're working with? How often are natural supporters included in the meeting when desired by the person in recovery? How often are the person's roles and responsibilities articulated in the plan along with the services to be provided by professionals/practitioners?

3.6.2.4. Doesn't accreditation, reimbursement and accountability drive care and support?

Often in practice, the service and treatment plan is a technical document that has to be completed to satisfy accrediting or reimbursement bodies (eg. Medicare, Private Health Insurers, funding bodies such as DADHC etc.), and is useful neither to the professional/practitioner nor to the person receiving services. In such cases, the plan is completed and filed in the medical record or another filing cabinet and plays little, if any, role in actually guiding care and support. It is doubtful whether anyone involved would argue that this is an ideal way of providing care and support or occupying the time and talents of dedicated professionals/practitioners. While this is the unfortunate reality of most treatment or support plans written in today's mental health and disability support systems, it can be proposed that the truly person-centred plan – one created through a process of partnership and shared discovery - has the potential to be a powerful transformative tool. Rather than being a bureaucratic document that takes time away from the real work of direct person care, creation of the person-centred plan is an intervention in and of itself, as it becomes the very heart of the work and the recovery process.

Person-centred planning emphasizes the need for the professional/practitioner and person to enter into a collaborative process of exploring and identifying the goals and objectives that will promote the person's recovery and increase his or her quality of life. The person-centred plan is a road-map for pursuing the person's valued life goals, and the milestones which are achieved along the way (i.e., short-term objectives) serve to give both the professional/practitioner and the individual the critical experiences of success and forward momentum needed to continue on the road ahead. In this sense, the plan becomes a useful tool that has direct relevance in guiding the work of the team over time.

It can be consulted as needed in order to ensure that all parties stay on course, and revised as often as needed if the person encounters barriers or roadblocks along the way or reaches certain landmarks and wants to set a new destination.

A quality person-centred plan not only depicts the short and long-term destinations, but also explicitly identifies the role of all team members in contributing to the process. Supports are thought of broadly and include specific action steps for the professionals/practitioners involved as well as for the person in recovery and his or her natural supports. Thus, the person-centred plan is

an important tool that promotes accountability among all stakeholders as both tasks and timelines are clearly spelled out. The potential impact and value of the written planning document is further magnified when this document is offered in hard copy to the person in recovery (an essential practice in person-centred planning). This is not only an important symbolic gesture offered in the spirit of partnership and transparency; it also serves to activate the person in the day-to-day work of his or her recovery process. The written plan, while a valuable tool for setting a course and reflecting on progress, is only one piece of the picture. Equally, if not more, important is the process behind the development of the plan.

3.6.2.5. Can people with serious mental illnesses and psychosocial disability be relied upon to want to make changes?

Most people do not live their lives explicitly in terms of “goals.” We may have dreams and aspirations, but often we do not take the time to break these down into the various steps that will be required for us to pursue them. So, while many people with serious psychosocial disabilities will not have explicit goals, and may well not know how to answer questions that ask them about goals, they nonetheless will have ideas about what could make their lives better. Do they, for example, want to work and make money? Would they perhaps like to have a better place to live? How would they prefer to spend their time on a day-to-day basis? What gives them pleasure or a sense of success? This type of dialogue differs significantly from the more restrictive conversation in which the ‘subject’ is expected to merely report on symptoms and side effects, or patterns of eating, sleeping, and taking medications. Using strength-based inquiry to inspire hope and to support people in goal-setting is a process that requires both professional/clinical skill and perhaps a willingness to step outside the comfort zone of our inherited professional discourse.

For many people receiving public psychiatric/disability health services, it may also at first feel dangerous to allow themselves to dream once again — with so many of their previous dreams having been abruptly interrupted by illness or dashed by the legacy of the low expectations we have had for persons with serious mental illnesses and the psychosocial consequences that can arise. Based on these experiences, individuals living with prolonged conditions may initially report that they have no goals or aspirations. Recovery is a difficult concept to accept for some persons. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted and the psychosocial impacts arising from a mental illness.

Over time, it is not uncommon for people to lose touch with the healthier and more positive aspects of themselves and become unable to see a future beyond the “patient” role. When facing such circumstances, professionals/practitioners need to conceptualize one of their first steps as assisting the person to get back in touch with his or her previous interests and talents and to draw upon these to imagine a brighter tomorrow.

Helping people to figure out what is possible in relation to these different areas of life at any given time, and how to negotiate or make compromises among various goals, is a task for which professional/clinical skill and experience can be extremely useful.

3.6.2.6. Doesn't the emphasis on using evidence-based practices contradict the principles of person-centred care?

Person-centered planning does not mean simply giving a person whatever he or she wants. Instead, it requires professionals/practitioners to take into account, and to base the services they provide, on a collaborative decision-making process in which the person plays a central role. Rather than being

in conflict with evidence-based practice, this emphasis on the person's own values, goals, and preferences is perfectly in accordance with the principles of evidence-based approaches, that all adults have the right to make their own decisions. It is for this reason that evidence-based research and basic human rights explicitly includes the person's role as decision-maker (including his or her needs, cultural values, and preferences, including the right to defer decision-making to others) as one of the three components that the professional/practitioner has to consider (the other two being the available scientific evidence and the professional's/practitioner's accumulated knowledge base and clinical experience).

Since the person is free to (and in one way or another, will, except in very limited situations) ultimately make his or her own decisions, it behooves professionals/practitioners to accept this fact and to communicate with the person and his or her family in as accurate, informative, culturally and personally responsive, and perhaps even persuasive, a way as possible so as to maximize outcomes. The apparent contradiction between person-centred planning and evidence-based practice is due to confusion, currently prevalent in the field, between evidence-based medicine or practice, on the one hand, and evidence-based practices, on the other. As described above, evidence-based medicine or practice is based on the available scientific evidence, the professional's/practitioner's accumulated knowledge and experience, and the person's choice. Evidence-based practices, on the other hand, are those interventions for which scientific evidence exists attesting to their effectiveness for certain conditions or populations. Evidence-based practices may (or may not) be used within the context of evidence-based medicine, depending on the practitioner's clinical judgment, the person's particular conditions and circumstances, and the person's informed choice. Somewhere along the way, evidence-based practice (i.e., what practitioners do) became confused with evidence-based practices (those interventions which have been shown to be effective), leading some in the field to suggest broad-scale and indiscriminate adoption of evidence-based practices for everyone with a select condition (regardless of other evidence and other relevant factors).

Evidence-based practice is not however "cookbook" medicine as it requires a bottom up approach that integrates the best external evidence with individual professional/clinical expertise and person's choice concerning individual person care. Within this context, person-centered planning can be viewed as a technology and strategy for maximizing the effectiveness of the role of person choice in this "bottom up approach."

3.6.2.7. Isn't the first step getting peoples' clinical issues under control?

There are undoubtedly times when people with mental illnesses and resulting psychosocial disabilities want to be taken care of, just as there are times when people who do not have serious mental illnesses or psychosocial disability issues want to be taken care of. In the former case, such times may likely be when they are experiencing acute episodes of illness and/or when they are in extreme distress. Based on first-person accounts of people in recovery, and on the wisdom of various accrediting bodies and laws, however, we are not to take this preference for being taken care of during acute episodes to generalize to the remainder of the person's life. The majority of individuals with serious mental illnesses will spend only about 5% of their adult lives in acute episodes, the remaining 95% of the time being spent in periods of relative symptomatic and functional stability. It is during this 95% of the time that person-centred planning is best carried out for how the person would like to be treated and supported during that 5% of the time that he or she may be too disabled to make his or her own decisions.

For those person's who appear to violate the 95% rule, and/or who may appear to be too disabled to make their own decisions on an ongoing basis, there remains a significant amount of latitude for professionals/practitioners to elicit and be guided by the person's own values, needs, and

preferences. It is equally important for persons with significant disabilities to live with as much choice as possible, even if that choice is based on a restricted range of options due to the individual circumstances. Simple examples of how this principle can be honoured in practice are in asking people in institutional settings how they would like to spend their time, what and with whom they would like to eat, and what activities would give them some degree of pleasure, rather than insisting they first participate in treatment and other activities which have proven not to be effective for them in the past. Even if these core treatment activities did have a proven effectiveness, to expect all persons to rigidly move through a pre-determined continuum of care is, a subtle yet pernicious form of coercion.

Unfortunately, despite the positive changes brought about by recovery-oriented system transformation, it is still not uncommon for individuals to be expected to jump through “clinical hoops” and demonstrate stability before moving on to pursue broader life goals (e.g., requiring 6 months of medication compliance as a pre-requisite for referral to supported employment or dictating a certain compliance level with unit groups before a person is allowed to participate in a hospital’s treatment mall rehabilitation programming).

Engagement in these personally preferred activities is often the factor that ultimately increases individuals’ desire to acknowledge, and begin to work on, the core clinical issues that interfere with progress.

Finally, the consumer/survivor literature has argued that much of what professionals/practitioners view as apathy, passivity, or a lack of motivation to engage in person-centred planning is actually due to “learned helplessness” stemming from years of having other people take over one’s control and decision-making authority for one’s own life. Just as the processes of sharing power and responsibility in planning is a sometimes disconcerting role-shift among professionals/practitioners, many persons with serious mental illnesses and psychosocial disabilities truly want to exert greater control over their lives but feel unprepared to do so. To the degree that this is a contributor to a person not wanting to make his or her own decisions, or to take a backseat in planning, the process of re-instilling a sense of control, competence, and confidence in one’s own decision-making capacity will require time, incremental successes, and the provision of mentoring and skill-building opportunities specific to the process of person-centred planning.

Regardless of how long such a process takes, however, it is most likely true that such a process will not even begin as long as people continue to have others make their decisions for them in the context of a ‘professional-knows-best’ model of service planning. The importance of assisting people to make their own decisions so that they can get better at making their own decisions, and on the failure of good intentions alone to foster autonomy cannot be understated.

3.6.2.8. Do we have the time available to do this properly?

Though disability service funding has significantly improved through Commonwealth and some State/Territory initiatives over the past few years and with the advent of the NDIS, resources will always be stretched, making this seem like an ill-advised moment to advocate for the expansion of person-centred planning which further taxes the time of professionals/practitioners. While conversations regarding goals, dreams, strengths, and aspirations may take more time up front, these conversations are an investment in a collaboration that stands to be timesaving in the long run. With the focus on person responsibility and action, professionals/practitioners can shift from a ‘do for’ or ‘do to’ the person perspective to a ‘do with’, fostering increased independence on the part of the person and a shift toward maximizing natural community connections rather than relying on institutional ones.

Program evaluation findings on person-centred planning models suggest that this approach may also serve to interrupt the reactive cycle of crisis response, leading to reductions in hospitalizations, incarcerations, and assaultive or self-injurious behaviour.

One could argue that the management of these crisis-oriented situations stretches systems and professionals/practitioners far more than the additional time needed to engage in collaborative person-centred planning. Ultimately, person-centred planning may take more time to create than the cookie-cutter documents that still populate many charts in mental health systems around the country. However, this is time well spent and it is a prudent investment in improving the quality of the partnership, and ultimately, the quality of life among persons in recovery.

3.6.2.9. Is person centred care consistent with the concept of “medical necessity”?

The concern is that person-centred planning violates professional roles and identities and is inconsistent with the traditional service/medical model and the regulatory, accrediting, and reimbursing bodies that govern disability/mental health care. This concern is complex, as the issues involved are themselves complex.

In the United Kingdom, United States of America, in Australia and other countries, over the past decades a much greater emphasis has been placed on person-centered and goal-directed care and support. Individually responsive care oriented to achievement of each person’s unique situation and goals has been the mandate in Australia for many years, although often not well articulated. Care and support is expected to be strength-based, culturally competent, and responsive to each individual’s life context. The NDIS provides for this as do many Commonwealth/State/Territory pieces of legislation and strategic plans.

Person-centered planning principles do not translate readily into the categories and concepts of conventional care plans. Were they to do so, it would be questionable how much their introduction actually effects change in the way we provide care and support. Efforts must therefore be made to re-conceptualize plans and documentation tools to become person-centered, strength-based, and goal-directed. Doing so does not minimize the importance of disability, illness, and problems, but does reframe them within the context of the person’s overall life. That said, it is still true that Medicare for instance, currently will not provide reimbursement for certain services or supports that people with serious psychosocial disabilities desire and will find useful. The NDIS Draft Rules for Disability Care Australia are also specific about what can be funded.

Even at the current time, it is common for professionals/practitioners to view regulatory and funding bodies as more formidable barriers to providing person-centered planning than they in fact need to be. Hopefully this will change with the NDIS.

3.6.2.10. Won’t allowing people to set their own goals and make their own decisions increase risk and expose practitioners to increased liability?

Person-centered planning does not override a professional’s/practitioner’s ethical and societal obligation to intervene on a person’s or the community’s behalf should someone pose a serious and imminent threat to self or others. In such cases, just as in the case of an automobile accident or traumatic brain injury, professionals/practitioners are sanctioned to intervene on the person’s behalf without getting prior consent.

In reality, as in most other branches of care and support, however, such cases are the extremes and the exceptions, not the norm. The literature suggests that most people with psychosocial disabilities

arising from mental illnesses pose few if any risks most of the time. Risk can be exacerbated by substance use and by non-adherence to medication, but even then the risk posed by people with serious issues pales in comparison to the risks they face from others, as it is much more common for a person with a serious mental illness or psychosocial disability to be the victim of a crime than to be a perpetrator.

What this suggests is that heightened concerns about increased risk and liability are misplaced when applied to most people most of the time. In the circumstances in which they are warranted, prudent risk assessment and management are central and crucial aspects of effective care. When not warranted, though, they place undue restrictions on the liberty of persons with serious mental illnesses or psychosocial disability.

Issues of risk and liability put aside for the moment, how do we respond to the concern that people with serious issues will still make bad decisions if left up to their own devices? Initial studies in shared-decision making in fact point to the opposite and indicate that people with schizophrenia, for example, make decisions in similar ways as those with other medical issues. Simply put, some people with mental illnesses or psychosocial disability make good decisions most of the time, some make good decisions some of the time, and some make good decisions only rarely; but the same is true of the general population. At this time, the only main legal or statutorily justified way to interfere with an individual's personal sovereignty (other than based on serious and imminent risk to the person or to others) is when the person has been determined to be incapable of making (some of) his or her own decisions by a Court or Tribunal, and therefore has been assigned a legal guardian or financial manager. Even in these cases, in many states a Court or Tribunal's decision needs to (or should) outline those specific areas in which the person is unable to make his or her own decisions. Short of this, the vast majority of individuals with serious mental illnesses or psychosocial disabilities have both the right and the responsibility of making their own decisions and of dealing with and learning from the consequences of these decisions.

Where then does all this leave the professional/practitioner who wishes to support someone in his or her personal choice but fears the person is making potentially detrimental decisions that will jeopardize his or her recovery and well-being; e.g., a person is choosing not to take medications that seem to be helpful or is spending time with someone who has physically abused them or provided them drugs? In these situations, the professionals/practitioners should not sit silently on the sidelines in the name of being person-centred or in the hope the individual will ultimately learn from suffering the "natural consequences" of an apparent self-defeating choice. Rather, in keeping with emerging best-practices in recovery-oriented care, the role of the professional/practitioner in such situations is to remain fully engaged with the person to explore what the choice means and why it is important to him or her; to identify potential pros and cons; to brainstorm alternative choices; and to ensure the person has all the information necessary in order to make an informed decision. But in the end, barring any immediate safety concerns, it is the person's decision to make, just as it is for any other person.

Following the type of collaborative dialogue described above, the person, in fact, might arrive at a different decision that both parties are comfortable with. However, there also will be circumstances in which the person and the professional/practitioner may need to "agree to disagree" moving forward. In these circumstances, some professionals/practitioners have expressed concern that they are exposing themselves to liability or failing to meet their professional or clinical obligations, if the issue at hand is not identified in writing as an active problem area or treatment goal on the recovery plan.

Rather than putting oneself at odds with the person by insisting the issue become the focus of the planning process (e.g., substance abuse, medication non-compliance, etc.), the professional/practitioner is encouraged to document fully the conversation in their records, capturing both perspectives in writing in the person-centred plan, making clear the person's position as well as that of their supporters and their own efforts to communicate these concerns and to provide necessary support and information. While each and every situation must be evaluated on a case-by-case basis, this represents a balanced approach which both respects the individual's right to make decisions and professional's/practitioners' desires to ensure they have done their due diligence and upheld their professional obligations.

The acceptability of risk is and will remain a big issue for many professionals/clinicians and families and carers. Many people hold firmly to the belief that a person with a mental illness/psychiatric disability or psychosocial disability is vulnerable and must be protected from harming themselves or even others. This perception of vulnerability and lack of insight on behalf of the person has resulted in many coercive actions, legislation and treatment approaches which in many cases has been unjustified and simply taken away the basic rights of the person. Living life and change requires taking risks, trying and failing, regrouping and trying again. The recovery approach and person-centred planning doesn't seek to take away the importance of professionals/clinicians and the knowledge, expertise and competence that they bring and neither does it seek to take away the concerns of families and carers about a person's current and future well-being and health. What it does try to do is give greater attention to what the impact of focussing solely on treatment has to all other aspects of a person's life.

The one general principle at the heart of person-centred planning is that people with mental illnesses or psychosocial disability have been, are, and will remain people first and foremost, just like everyone else and this principle is itself derived from the fundamental assumption of the recovery movement.

If people with mental illnesses and the psychosocial disabilities often arising are first and foremost people, then it follows that person-centred planning is first and foremost similar to, if not exactly the same as, person-centred planning for other people. We need only depart from this approach when required by specific challenges posed by the illness or by other aspects of the person's life history, such as a history of demoralization and despair. Any adaptations or additions that need to be made to the basic process of identifying the person's goals, the barriers to those goals, and an action plan to pursue the goals and overcome the barriers, need not fundamentally alter the nature of the approach itself.

Beginning with an approach to person-centred planning that would be relevant and applicable to anyone at all, and then making the adaptations and additions as required by the nature of the specific mental illness or psychosocial disability this specific person is experiencing and its specific impact on his or her ability to participate fully in the process appears to be appropriate. Developing strategies and tools that can assist people in these specific tasks of identifying and setting goals and making their decisions remains an important area for development in the future under the NDIS plans.

4. Evaluation Framework and Approach to Testing

4.1 Introduction

This evaluation and testing framework does not provide any 'proformas' to use as that is not its intention. Instead its aim is to explore what could and should be evaluated and tested in terms of the RichmondPRA 'Good Practice Guidelines (the Guidelines) for Person-Centred Planning and Goal Setting for People with Psychosocial Disability' (April, 2013).

The Framework is 'high level' but it is impossible not to also 'drill-down' to some basic questions. It is questions and their answers that is the driving force of this Framework and is its approach to 'evaluation and testing'.

4.2 The Methodology

The methodology used to prepare this evaluation and testing framework included:

- an extensive literature review of person-centred planning approaches and good practices particularly in the United Kingdom, the USA and Australia;
- the outcomes of consultations with major peak bodies, academics, consumers and carer groups.

It should be noted that there is very little research available concerning 'guidelines for person-centred planning' per se. What there is tends to concern itself with mostly qualitative findings about what benefits a person-centred planning approach did have/didn't have as against an actual evaluation or testing of any guidelines themselves.

What does exist invariably are very general and non-specific guidelines and a very broad-brush approach to evaluation or research findings about what hampered or tended to frustrate the person-centred planning approach (eg. the 'quality' or 'consistency' of a facilitator/planner, the person-centred or non-person-centred nature of the services used by the person etc.).

4.3 The Evaluation Framework and Approach to Testing

This Evaluation and Testing Framework is meant to be about the Guidelines. Such an evaluation and testing could be simply 'internal' (focussing mainly on customer satisfaction with the process, whether the Guidelines were clear and simple to read and follow etc.) and/or 'external' (focussing on what a funding body may need such as the numbers of this and numbers of that and what it all cost).

The evaluation and testing framework of this paper however, focuses primarily on 'personal goals and their achievement' and 'policy goals' of the NDIS, Person-Centred Planning and Recovery as there is limited if any difference between their principles and values and hence policy goals.

The approach taken seeks to look at questions such as:

1. were the Guidelines appropriately and properly implemented by the NDIS Launch Transition Agency or Disability Care Australia;
2. the quality of the plans produced;
3. the outcomes for the 'Focus' person (ie. the person central to the plan and whether they have achieved their initial goals, objectives and aspirations) over a reasonable and measureable time period; and,
4. the contribution if any of the person-centred plans developed and implemented to the Agency's or Disability Care Australia's strategic, service planning and development goals.

The focus is therefore on whether the planning was done well in the first place and if so then on 'personal goals' and 'policy goals'. It seeks to do these multiple things through a series of questions (which could be described as checklists) requiring answers.

4.3.1 How Well Were the Guidelines Implemented?

This comes down to the quality, skills, training, commitment, knowledge of the facilitators/planners engaged by the NDIS Launch Transition Agency which is responsible for facilitating Plans. It also comes down to the Focus person and his/her supporters and commitment to develop a high quality person-centred plan, and consistently monitor its implementation and review it.

So what are the essential characteristics of a 'good' facilitator/planner as without these any evaluation and testing of the guidelines becomes almost meaningless or at least severely and possibly irreparably compromised.

Any evaluation and testing of the Guidelines needs to start with an assessment and review of the facilitator/planner and this could be done by a well experienced and knowledgeable person/reviewer sitting in on person-centred planning or review meetings.

The questions to be asked and answered about the facilitator/planner start with the Characteristics of the facilitator, as outlined in 3.6 above.

The quality of the person centred planning process will reflect the capacity of the facilitator, and the relationship he/she has managed to develop with the Focus person,. Making sure that the 'right' supporters attend the planning meeting and subsequent ones (as such supporters may need to be changed as the Focus person's needs, situation and circumstances change such as in major periods of transition) is also critical.

A quality person-centred plan and its implementation will give effect to the principles/values/beliefs encompassed by the NDIS, person-centred and recovery planning approaches. In evaluating the quality of the planning process, the questions to be asked are:

4.3.1.1 The One-Page Profile: Does the One Page Profile clearly document:

- how well the Focus person's skills/abilities, capacities, qualities, achievements are recognised and documented?
- what is important to and for the Focus person is made clear?
- how best to support and assist the Focus person is discussed and agreed?
- differences of views are not ignored, they are acknowledged and documented for further review and discussion and are followed-up?

- what is currently working, not working or missing for the Focus person is discussed and identified?
- the Focus person's goals, objectives and aspiration are clearly identified?
- the Focus person's living arrangements, situation and circumstances is made clear?
- what formal and informal support and assistance that the Focus person receives/uses is stated?
- what involvement the Focus person has in terms of social and economic participation in the community is stated?

4.3.1.2. The Action Plan : Does the Action Plan make clear

- the major goals and aspirations of the Focus person (from 'the important to and for the person' in the one-page profile) and are SMART (ie. sensible/serious, meaningful/manageable, achievable/attainable, realistic/reasonable, and timely/time-framed)?
- where the Focus person is at now in terms of achieving their goals and aspirations is set out clearly along with a road ahead in terms of assistance of supporters to be provided to do that?
- the actions steps to be taken, by whom, how and by when are set out?
- what supports and assistance through Disability Care Australia is required and what other informal or mainstream supports will be involved?
- did the Focus person elect to self-direct/manage any NDIS funding or to opt for a registered plan provider, the Agency itself or for a Plan Nominee?

4.3.1.3. The Personal Situation Support Plan: Does this Plan clearly summarise:

- any past and significant health, wellness, physical, psychosocial experiences of the Focus person are noted along with the situation and circumstances that did or could have given rise to such an event were identified and described?
- how the Focus person has previously responded/reacted in the lead-up to and in response to such events and his/her coping techniques and strategies are noted along with any 'warning signs' identified by him or her?
- strategies/techniques/approaches to be used if a similar or possibly new event appears or may arise or actually does arise are identified?
- what actions would then be taken if that happens and by whom is made clear?
- any specific recommendations and information that may be essential to de-escalate the situation or which would be needed by the person/s trying to do that is set out?
- what needed additional support may be required by the person and has been identified by them that would be beneficial either prior to or during a personal situation event for them is identified?

4.3.1.4 The Supporters:

The Focus person's supporters and having the right persons to do this is essential. Each supporter needs to know the Focus person well, be important to them, want to provide support and assistance and improve the Focus person's life, situation and circumstances.

- were the supporters open, honest, full and committed participants in the planning process?
- did they provide accurate and full information and advice to assist and support decision-making by the Focus person?
- did they focus on the Focus person's strengths, capabilities, capacities and not on his/her weaknesses, clinical label, previous behaviours and difficulties?
- were they able to challenge stereotypes and 'clinician-to-patient' treatment and medication methodologies and approaches when appropriate?
- did they understand the NDIS, Person-Centred and Recovery approaches to planning and the actual purpose of the initial planning and future planning and review meetings?
- were they willing to and agreed to take on whatever actions/tasks/goals required to give full effect to the 'Action Plan' and to be held accountable for doing so?
- did they consistently advocate for the Focus person?
- could they 'look-outside-of-the-square' and the existing 'menu-of-services' and be creative in their thinking and suggestions?
- did they actively assist and support the Focus person to make decisions and choices and to take control?

4.3.2 Review, Reflection and Revision

This is an on-going process which can be brought on by a significant change to the Focus person's situation and circumstances, a major transition period for them, strategies and agreed actions to be taken striking unanticipated barriers/blocks, changes in support people etc. or because of the results of an annual outcome-focussed review of the person-centred plan. The lessons learned, what worked or didn't work, what could or should have been done and how are essential to capture and document. The updating/amending/adjusting a person-centred plan can be done at any time and feeds back into the 'on-going learning, review and reflection' in the planning process.

4.3.3 An Outcome-Focussed Review of Each Person's/Participant's Person-Centred Plan

Such a review should take place annually and not just when somehow it becomes apparent that a review is needed. If the latter situation takes hold we could have a Plan (whether just simply called a Plan or a Person-Centred Plan) not reviewed for years and with nothing ever changing for the Focus person the question of 'why that's the case' is never raised.

An outcome-focused review is about a Focus person's 'personal goals and aspirations'. It looks at what was meant to be achieved and what exactly was achieved to improve the life, situation and circumstances of the Focus person. It is a chance to review where the Focus person is at, what challenges and surprises they have encountered, whether their needs have changed, whether what is important to and for them has changed, whether their supporters have changed, whether a re-assessment is appropriate and whether their individualised or self-directed funding needs adjustment etc.

If this is the first review then most of the questions asked in above would need to be asked and answered, however, they would need to be updated in some cases. Questions about 'How Well or Otherwise the Guidelines Were Actually Implemented' in the first place and about 'The Quality of

the Person-Centred Plan Created' don't go away with time and are as equally relevant after 12 months as they were at the start. Errors, omissions and inadequacies can still be, although belatedly, addressed during the annual outcome-focussed review and rectified.

The following questions to be asked and answered are only the updated/progress related ones and don't include the earlier ones:

- what is still working well, now working well or needs to change or is missing?
- did the steps taken to assist and support the Focus person to achieve their goals and aspirations work?
- what barriers/blocks/problems/disappointments/difficulties were encountered?
- what new strategies/techniques/actions can be taken?
- has the Focus person's needs/situation/circumstances changed significantly?
- are such changes significant enough for a further 'needs assessment' to be undertaken/requested and the individualised and/or self-directed funding adjusted?
- has what is important to the Focus person and his/her goals and aspirations changed?
- how can any such new or additional goals and aspirations be worked towards?
- what actions/steps/tasks are now needed and who is going to do that and how and by when?
- has the make-up of the Focus person's support team members changed and if so why was that needed?
- if self-directed funding was involved then how has that been managed and reported and is it working well or not well and needs to change?
- has there been any crisis event and what happened and what was done?
- what has been learned throughout the 12 months that will help guide the next 12 months?

4.3.4 How Individual Person-Centred Plans Could Drive Change

The Guidelines if properly and fully implemented should lead to high quality person-centred plans being developed. Although the information contained in such plans is highly 'personal' to all parties (and should be subject to appropriate privacy and confidentiality provisions/protections), the aggregation/collation and analysis and review of the information can help inform strategic planning and service planning and development as well as DisabilityCare Australia's decision-making about commissioning/funding new services/approaches/initiatives or continuing to fund some existing services.

Person-centred plans (and their outcome-focussed and ongoing reviews), can provide a wealth of information to DisabilityCare Australia and an easy and ready means to:

- listen to what programme participants are saying that is both important to them and for them;
- what is working and not working for them;
- what needs to change or is missing for them and possibly needs creation;
- what their major unmet goals, objectives and aspirations are;

- what strategies/techniques/approaches have worked for them and what haven't worked;
- what collectively is 'best practice' and what is 'bad practice';
- what existing services have a track-record of poor service delivery and need to change or be de-funded;
- what the participants personally want and need now and don't currently have access to;
- where gaps are and new innovative approaches are required.

So how can this be done?

The Agency or DisabilityCare Australia needs to ensure that:

- what Focus person's (and their supporters) say is **working well** for them can be collated and analysed and reviewed to help inform best practices and learning/reflection which could then inform generally to be expected practices across the disability support system?
- what Focus person's (and their supporters) say is **not working or not working well** for them could be similarly collated and analysed and reviewed to inform what needs to change in terms of insufficient services or ineffective services and provides the opportunity to explore how things could/can be done better and determine what are the root causes of the problems let alone the wasted money being expended on some services which could be better spent elsewhere?
- what is **important to** Focus persons now and in the future and which may not currently exist and need s to be developed can be mapped against the existing restricted 'menu' of service options including those categories defined under the NDIS?

This could be done by any analysts and reviewers/evaluators engaged by the Agency or Disability Care Australia including by bringing together forums of Focus persons and their supporters in local areas to discuss these issues.

This evaluation and testing framework of the RichmondPRA "Best Practice Guidelines for Person-Centred Planning and Goal Setting for People with Psychosocial Disability (April, 2013)" has morphed a little from its original intentions. It was proposed to be a 'high level' evaluation and testing approach and has done that in some ways but has also sought to drill-down with some questions (or even possible checklists) which was not part of its original intentions.

It was determined that the issues this paper would canvass were those involving:

1. How Well or Otherwise the Guidelines Were Actually Implemented?
2. The Quality of the Person-Centred Plan Created?
3. An Outcome-Focussed Review of Each Person's/Participant's Person-Centred Plan? and,
4. How Individual Person-Centred Plans Can Drive More Strategic/Systemic Change?

We have shown having a 'person-centred plan' means nothing as having one is not an outcome. An outcome is having something happen which changes the Focus person's life, situation and circumstances and the Plan is a means to do this. A person-centred plan merely sets-out a path or strategy or series of tasks and actions to get there and where the Focus person wants to go.

What means something for NDIS, Person-Centred and Recovery Planning is having a planning process that:

- captures what it should capture (ie the goals/aspirations/dreams of the Focus person);
- encourages the Focus person to identify what needs to change in their lives and what is important to them and for them;
- leads to agreement about what assistance and support people can receive or hope to receive from their supporters and the actions to be taken; and
- delivers the best mix between specialist, general/mainstream and informal sources such as families and friends.

5: Appendices

Appendix 5.1 Consultations

Title	First name	Family name	Position	Organisation
Mr	Matthew	Bowden	Co-Chief Executive	People with Disability Australia
Professor	Frank	Deane	Director	Illawarra Institute of Mental Health
Ms	Kim	Koop	CEO	Vic Serv
Mr	Richard	Nelson	CEO	Queensland Alliance for Mental Health
Dr	Peri	O'Shea	CEO	NSW CAG Mental Health
Mr	Frank	Quinlan	CEO	Mental Health Council of Australia
Mr	Ian	Rentch	Executive Officer	Community Mental Health Australia
Professor	Luis	Salvador-Carulla	Professor of Disability and Mental Health	Centre for Disability Research and Policy
Ms	Kathryn	Sequoia	Executive Officer	National Mental Health Consumer and Carer Forum
Ms	Jaelea	Skehan	Acting Director	Hunter Institute of Mental Health
Dr	Kylie	Valentine	Acting Director	Social Policy Research Centre

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