People Map

Home & Supports

Family

Friends

Work

CIRCLE OF SUPPORT (FRIENDS)

First Circle: *Circle of INTIMACY*

Second Circle: *Circle of FRIENDSHIP*

Third Circle: *Circle of PARTICIPATION*

Fourth Circle: *Circle of EXCHANGE*

Fill Circles from the Outside—In!

This exercise is a social scan. It will give a quick picture of who is in your life. It is very useful to gain clarity about who might be involved in certain activities, or circles that need to be filled. We recommend it personally and consider it an essential preventive health check for students, teachers and citizens. The hidden key question is: *"Who loves this person?"*

Instructions:
• *Draw four concentric circles.*
• *Put yourself in the middle then take a few minutes to fill in the people in each of your four circles.*

> • FIRST *Circle: The Circle of INTIMACY*
> List the people most intimate in your life – those you cannot imagine living without.

> • SECOND *Circle: The Circle of FRIENDSHIP*
> List good friends – those who almost made the first circle.

> • THIRD *Circle: The Circle of PARTICIPATION*
> List people, organizations, networks you are involved with (work colleagues, the choir, the square dance club, your soft ball team, etc. – people/groups you participate in.

> • FOURTH *Circle: The Circle of EXCHANGE*
> List people you PAY to provide services in your life. (medical professionals, tax accountants, mechanics, hair dressers, barbers, teachers, etc.)

> Note: People can be in more than one circle. Example: your doctor or teacher could also be a very close friend; a deceased parent/friend or even a pet, might be an intimate personal supporter, etc.

PERSON CENTERED PLAN Pre-Planning Worksheet for _____

RELATIONSHIP MAP

PCP Meeting plans: Where_____

When_____ time _____

Who is invited _____

Topics to discuss_____

Topics to deal with differently / how._____

RESUME

FACILITATOR _____

RECORDER / STYLE _____

<u>PREFERENCES, DREAMS, ASPIRATIONS OF / FOR</u>

Where and with whom I live....

The Work I do...

Relationships

My free time.....
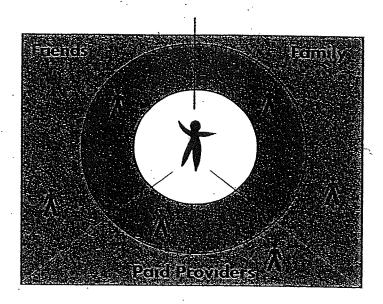
What I'd like to learn......

Security, Safety & Health

Actions I want to take

Economic exchange

Participation

Friendship

Intimacy

What I notice by filling in my circles today

TOOL:
THE RELATIONSHIP MAP

A relationship map identifies important people, friends, and allies who can contribute to a capacity description and perhaps plan together with the focus person over time. We also find many immediate opportunities for building and strengthening relationships.

Construct this map by placing the focus person in the center, and listing important relationships in at least three clusters: 1) family, 2) friends and community members, and 3) paid service providers. Indicate intensity and depth of relationships by putting the most important people close to the center of the map, near the focus person. You can also indicate intensity by using thick lines pointing to key people. Others who are less involved can be drawn further from the center with thinner or dotted lines indicating connection. Consult appendix page 68 for a closer look at a relationship map.

Remember that the purpose of this exercise is to get to know the person, to look for clues to potential relationship building activities, and to make decisions about how to proceed with the planning process. Once you complete this map with the person, work together to generate five ways to deepen and strengthen these relationships. The following section indicates some common discoveries from relationship mapping.
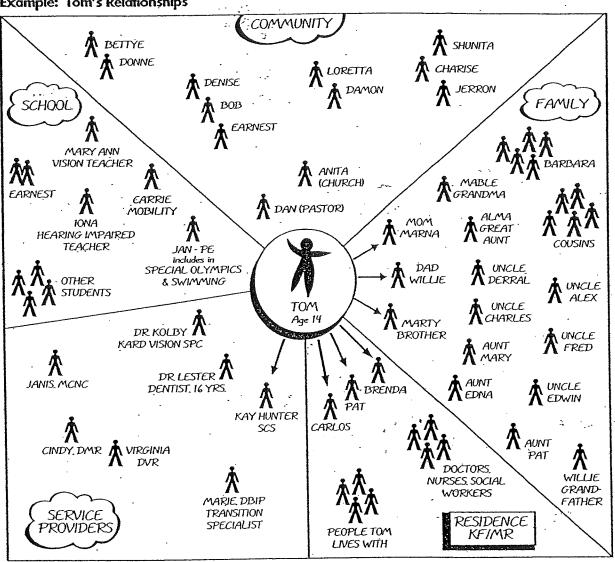
RELATIONSHIP MAP

Purpose: To identify personal support, the most important people in the focus person's life, and people who may be interested in planning together over time.

Example: Tom's Relationships

COMMUNITY

BETTYE
DONNE
DENISE
BOB
EARNEST
LORETTA
DAMON
SHUNITA
CHARISE
JERRON

SCHOOL

MARY ANN
VISION TEACHER
EARNEST
IONA
HEARING IMPAIRED
TEACHER
CARRIE
MOBILITY
JAN - PE
includes in
SPECIAL OLYMPICS
& SWIMMING
OTHER
STUDENTS

ANITA
(CHURCH)
DAN (PASTOR)

FAMILY

BARBARA
MABLE
GRANDMA
ALMA
GREAT
AUNT
COUSINS
MOM
MARNA
DAD
WILLIE
UNCLE
DERRAL
UNCLE
ALEX
UNCLE
CHARLES
MARTY
BROTHER
AUNT
MARY
UNCLE
FRED
AUNT
EDNA
UNCLE
EDWIN
AUNT
PAT
WILLIE
GRAND-
FATHER

TOM
Age 14

DR KOLBY
KARD VISION SPC
JANIS. MCNC
DR LESTER
DENTIST. 16 YRS.
KAY HUNTER
SCS
CARLOS
PAT
BRENDA
CINDY. DMR
VIRGINIA
DVR
MARIE. DBIP
TRANSITION
SPECIALIST
PEOPLE TOM
LIVES WITH
DOCTORS.
NURSES. SOCIAL
WORKERS

SERVICE
PROVIDERS

RESIDENCE
KF/MR

Facilitation Tips:

1. Divide the circle into at least three categories: family, friends, and paid staff members.
2. Put each person on the map with a symbol of a person and their name.
   Indicate the nature of the relationship and how long they have known each other.
3. Put the people who are closest to the person, who are most important toward the center of the circle.
   Indicate intensity and strength of the relationship with heavier lines.
4. Highlight in yellow people who might be involved in the support circle.

Who is a part of your life?

FAMILY

RK/
IOOL

CLOSEST TO YOU

HOME and
OTHER PA
SUPPORT

FRIENDS and NON PAID
RELATIONSHIPS

Identify the people you want to guide you

Path is a facilitated process that uses a graphic record to focus energy and to support memory. It calls for two people to act as as team guides: a process facilitator and a graphic recorder.

- A process facilitator, who looks after time and pace while assisting the pathfinder through the steps and questions. The process facilitator attends to the process as revealed through words, voice, and eyes.

- A graphic recorder, who captures the pathfinder's words and images on paper and offers the pathfinder occasional summaries of the work and helps the pathfinder identify emergent themes that unify the ongoing process. The graphic recorder focuses on imagery, using their ears and hands to highlight their listening and intuition.

In our experience, a team of outsiders provide the most effective guidance for *Path*. We have seen good, often surprising, results among people who are trying out the guide roles for the first time. It would be extraordinary for someone from within a group to guide as well as an outsider and most uncommon for one person to be both process facilitator and recorder.

It is absolutely necessary that the guides themselves experience being a pathfinder. There is no substitute for personal experience in discovering the texture of feelings and the pace of the questions without trying the process oneself.
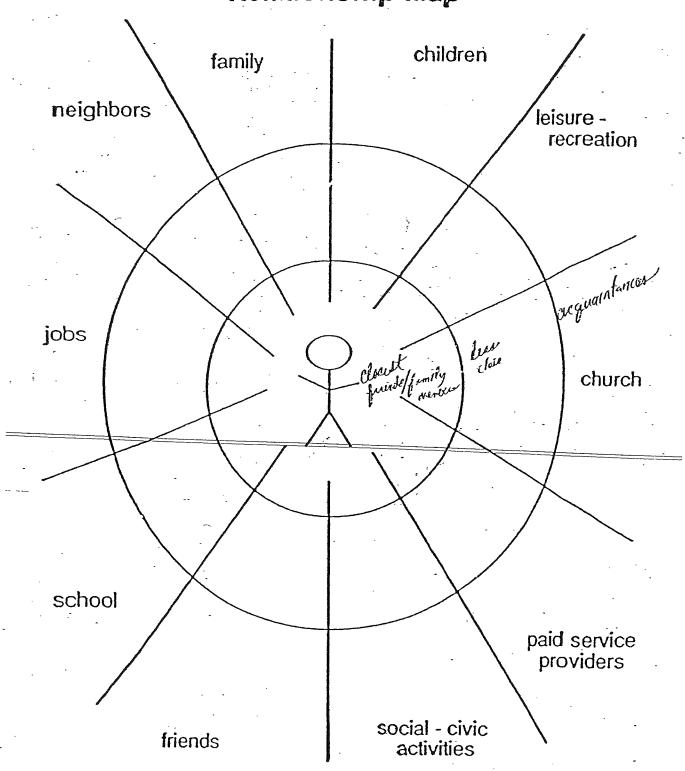
Because the situations pathfinders face generate high emotion, pathfinders need to chose guides they can trust to deal constructively with people's and group's feelings of pain, fear, and anger. Expression of such feelings is not the goal of *Path*, as it is in some kinds of group work, but the feelings are real in the situation and guides need the skill and willingness to encourage pathfinders to face them and learn from them rather than fleeing them.

Invite people to join in

Path is a social process. Even when focused on an intensely personal issue for an individual, the process is immeasurably enriched by the active involvement of others who know and care about the person.
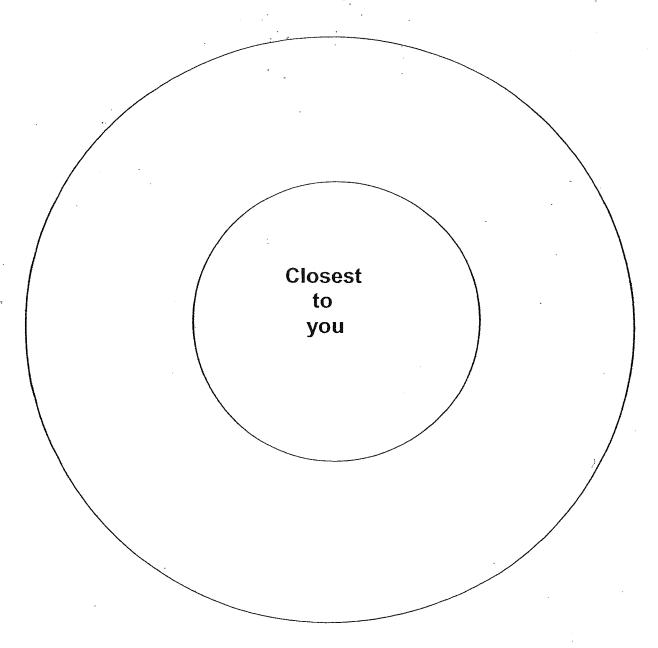
Relationship Map

family

children

neighbors

leisure - recreation

jobs

acquaintances

less close

closest friends/family members

church

school

friends

social - civic activities

paid service providers

Who is part of your life?

Closest
to
you

PREPARATION FOR PLANNING

"Until now, we planned with program people.
Information about My Life allowed us to prepare with family
as well as with a respite provider who could not come to the meeting.
We learned this person really likes to watch bowling pins fall and golf balls being
hit. This is giving us new ideas for exploring day activities and possible jobs."
-Vocational Coordinator

Identifying Who Will Help Plan

The person whose plan is being developed identifies with whom they would like to plan. Key people they include may also be asked for ideas of others who would be particularly helpful in planning, and the person may decide to include these people as well. To develop a plan that addresses the person's whole life, participants will ideally be representative of that life rather than only representative of the programs which serve him or her. People with strong past connections, such as school teachers, should also be considered. If the person is unable to identify participants, family and/or significant others can assist with this.

THRIVING* IN MY COMMUNITY

Name_____   Plan Date_____

The following people contributed to the development of this plan.

NAME   RELATIONSHIP   INITIAL AGREEMENT
                                                                   OR TYPE OF CONTRIBUTION
                                                                   IF NOT PRESENT

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Thrive: To make steady progress, to prosper, to grow vigorously, flourish
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THRIVING* IN MY COMMUNITY
A Plan for Independence, Support and Belonging

SECTION A. INFORMATION ABOUT MY LIFE

Name _____   Date _____

Name of person who helped me complete this section, if any _____

Questions that are not useful to me do not need to be answered.
Prior to and during my meeting other team members may help me expand my vision. Only information that I agree with will appear on my final form. Information provided by me will be highlighted.

1. MY GIFTS & TALENTS
   This is what people like about me:

   These things make me feel good about myself:

   These are my favorite things to do (my hobbies and interests):

   My talents include:

2. IMPORTANT PEOPLE PLACES, ACTIVITIES AND SUPPORTS
   These are the people I know in my community, where I like to go and what I like to do with them:

   The people I really like to be with are:

   The things I do with them are:

   The people I would like to spend more time with are:

   If I have a problem or need help, the people I like to talk to are:

   Family and friends not already listed above:

   I receive assistance from these support agencies:

Thrive: To make steady progress, to prosper, to grow vigorously, flourish
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Developing First Plans: A Guide to Developing Essential Lifestyle Plans

Talking to People Who Know and Care:
An Individual Interview

Name of the Person Interviewed: _____

What is your relationship to "person"?

How long have you known "person"?

How much time do you/did you typically spend with "person"?

What do you like the most about "person"?

What do you admire the most about "person"?

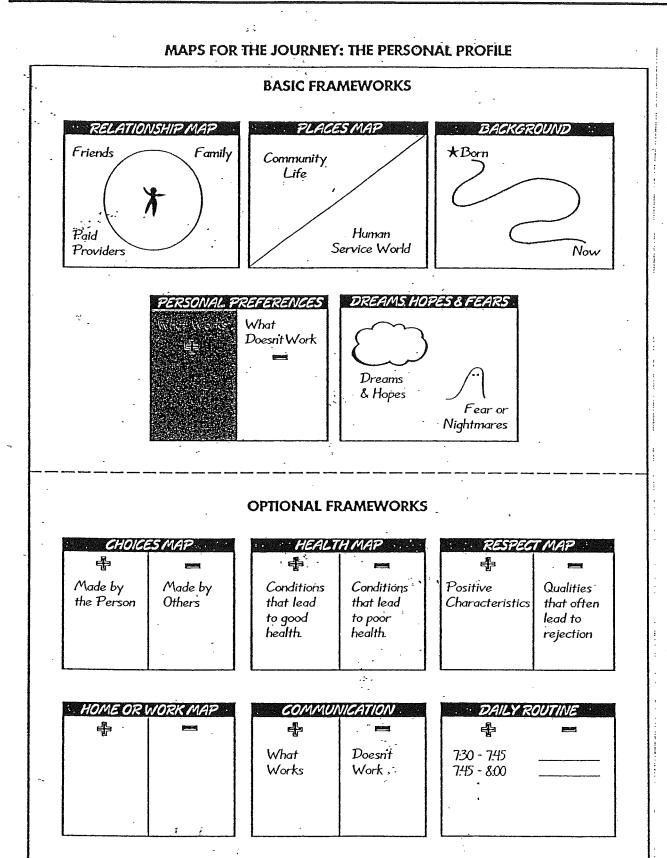When was the last time you had fun together, what did you do?

What would be "person's" best day, worst day?

Other Notes:

MAPS FOR THE JOURNEY: THE PERSONAL PROFILE

BASIC FRAMEWORKS

RELATIONSHIP MAP

Friends   Family

Paid Providers

PLACES MAP

Community Life

Human Service World

BACKGROUND

★ Born

Now

PERSONAL PREFERENCES

What Doesn't Work ▬

DREAMS, HOPES & FEARS

Dreams & Hopes

Fear or Nightmares

- -

OPTIONAL FRAMEWORKS

CHOICES MAP

✚ Made by the Person	▬ Made by Others

HEALTH MAP

✚ Conditions that lead to good health.	▬ Conditions that lead to poor health.

RESPECT MAP

✚ Positive Characteristics	▬ Qualities that often lead to rejection

HOME OR WORK MAP

✚	▬

COMMUNICATION

✚ What Works	▬ Doesn't Work

DAILY ROUTINE

✚	▬
7:30 - 7:45	_____
7:45 - 8:00	_____

INDIVIDUAL SUPPORT PLAN

NAME:_____ CMH ID#_____

WHAT'S IMPORTANT TO ME?

1. *Strengths:* Things I am good at / Things that are positive about my life:

Great smile
Great sense of humor
Very social
Likes everyone
Polite: excellent manners
Proud of my independence, likes to be able to take care of herself
Voices her wants and needs
Coopertive, happy to help out
    Knows that she has her own limitations, but she know to tell people to
        stop if they cross over the line
    Has a great support system and fantastic advocates in her parents
    Enjoys: listening to music, puzzles, watching videos; going for walks,
        going for bike rides with her day, participating in Special
        Olympics.
    Her favorite foods are spaghetti and pizza

THE PERSONAL PROFILE:
BASIC FRAMEWORKS FOR GETTING TO KNOW THE FOCUS PERSON

Relationship Map: *Identifies opportunities for personal support and assistance.*

Helps to illustrate the most important people in the focus person's life. People interested in planning together over time, and opportunities for building relationships.

Places Map: *Describes the pattern of current daily life.*

Helps to illustrate how the focus person spends her time. How much time is spent in segregated or community settings, and existing opportunities for building community.

Background Map: *Provides an overview of the life experience of the person and family.*

Helps to illustrate positive experiences form the past to build on. Appreciation of the traumas, loss, and grief in life. Celebration of accomplishments, and opportunities now as a result of the past.

Preferences Map: *Describes personal preferences, gifts and interests, as well as conditions to avoid.*

Helps to illustrate patterns in the gifts, potential, and unique contributions of the person. Describes patterns in conditions that challenge development.

Dreams Map: *Describes ideas about personal dreams and desires for the future.*
Hopes and Fears

Describes how people feel about the opportunities and obstacles they see to making things happen.

Helps to understand inner images about desires, and both the hopes and fears about the future through the eyes of the focus person.

OPTIONAL MAPS TO USE IN THE PERSONAL PROFILE PROCESS

Choices Map: *Describes decisions made by the person and decisions made by other people.*

Helps to illustrate the degree of control the focus person has over life decisions, and the degree to which decisions are made by other people. Helps clarify the need for personal assistance.

Health Map: *Describes the conditions that promote or threaten the health of the person.*

Helps to illustrate real limitations and constraints imposed by health concerns, medications, therapies, and other conditions and routines that assure or threaten good health.

Respect Map: *Describes personal characteristics that can create barriers to community acceptance as well as remembering qualities that will be a contribution in relationship life.*

Helps to illustrate the personal characteristics, behaviors and social roles that may lead to rejection by others as well as positive qualities that can be strengthened in personal relationships.

Other Optional Maps:

Other maps can be invented by the facilitator to help them understand life as it is experienced through the eyes of the focus person. For example, it is important to understand methods and channels of communication for people who live with visual and auditory impairments. In this section, we will outline some optional maps that focus on **communication.**

2. What are some great things about you?

What are some great things about you? What do you like about you? What are some things you're good at? proud of? What are some nice things that people say about you? What do people thank you for? This is sometimes hard for people to answer, so you might want to start by asking a friend or relative.

These are important things to think about when you are figuring out the kinds of services and supports you need and want.

Great Things About You

3. What things do you like to do?

To help you get started on your lists, ask yourself and people who know you:

What things do you like to do? at home? at work? at program? at college? for fun? around town? on vacation? What kind of music do you like? What kind of movies do you like? What kind of food do you like? Do you have any hobbies? Do you collect things? What are the things you don't like or don't like to do?

Your List of Favorite Things ...

Things You Don't Like or Like to Do ...

The Worst Week Day Would Be

When you first get up

The Week Day Right Now

????

When you first get up

The Best Week Day Would Be

When you first get up

The Worst Week Day Would Be

During the day

The Week Day Right Now

????

During the day

The Best Week Day Would Be

During the day

The Worst Week Day Would Be

At night

The Week Day Right Now

????

At night

The Best Week Day Would Be

At night

The Worst Weekend Would Be

The Weekend Right Now

?????

The Best Weekend Would Be

Person-centered Plan

1. Who is here to help me plan my life?

2. What are the most important things that have happened to me so far in my life?

3. Who are the people and places that are most important to me?

4. What are my likes and dislikes?

5. What things in my life make sense?

6. What things in my life do not make sense?

7. What is my daily schedule?

8. How could we improve my daily schedule so that it included more of what I like?

9. What are my strengths and interests?

10. If I could have a perfect day, how would it be different from my days currently?

11. What are activities I could be involved with in the community?

12. The outcomes I would like to see occur for me include:

   ▪
   ▪
   ▪
   ▪
   ▪
   ▪

13. What is the timeline for outcomes to be met?

14. Who is going to make sure that my outcomes are being met?

15. When can we get together to see how things are going?
   - Date
   - Time
   - Location

16. What is the best thing about my person-centered planning process?

17. Evaluation of the process

Things I love:

Things I like a lot:

Things I don't like:

Things I really don't like:

Some things make me happy:

And sometimes I get sad because...

These are my greatest fears:

These are new things I want to do and learn:

I currently receive these services:
✓

✓

✓

✓

People at work think these things about me:

People at home think these things about me:

My friends and family think these things about me:

These are the best things about my job:

About my home:

The things I most often need help with at home and work are:

My perfect job would be...
(explain why)

My perfect home would be....
(explain why)

My health needs:

I need this much money to live and this is where it comes from:

Places to go...
        People to see...

If my world were perfect, this is what I'd be doing:

At home:

At work:

In the community:

With my friends:

THRIVING* IN MY COMMUNITY

A PLAN FOR INDEPENDENCE, SUPPORT, AND BELONGING

SECTION B. MY PLAN

Name _____   Date _____

1. MY PERSONAL VISION STATEMENT

(Your Personal Vision Statement should describe how you would most like your life to be in the future. It should reflect the things most important to you from Section A, Information About My Life. Your Personal Vision Statement should guide all future plans and services, and can be modified later if you wish.)

*Thrive: To make steady progress, to prosper, to grow vigorously, flourish

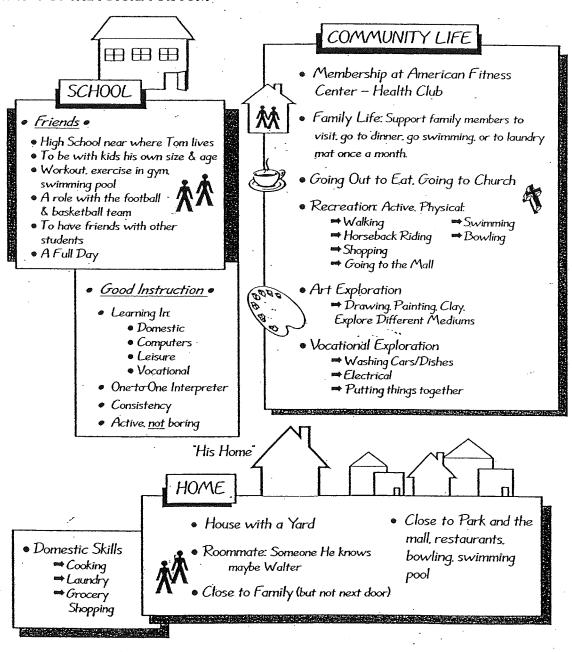© The Arc Resource Group

APPENDIX I Page 10
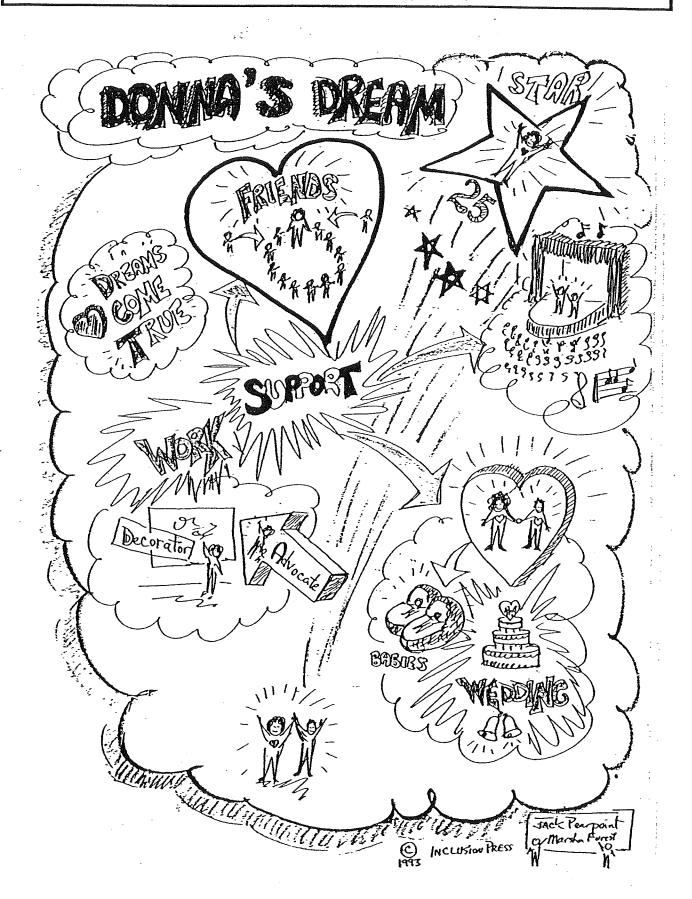
IMAGES OF THE FUTURE: DREAMS MAP

Purpose: To explore inner images about desires and dreams for the future. It helps to illustrate the experiences the person or the family wants to have more of, including dreams for a home, a job, community life, and personal life. The difference between this map and the "vision" map developed during the Futures Planning meeting is that this map expresses the images and hopes of the person and those who know them best. The vision map may include many other ideas contributed by lots of other people.
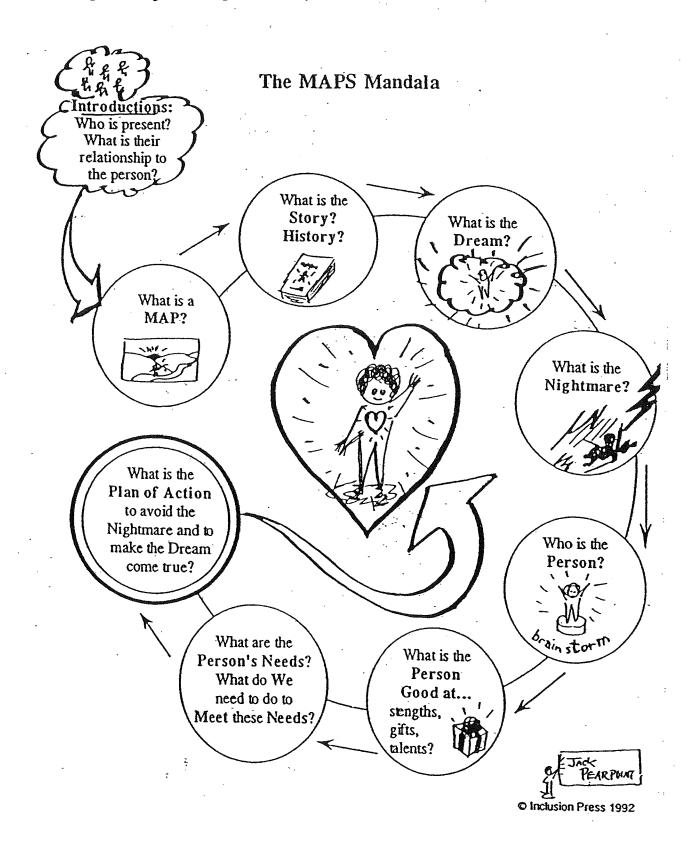
IMAGES OF THE FUTURE FOR TOM:

SCHOOL

- *Friends*
  - High School near where Tom lives
  - To be with kids his own size & age
  - Workout. exercise in gym, swimming pool
  - A role with the football & basketball team
  - To have friends with other students
  - A Full Day

- *Good Instruction*
  - Learning In:
    - Domestic
    - Computers
    - Leisure
    - Vocational
  - One-to-One Interpreter
  - Consistency
  - Active, *not* boring

COMMUNITY LIFE

- *Membership at American Fitness Center – Health Club*

- *Family Life:* Support family members to visit. go to dinner. go swimming. or to laundry mat once a month.

- *Going Out to Eat. Going to Church*

- *Recreation: Active. Physical:*
  - → Walking   → Swimming
  - → Horseback Riding   → Bowling
  - → Shopping
  - → Going to the Mall

- *Art Exploration*
  - → Drawing. Painting. Clay. Explore Different Mediums

- *Vocational Exploration*
  - → Washing Cars/Dishes
  - → Electrical
  - → Putting things together

"His Home"

HOME

- *Domestic Skills*
  - → Cooking
  - → Laundry
  - → Grocery Shopping

- House with a Yard

- *Roommate: Someone He knows* maybe Walter

- Close to Family (but not next door)

- Close to Park and the mall. restaurants. bowling. swimming pool
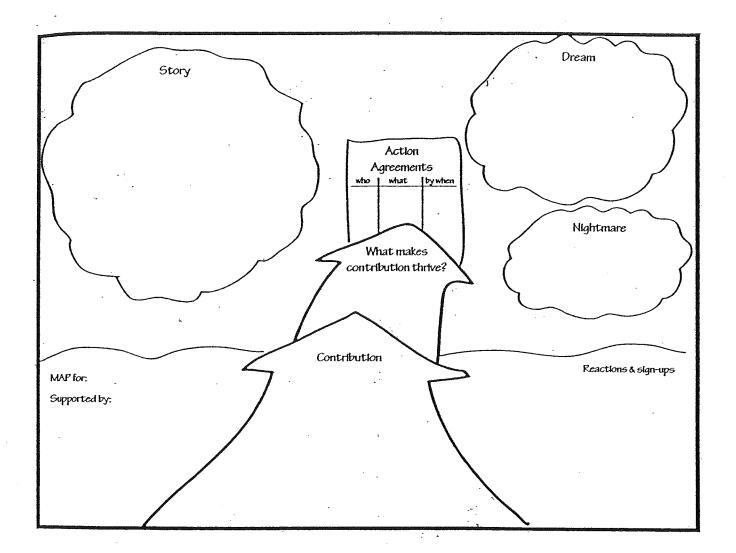
Forest, Pearpoint, Falvey & Rosenberg

The MAPS Mandala

Introductions:
Who is present?
What is their relationship to the person?

What is a MAP?

What is the Story? History?

What is the Dream?

What is the Nightmare?

What is the Plan of Action to avoid the Nightmare and to make the Dream come true?

Who is the Person?
brainstorm

What are the Person's Needs? What do We need to do to Meet these Needs?

What is the Person Good at... strengths, gifts, talents?

All My Life's A Circle

Story

Dream

Action Agreements
who | what | by when

Nightmare

What makes contribution thrive?

Contribution

MAP for:

Supported by:

Reactions & sign-ups

A NEW format for Recording your MAP

After many years of doing MAPS, and experimenting with many formats for recording a MAP, this is our collective best outline - for now. One of the advantages of this format is that you can use a yellow (light) marker to make the outline in advance (if you choose) - and then you have a template to guide your recording. This is yet another stage in the evolution of MAPS. If you discover a new, better or different recording format, please let us know.

INDIVIDUAL SUPPORT PLAN

NAME:_____ CMH ID#_____

2. Dreams / Goals / Things I want:

And her family are pleased with her new home and hope she stays for a long time.
Wants to keep in touch with other friends from Our Lady Of Providence.
Wants to continue working with the mobile crew.
Wants to enjoy a veriety of recreational activities in the community.

PERSON CENTERED PLAN Pre-Planning Worksheet for _____

RELATIONSHIP MAP

PCP Meeting plans: Where _____
When _____ _time_ _____
Who is invited _____
Topics to discuss _____
Topics to deal with differently / how. _____

RESUME

FACILITATOR _____
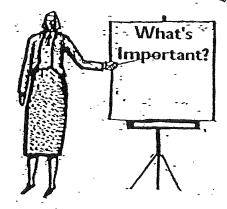
RECORDER / STYLE _____

PREFERENCES, DREAMS, ASPIRATIONS OF / FOR

Where and with whom I live....

The Work I do...

Relationships

My free time.....

What I'd like to learn......

Security, Safety & Health

6. What is most important to you and what can we do to successfully support you?

What's Important?

Look back at the things you wrote down or said when we talked about who is in your life (#1), great things about you (#2), things you like to do (#3), and your best and worst week day and weekend (#4 & #5). What is most important for us to remember? What things do you want to make sure are in your life every day (like a cup of coffee in the morning or a favorite friend)? What things do you want to make sure are not in your life every day (like a certain kind of music or some food you can't stand)? How can we successfully support you with those things that are most important. At work? At program? Around town? For fun? On the weekends?

What is Important to You?	What Can We Do to Successfully Support You?

THRIVING* IN MY COMMUNITY

Vision For _____'s Life

At the upcoming Individual Plan meeting, we will use the following information to help identify the outcomes for next year. Please review this and write down information you would like to share. Please return it to:

_____At: _____ By:_____
If you need more room please use the back of this page or another sheet of paper.

1. GIFTS & TALENTS

2. IMPORTANT PEOPLE, PLACES ACTIVITIES AND SUPPORTS
Favorite people, and things the person likes to do with them; favorite activities at home, work, and in the community; recreational activities, support agencies, and informal supports

3. LIFE TODAY
Things that help make a good day, favorite places, people and activities; other things that are fun; things that can ruin a good day; things that bring about anger, or are frightening

4. THE FUTURE (If the person could have anything)
New things and changes the person would like; things that should not change; things needed
to stay healthy and to feel and be safe; things the person wants to learn that will increase independence (consider living situation, job, relationships and community connections)

*Thrive: To make steady progress, to prosper, to grow vigorously, flourish
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5. THINGS SUPPORT PEOPLE SHOULD KNOW
   Things that help when the person is sad, angry, or upset; the best way to remind the person
   of something; the way the person communicates best, support they need to communicate
   with others

6. LIFE EVENTS, KEY ACCOMPLISHMENTS, CHANGES AND LOSSES THAT ARE
   IMPORTANT TO CONSIDER WHEN PLANNING FOR THE FUTURE

7. ADDITIONAL INFORMATION

Completed By: _____   Date: _____ /
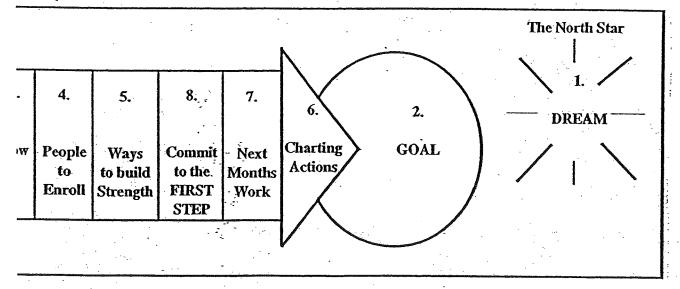
All My Life's A Circle
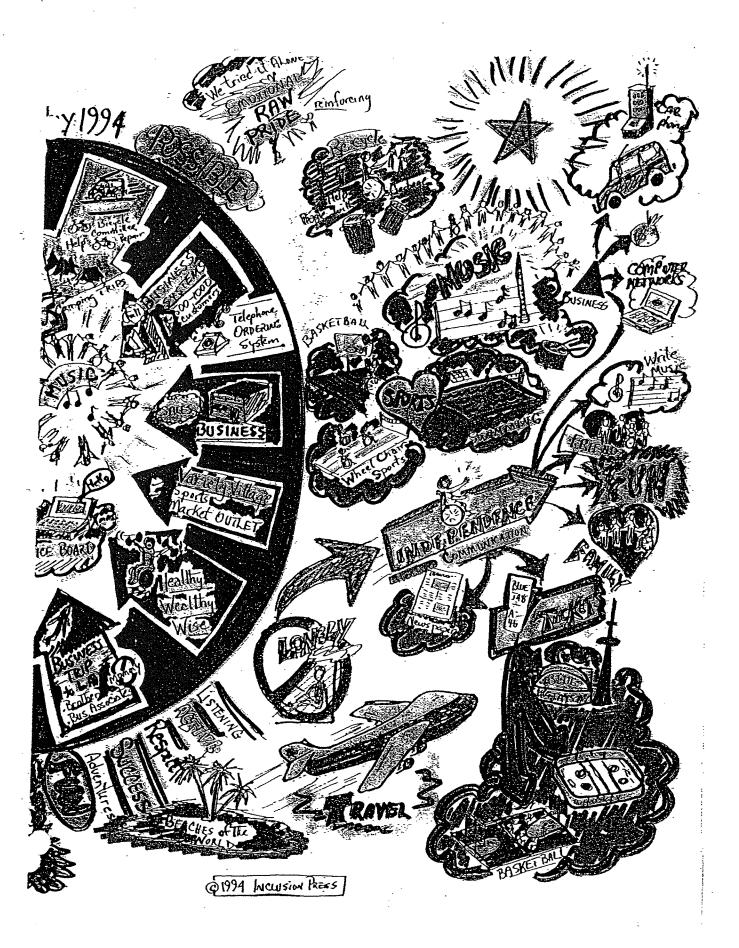
Step 1 - The North Star - the Dream

The time is spent focusing on the individual identifying his or her DREAMS and ultimately their North Star. Some of the questions that can assist a person identify their North Star may be:

- What ideals do you most want to realize?
- What values do you want to guide you?
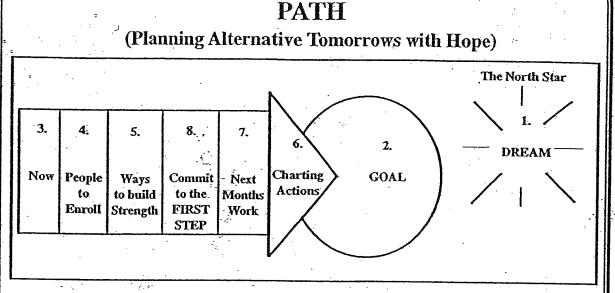- What gives direction to your life?
- What drives you?

Barry's North Star was: to be able to live in a home with just a few people, he wanted support so that he could eat when he wanted to, go to the bathroom when he wanted to, have a bath when he wanted one, and leave the house when he wanted to. The facilitator finished this step by summarizing the dream and solicited from Barry his perspective on the accuracy of the information that had been graphically depicted.

PATH

(Planning Alternative Tomorrows with Hope)

	4.	5.	8.	7.	6.	2.	1.
'w	People to Enroll	Ways to build Strength	Commit to the FIRST STEP	Next Months Work	Charting Actions	GOAL	The North Star — DREAM

L·y 1994

We tried it Alone

RAW PRIDE

Reinforcing

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PATH
(Planning Alternative Tomorrows with Hope)

3.	4.	5.	8.	7.	6.	2.	The North Star
Now	People to Enroll	Ways to build Strength	Commit to the FIRST STEP	Next Months Work	Charting Actions	GOAL	1. DREAM

YOUR PATH
A focused Planning Process

Steps
Situate yourself in a very postive future,
picture it clearly, then think Backwards.

1. Touching the Dream (the North Star).

2. Sensing the Goal: Focus for the next year.

3. Grounding in the Now: Where am I/are we?

4. Identifying People to Enroll on the Journey.

5. Recognizing Ways to Build Strength.

6. Charting Actions for the Next few Months.

7. Planning the Next Month's Work

8. Committing to the First Step (the Next Step)

(Including a Coach to Support your First Step)

Joe's PATH

Created June 22, 1993
Martha Forest
Jack PEARPOINT ©1993

POSITIVE

NOW   ENROLL   TRANSITION   HOT SEAT   AUG 93

Joe
George
Wendy
Martin
Norman
Noah
Savoy
Kevin
Peter
Judith
Beth
Dawn
Denise
Jack
Martha

Empty
WAS
ISOLATED
LONELY

Variety Village

EXPLORATION!
STARTING

TRANSPORTATION

REAL TREES

Gage Transition Centre

Stuck
DISABILITY

Grandfather
Grandmother
SAD

Stress

New person

Knows himself

Discovering he can DO IT!

Joe
SAVOY
Martin
JUDITH Denise
NOAH Karen
Beth
Norman
Support
Circle

Communication
Expert
on Computers

Attendant
CARE Support

Fred, Heather
Jeff

Expert in
$ Finance

w/ Gary (MPP)
N. Mullarski

Include
SUPPORT

Coop
Circle

Family
Circle

• Attendant
Training
* • Stereo Setup
• Secure/coded

Bicycle
Committee

Nutrition
Bars

Commitment
Clarity
Brutal
Honesty

Meeting

PUSH

Involvement
FRIENDS

NoAH

Evaluation
home
recreation
business

Outcomes

Suggestions

phone #s
programed

June

Joe
21st B-day
Aug 11

July 8
Support Circle
Meeting

Summer Camp

Kevin's
Wedding

June

My Move
MOVE

June

FRIEND

INDEPENDENCE   SECURE Rewarding   FREEDOM

HAPPY
Optimistic
Empowered
Industrious

Choosing
Down a Now
Typical
Normal   MORE

People
Achieving Personal Growth

BUSINESS

Revealing

Leader in Coop

SAD

(Version A)

THRIVING* IN MY COMMUNITY

Name _____   Date _____

4. ADDITIONAL SERVICES TO BE RECEIVED
These May Not Relate Directly To My Vision Statement

TYPES OF SERVICES OR ACTIVITIES THAT ARE SOMETIMES NEEDED INCLUDE, BUT ARE NOT LIMITED TO:

ASSISTIVE TECHNOLOGY	FAITH SUPPORT	MEDICAL	PHYSICAL THERAPY	RECREATIONAL	SOCIAL	TRANSPORTATION
AUDIOLOGICAL	FINANCIAL	NURSING	PODIATRY	RESIDENTIAL	SPEECH AND LANGUAGE	VISION
*BEHAVIORAL	GYNECOLOGICAL	NUTRITION	PROSTATE SCREEN	RETIREMENT NEEDS	PSYCHOLOGICAL	VOCATIONAL
DENTAL	MAMMOGRAM	OCCUPATIONAL THERAPY	PSYCHIATRIC			

*IF A PERSON HAS A BEHAVIOR CHANGE PROGRAM, IT SHOULD BE ATTACHED TO THE INDIVIDUAL PLAN

SERVICE OR ACTIVITY	MY PREFERENCE RELATED TO THIS SERVICE OR ACTIVITY	WHEN IT WILL HAPPEN		WHO WILL		REVIEW SCHEDULE	REVIEW OF MY PLAN
		BEGIN	COMPLETE	MAKE IT HAPPEN	REVIEW PROGRESS	DATE	INCLUDE, DATE OF REVIEW, SOURCE, ACCOMPLISHMENTS, BARRIERS, AND STRATEGIES

Thrive: To make steady progress, to prosper, to grow vigorously, flourish.
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APPENDIX I Page 13

THRIVING* IN MY COMMUNITY

(Version B)

4. ADDITIONAL SERVICES TO BE RECEIVED
These May Not Relate Directly To My Vision Statement

Name _____

Date _____

TYPES OF SERVICES OR ACTIVITIES THAT ARE SOMETIMES NEEDED INCLUDE, BUT ARE NOT LIMITED TO:

ASSISTIVE TECHNOLOGY	FAITH SUPPORT	MEDICAL	PHYSICAL THERAPY	SOCIAL	TRANSPORTATION
AUDIOLOGICAL	FINANCIAL	NURSING	PODIATRY	SPEECH AND LANGUAGE	VISION
*BEHAVIORAL	GYNECOLOGICAL	NUTRITION	PROSTATE SCREEN	PSYCHOLOGICAL	VOCATIONAL
DENTAL	MAMMOGRAM	OCCUPATIONAL THERAPY	PSYCHIATRIC		

*IF A PERSON HAS A BEHAVIOR CHANGE PROGRAM, IT SHOULD BE ATTACHED TO THE INDIVIDUAL PLAN

SERVICE OR ACTIVITY	MY PREFERENCE RELATED TO THIS SERVICE OR ACTIVITY	WHEN IT WILL HAPPEN		WHO WILL		REVIEW	
		BEGIN	COMPLETE	MAKE IT HAPPEN	REVIEW PROGRESS	DATE	

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APPENDIX I Page 14

Needs/Desires	Other Necessary Supports (optional)	
	Recommended Supportive Action	Monitoring/Responsible Person
Assessing Risk & Safety Net Planning: A. Health Care Planning: 1. Can individual give medical consent? If not, is written permission available or is medical guardian easily accessible to give permission? 2. Can individual take own medications? If not, is someone available to assist? Who will monitor and how? 3. Can individual manage own medical needs? If not, who will assist with medical management? • Can individual explain medical needs? • Can individual schedule appointments? • Can individual provide physician needed medical information? • Can individual keep records of appointments? • Does individual have a list of physician's names and phone numbers? • Can individual arrange follow up care or follow through with orders by physician? 4. Does individual have insurance information and know procedure for presenting insurance information? If not, who will be responsible for assisting with this? 5. Can individual plan their diet and nutritional needs adequately, as well as, prepare	A. Health Care Planning: 1. 2. 3. 4. 5.	

Needs/Desires	Recommended Supportive Action	Monitoring/Responsible Person
planned meals? If not, who will assist with meal planning and preparation?		
6. If individual is diabetic or has some other concern related to diet needs is he/she able to monitor this independently? If not, who will assist in monitoring diet?	6.	
7. If applicable, does individual have appropriate medical alert bracelet/necklace?	7.	
8. Does individual have knowledge of basic first aid and know how to respond to a medical emergency?	8.	
B. Emergency Planning:	B. Emergency Planning:	
1. Does the individual have and carry identification and emergency information card? If not, who will assist to obtain ID and emergency information card and ensure that it is carried at all times?	1.	
2. Does the individual know his/her personal information (address, phone) or carry this information with him/her at all times? If not, who will ensure that the information is written down and carried with him/her at all times?	2.	
3. Does the individual know whom to call if something happens and have easy access to the phone number? Does the contact person(s) know what to do in an emergency	3.	

Needs/Desires	Recommended Supportive Action	Monitoring/Responsible Person
and whom to contact? Does the individual have a back up plan if none of the contact people are available?		
4. Do involved community members (apartment managers, neighbors) have a number to call if they have a concern about the individual?	4.	
5. Does the individual know how to respond to a fire, crime, or medical emergency and how to access emergency medical/fire/police services? If not, how will this be addressed?	5.	
6. Does individual know what to do in the event of a household system failure (loss of electricity, water, gas, telephone, etc.)? If not, how will this be addressed?	6.	
7. Does individual know what to do if a support person does not show up when scheduled? If not, how will this be addressed?	7.	
C. Personal Safety:	C. Personal Safety:	
1. Is individual aware of the risk of door-to-door salesman and telephone solicitors? If not, how will this be addressed?	1.	
2. Does individual possess knowledge of general strategies for remaining safe within his/her home (i.e. locking doors, closing	2.	

Needs/Desires	Recommended Supportive Action	Monitoring/Responsible Person
blinds) and the community (i.e. use familiar routes, let others know your where you will be)? If not, how will this be addressed?		
3. Does individual have knowledge of safe sex and prevention sexually transmitted diseases? If not, how will this be addressed?	3.	
4. Is individual at risk for exploitation or sexually vulnerable? If yes, how will this be addressed?	4.	
D. Environmentally Safety:	D. Environmental Safety:	
1. Does individual have spare key(s) and where are they located? Does anyone else need to keep a spare key?	1.	
2. Are grab rails needed on tub/shower?	2.	
3. Is there a non-skid surface in tub/shower?	3.	
4. Can individual safely adjust water temperature? Are scald guards needed?	4.	
5. Is the telephone programmable if needed? Does the individual have an easily accessible list of important or frequently used phone numbers available?	5.	
6. Are there smoke detectors and fire extinguishers in the residence and does the individual know how to use the extinguisher?	6.	

Needs/Desires	Recommended Supportive Action	Monitoring/Responsible Person
E. Financial Safety: 1. Does individual require assistance with banking, budgeting, and paying bills? If yes, who will assist with this? 2. Does the individual have a representative payee? Does the individual need a payee to monitor spending?	**E. Financial Safety:** 1. 2.	
F. Increasing Communication: 1. How will information be shared when more than one person is providing support? 2. Will team meet on an ongoing basis to problem solve and discuss any issues that may arise?	**F. Increasing Communication:** 1. 2.	

INDIVIDUAL SUPPORT PLAN

NAME:_____   CMH ID#_____

3. *Barriers:* Things that make it hard to reach my goals / dreams
Health and safety <u>must be addressed.</u>

Has a seizure disorder. She is taking medication for her seizures. Wears a helmet on hard surfaces, outside her home and where she knows she can injure herself. She needs to have awake staff while she sleep. Can sometimes tell when a seizure is coming on, and she will sit down so she does not injure herself.

Needs to be monitored while she is in the bathroom

Requires a lot of sleep. She needs to have a nap after work. If she does not get enough sleep, she can become very agitated with can increase her chance of having a seizure. Needs to slowly transition when she first gets up.

Might have cluster seizures before or after her menstrual cycle. Is taking medication for the discomfort and headaches.
Needst to be encouraged to drink fluids. She does not sweat and has atendency not to drink a lot.
Takes medication for agitation.
Rarely gets sick.
Stays with the group on outings and stays away from the road. However, she does become distracted in parking lots and may move toward her vehicle without looking for oncoming traffic.
Is very outgoing and friendly and could be vulnerable in the community if she did not have someone with her.

INDIVIDUAL SUPPORT PLAN

NAME:_____ CMH ID#_____

3. *Concerns about my health and safety: (*other than those listed previously)*

THE KIND OF HELP I NEED FOR MY HEALTH AND SAFETY IS:

Assistance with scheduling and attending appointments.
Assistance with medications.
Monitoring around the clock due to the frequency and intensity of seizures.
Medication helps, but the seizures are not under complete control.

Recommendations/ Referrals:

1) Continue with Support Coordination Services
2) Continue habilitation on CMH mobile crew.
3) Continue to receive financial support to maintain housing.
4) Continue to receive staff support to maintain safety, health and quality of life in supported living setting.
5) Community participation such as: bowling, classes, outings, having friends over and enjoying day outings. Attending church regularly is suggested.
6) Maintain contact with friends from Our Lady of Providence.
7) Maintain nursing services and regular monitoring as required.
8) Maintain psychology services for assessment, devising behavior plan and monitoring activity.
9) Dietician services available if needed
10) Excellent communication required between all members of support system to ensure the highest quality of life.

Opportunities / Dreams / Goals I'm not going to pursue right now and the reason:

The facilitator provided written information on CMH agency hearing Rights. It was agreed that the information will be used if needed.

How Can We Support Lucy?

Lucy said:

I need some help from someone in finding and learning a job

When I live on my own I need help with cooking

I will also need help getting groceries home

I need help with my medications

Others said.

Someone could help Lucy find a job working around animals.

Mom could put marks on oven dial, so that Lucy can start using the oven

Lucy could help put together a book of her favorite recipes using picture symbols

Lucy might need help for a while in changing sheets, getting used to public transit, getting to the doctor's office for her appointment, doing her laundry, and keeping her place clean

Make sure we help Lucy look for a place to live near a grocery store

Dad can get a small cart with a basket for Lucy to use to haul groceries from the store while she is living a home

Lucy's sister will make sure they have some fun time every week.

Lucy's Person-Centered-Plan:

My Plan for the Future Starts Now

This plan belongs to: Lucy Smith   When did I make this plan? 11/03/98

Moving toward the future, what are some first steps that I could take over the next six months to a year?	What kinds of support will I need from......	
	Family, friends, and community	Services
For fun: • Start a crafts project with my sister	• Go to the hobby store with my sister to see what kind of craft might be interesting. • Look at the adult education catalog to see if there are any interesting hobby or craft classes we could take together	
Learn how to type and use a computer	• Jenny will go with me to see what computer would be best for me • Make an appointment at the computer center in town	
For work: • Get a job	•	•
For living: • Learn more about living on my own or with others •	• Work on a plan at home with my parents to learn more about things like cooking and shopping for groceries, taking care of my own medications, etc.	•
For the future: •	•	•

The example of Lucy's Person-Centered-Plan is just that, an example. Agency

forms will be used to document the individual's plan. The example is to illustrate

that this indeed is the individual's plan based on their choices.

THRIVING* IN MY COMMUNITY

2. WHAT IS POSSIBLE

An Exercise in Brainstorming

Name: _____   Date: _____

PARTS OF MY VISION TO BE ACHIEVED	NEW EXPERIENCES, ACTIVITIES, GOALS, AND/OR ACTIONS THAT COULD HELP ME ACHIEVE MY VISION	FAMILY, FRIENDS, AND COMMUNITY CONTACTS THAT COULD HELP ME ACHIEVE MY VISION	OTHER RESOURCES THAT COULD HELP ME ACHIEVE MY VISION GENERIC SERVICES, SUPPORT AGENCIES, BENEFITS, FINANCIAL SUBSIDIES, ETC.

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APPENDIX I Page 11

St. Clair County Community Mental Health

Person-Centered Planning
Health and Safety

The items below are some examples of health and/or safety risks. This is, of course, not an inclusive list.

___ Is the person dangerous to self or others
___ Unsafe sex practices
___ Pregnancy
___ Sexual abuse
___ Alcohol abuse
___ Self harm
___ Aggression toward others
___ Verbal/emotional abuse
___ Physical abuse
___ Safety at home
___ Illicit drug use
___ Diet/nutrition
___ Nicotine use
___ Medication interaction
___ Medication side effects
___ Medication management
___ Chronic health problems
___ Non-attentive to need for health care
___ Hygiene
___ Household Maintenance
___ Physical disability
___ Seizures
___ Environmental Modifications

- Review Health & Safety issues that were identified by, discussed with the person, and identified by others.
- Identifies strategies for assuring that the person has access to needed and available supports to address health and safety issues.
- Identify individuals who are willing to assist the person in implementing strategies identified in the plan.
- Identify how follow-up will be accomplished.
- Justify if strategies are not included in the plan (i.e.) if the person is aware of the risk and chooses not to address it.)

Remember, if it isn't documented, it isn't done!

PV \\fileserv001\public\Peggy Lawton\Peggy's Files\PCP\HealthandSafetyChecklist.doc 04-25-01

INDIVIDUAL SUPPORT PLAN

NAME:_____   CMH ID#_____

3. Concerns about my health and safety: (*other than those listed previously)

THE KIND OF HELP I NEED FOR MY HEALTH AND SAFETY IS:

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For work: • Get a job	•	•
For living: • Learn more about living on my own or with others •	• Work on a plan at home with my parents to learn more about things like cooking and shopping for groceries, taking care of my own medications, etc.	•
For the future: •	•	•

The example of Lucy's Person-Centered-Plan is just that, an example. Agency forms will be used to document the individual's plan. The example is to illustrate that this indeed is the individual's plan based on their choices.

THRIVING* IN MY COMMUNITY

2. WHAT IS POSSIBLE

An Exercise in Brainstorming

Name: _____

Date: _____

PARTS OF MY VISION TO BE ACHIEVED	NEW EXPERIENCES, ACTIVITIES, GOALS, AND/OR ACTIONS THAT COULD HELP ME ACHIEVE MY VISION	FAMILY, FRIENDS, AND COMMUNITY CONTACTS THAT COULD HELP ME ACHIEVE MY VISION	OTHER RESOURCES THAT COULD HELP ME ACHIEVE MY VISION GENERIC SERVICES, SUPPORT AGENCIES, BENEFITS, FINANCIAL SUBSIDIES, ETC.

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APPENDIX I Page 11

PCP DECISION-MAKING PROCESS FOR DIFFICULT SITUATIONS

UTILIZING THE WHOLE PCP TEAM, INCLUDING THE CONSUMER:

1. Establish the basics:

   Who is on this consumer's PCP team? Other important people.
   Agree on the meeting format and decision making process.
   The consumer's dreams / wishes and aspirations for himself?
   Dreams / wishes of others for him?
   Strengths, positive characteristics, skills & abilities?

2. Determine what is important TO the consumer, and what is important FOR the consumer.
   What is important TO a person includes only what they themselves are "saying" with
      1) Their words, and
      2) Their behavior.
   When words and behavior don't match, the bias is to rely on behavior.
   What is important FOR people includes only those things that we need to keep in mind regarding
      1) Issues of health or safety
      2) What others see as important to help the person be a valued member of the community.

3. Identify what you know about the situation and what you need to find out.
   If you need more information, determine if you can go on at this point or whether you should reschedule the meeting.

   Determining what is working and not working for the individual and for those who support him could be useful. Utilize all sources of information, including people who may not be present.

4. If there is a dilemma about what and how much the paid services should do, determine the core responsibilities and what needs to be addressed with creativity and courage.

5. Brainstorm ideas, including the outlandish and impractical, about what could be done.
   All members of the team toss out ideas of what could be done. Keep it lively!
   All ideas should be recorded on a big sheet so that everyone can see them.
   DO NOT DISCUSS OR EDIT THESE IDEAS!

6. Review, evaluate, combine and extend the ideas until you have a possible approach to the situation.
   Use contrasting pens to link related ideas, zing the bad ones, highlight and expand good ones.
   Don't eliminate an idea just because you don't know who or how it could be implemented.
   Brainstorm again on knotty possibilities.

7. Try to anticipate what will happen if this approach is put into action. If the consequences of the plan are unacceptable then go to #8. If the anticipated outcome is positive, move to #9.

> *List what your fears are, including agency and community ones.*
> *List what you might try.*
> *List the most likely outcome of the ideas you've chosen.*
> *Decide whether the idea is worth whatever risk might develop.*
> > *Try to anticipate reduction-of-risk measures.*

8. Revise your ideas, by repeating the brainstorming process if necessary, and develop another approach.

9. Go back and check the plan against the requirements of what is important TO and FOR the individual.

10. Assign responsibility based on do-ability and commitment, utilizing the consumer, generic and natural supports before paid supports.

> *Identify each PCP team member's role, and the specific ways in which they support the*
> > *individual.*
> *Consider supports in this order:*
> > *1) the individual him/herself*
> > *2) family / friends*
> > *3) general community resources with or without accommodation (ADA)*
> > *4) other services for which he/she is eligible*
> > *5) CMH paid supports*

11. Determine the review period to evaluate the effectiveness of the outcome and consumer satisfaction.

12. Repeat the problem solving process as often as necessary to move toward effectiveness of and satisfaction with the plan.

NOTES: There are a lot of parts to working out a difficult issue. Occasionally the discussion will become contentious and the facilitator can redirect the team to the process that they have agreed to use to address the problem. Refocusing and re-stating the purpose of the meeting may help reduce animosity and lead toward more cooperative discussion. It is always work, for everybody. The focus person should be as much a participant as possible, and decisions made in his absence should be with his advanced agreement.

What is -

mportant to

Important for

What else do you need to learn/know?

Smull & Allen 2001

Important to
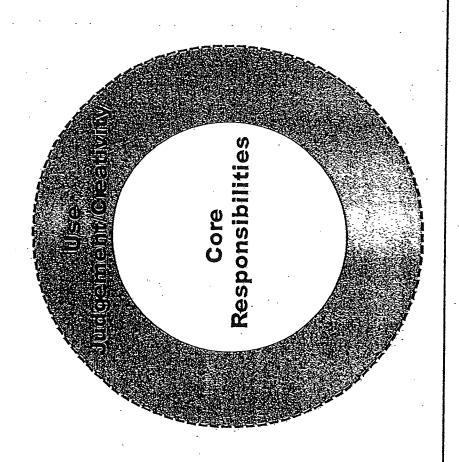
What is important to a person includes only what people are "saying":

- ❑ **with their words**

- ❑with their behavior

Where what people say is different from what they do the bias is to rely on behavior.

Smull & Allen 2001

Inside a Person's Life

Not Our "Paid" Responsibility
(Domain of friends)

Use Judgement/Creativity

Core Responsibilities

Smull & Allen 2001

Core responsibilities	Use judgment and creativity	Not our paid responsibility

Smull & Allen 2001

WHAT'S GOOD / WORKING FOR CONSUMER	WHAT'S BAD / NOT WORKING FOR CONSUMER
WHAT'S GOOD / WORKING FOR CONCERNED SUPPORTERS	**WHAT'S BAD / NOT WORKING FOR CONCERNED SUPPORTERS**
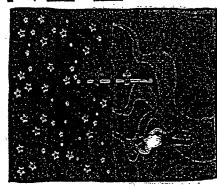
	What makes sense? What works? What needs to be maintained? (The Upside Right Now)	What doesn't make sense?...What needs to change? What doesn't work? (The Downside Right Now)

from Julie 's perspective	• Shopping as often as possible, daily even, for favorite things
	• Having lots of jewelry and watches to choose from and no one getting into them until I tell them it's OK
	• Having my sister, Joanne, who lives in Seattle in my life
	• Lots of clothes in my favorite colors, blue, red and black
	• Getting my nails polished in many colors and many layers
	• Living with my new friend, Teddy, the Yorkshire
	    o Sleeping on my bed at night
	    o Snacks from my plate
	    o In my lap when I watch TV
		• Staff don't let me drink whatever I want
		• The dog has to go in the other room during mealtime
		• When there's no work to do at WAC Inc
		• When I go shopping staff don't let me buy some things I want

from staff perspective:	• Favorite people doing activities with her, especially John Dandy
	• Keeping Julie from falling
	    o Reminders to use her walker
	• Blood sugar kept level
	    o Staff know Julie's signs of low and high blood sugar
	• Joanne is active in Julie's life
	• Planning before she goes shopping what she is going to buy
		• Julie is less steady on her feet and falling more than she used to
		• If you don't make a plan with her before shopping, she will want to buy more than she has money for
		    o Julie may get very upset which can alter her blood sugar
		• Julie gives Teddy food off her plate which means staff can't accurately track her nutrition

What are we worried about?	What might we try?	Likely result of what we tried?	Try – Yes, no, maybe

Smull & Allen 2001

7 questions that you should be able to answer for each person you support

1. What is **important to** the person?

2. What is **important for** the person?

3. Is what is **important for** being addressed in the context of what is **important to?**

4. Is there a "good" balance between **important to** and **important for?**

5. What does the person **want to learn**, what else do we **need to learn?**

   If the person is to get the balance described and we are to learn –

6. What **needs to stay the same** (be maintained or enhanced)?

7. What **needs to change?**

Smull & Allen 2001

3/24/03

7. Are there other things we need to know or do to support you?

Are there things that we haven't talked about that would help us
support you? For example, are there things we need to know or
do to support your health? Are there certain medicines you
take? Are there certain physical things that you should or should
not do? Are there certain things that we need to know or do to
make sure you stay safe? Are there things we need to know
about the food that you eat? Are there things that make you
upset that we need to know about?

Other Things We Need to Know and Do?

Listen to Me Communicate

This part of the workbook is designed to support people who do not use words to talk, or who have difficulty in communicating with words. This section is also useful for people who do use words to talk but are difficult to understand and as a way of recording how we communicate with people who have difficulty in understanding what we say.

The heading **what is happening** describes the circumstances that seem to affect what the person does. For example, it could be the place, the people around, or the activity that affect someone's behavior. The headings **and (person's name) does** describes what the person does in terms that are clear to a reader who has not seen it and would still recognize it. For people where it is something hard to describe (e.g., a facial expression), a picture or even a video recording may be preferred. The heading **we think it means** describes the meaning that people think is present. It is not uncommon for there to be more than one meaning for a single behavior. Where this is the case, all of the meanings should be listed. The heading **and we should** describes what those who provide support are to do in response to what the person is saying with their behavior. The responses under this heading give a careful reviewer a great deal of insight into how the person is perceived and supported.

What is happening	_____ does	We think it means	And we should

Solution Circles

A Solution Circle is a straightforward and efficient tool that helps people to get "unstuck" from a problem in life or work.

Time: 30 Minutes

Roles: Problem presenter; Process Facilitator to keep the process on task and on time; Graphic Recorder, and 3-9 amazingly creative solution team members. The more diverse the team, the better, sometimes people who know nothing in particular about an issue have ideas that spark real creativity.

Step One: (6 minutes)
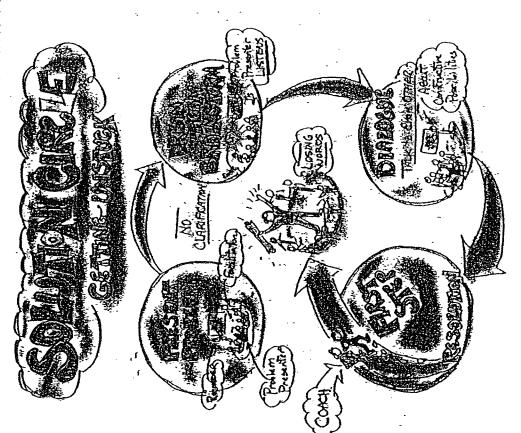
The Problem Presenter will have six uninterrupted minutes to outline the problem. The job of the Process Facilitator is to keep time and make sure no one interrupts. Get people in a tight circle so they can hear and see each other.

The recorder takes notes. The brainstorm team listens. If the Problem Presenter stops talking before the six minutes elapse, everyone else stays silent until the six minutes pass. The Problem Presenter gets six uninterrupted minutes. The Process Facilitator holds the silent space for the problem presenter.

Step Two: (6 minutes)

This is a brainstorm. Everyone chimes in with ideas about creative solutions to the problem that was just presented. It is not a time to clarify the problem or to ask questions. It is not a time to give speeches, lectures or advice. The Process Facilitator must make sure this is a brainstorm. Everyone gets a chance to give his or her brilliant ideas. No one can dominate. The Problem Presenter listens - without interrupting. He/she must not talk or respond. We often give the person masking tape to seal their

Solution Circles

-11-

lips (symbolically) and facilitate their listening. It's hard to just listen!

Step Three: (6 minutes)

Now the team holds a discussion with the Problem Presenter. This is the time to explore and clarify the problem. Focus on the positive points only and not on what cannot be done. The problem presenter leads off by identifying ideas that seem interesting, or different, or worth a try, or worth refining into possibilities for action.

Step Four: (6 minutes)

The Problem Presenter and the group decide on first steps that are possible within the next 3 days (and preferably within 24 hours). This is critical. Research shows that unless a first step is taken almost immediately, people do not get out of their ruts. The Problem Presenter chooses a coach from the group who volunteers to phone or see the person within the agreed time (1 to 3 days) and check if he/she took their first step. This creates a positive supportive pressure that helps people get into action.

Finally, the team does a round of words (each person uses one word to describe the experience) and the Recorder gives the completed record to the Problem Presenter. If the group is large, the teams return to the main group, debrief and continue.

Helpful Hints:

* Obey the rules - it works for you.
* The crisper the facilitation, the better the solution circle.
* Don't let people 'clarify' between step one and two.
* In Step Three, focus on the positive doable items - not what has already failed.
* Insist that people listen.
* Use the time pressure to push through - there is no time to waste.

Outcomes:

In our experience, people often find that this exercise generates action. It does not guarantee a solution, but often gets people unstuck, at least pointing to a different way to look at the situation or to a next logical step.

People sometimes discover that by following the rules of the exercise and focusing on an issue with a small group, breakthroughs can occur quickly. It is possible to move, through heavy constraints and be liberated to try new options.

Caution: The Solution Circle a great tool to use when you aren't sure where to begin. It is quick and can get people focused constructively. However, if you know the problem you are dealing with is complex you may choose to move directly to a MAP, PATH or other more comprehensive tool.

Marsha's Challenge:

Are you trying fast paced group problem-solving techniques?
If not, why not?

If you are worried about using Solution Circles yourself, who in your team will you ask to initiate them?

HEALTH MAP

Optional Map-Health Map: The purpose of the Health Map is to describe conditions that promote or threaten the health of the focus person. This is a good map to do when people have complex health, therapy, or medication issues that must be considered in the development of a plan.

Facilitation Tips

1. Note the conditions and indicators of good health in green, and the symptoms or problems of poor health in red.
2. Note special physical care needs, needed equipment and health routines, and issues such as diet and exercise.

HEALTH MAP	
✚	▬
Conditions that lead to good health.	Conditions that lead to poor health.

RESPECT MAP

Optional Map-Respect Map: The purpose of the Respect Map is to identify personal characteristics that create barriers to community acceptance, and that may lead to rejection by others, in contrast to the positive personal characteristics that help the focus person gain respect by others and develop relationships. This is a helpful map when people have complex characteristics and behaviors that challenge others.

Facilitation Tips:

1. Record respected characteristics and roles in green. These are qualities and characteristics that other people admire, value, and appreciate.
2. Record the odd or unusual behaviors that can lead to rejection or alienation by typical community members.
3. Clarify the frequency and context in which these behaviors occur.

RESPECT MAP	
✚	▬
Positive Characteristics	Qualities that often lead to rejection

St. Clair County Community Mental Health
Person-Centered Planning
Health and Safety

The items below are some examples of health and/or safety risks. This is, of course, not an inclusive list.

___ Is the person dangerous to self or others
___ Unsafe sex practices
___ Pregnancy
___ Sexual abuse
___ Alcohol abuse
___ Self harm
___ Aggression toward others
___ Verbal/emotional abuse
___ Physical abuse
___ Safety at home
___ Illicit drug use
___ Diet/nutrition
___ Nicotine use
___ Medication interaction
___ Medication side effects
___ Medication management
___ Chronic health problems
___ Non-attentive to need for health care
___ Hygiene
___ Household Maintenance
___ Physical disability
___ Seizures
___ Environmental Modifications

- Review Health & Safety issues that were identified by, discussed with the person, and identified by others.
- Identifies strategies for assuring that the person has access to needed and available supports to address health and safety issues.
- Identify individuals who are willing to assist the person in implementing strategies identified in the plan.
- Identify how follow-up will be accomplished.
- Justify if strategies are not included in the plan (i.e.) if the person is aware of the risk and chooses not to address it.)

Remember, if it isn't documented, it isn't done!
PL/ \\fileserv001\public\Peggy Lawton\Peggy's Files\PCP\HealthandSafetyChecklist.doc 04-25-01

PLANNING FOR RISK

A SAFETY NETS PLANNING TOOL

DEVELOPED BY
THE MARYLAND SELF DETERMINATION INITIATIVE

Permission to include this tool was granted by The Maryland Self Determination Initiative.

USE OF SUPPLEMENTAL TOOLS

A variety of supplemental tools are included with *Thriving in My Community: A Plan for Independence, Support, and Belonging*. The core plan is intended to be used with the supplemental tools that reflect the person's situation and needs. The supplemental tools may be used as presented or adapted. The key is to assure that pertinent information is addressed in the planning process.

PLANNING FOR RISK: A Safety Nets Planning Tool Developed by The Maryland Self Determination Initiative (*Appendix II Pages 1-5*)

To develop a safety net, it is necessary to think through emergency back up plans related to significant health or safety issues and arrange for them to be in place *before* a new situation begins. This tool offers a guideline for assessing individual health and safety risk factors and planning safety nets in response to such factors. It addresses health care, emergencies, competencies, environment, financial, communication, life cycle changes, amount of support hours needed, and training of paid support.

For a person who desires increased independence in their living situation, it is useful for someone who knows the person well to review the guidelines with him or her and identify areas where support will be needed. This may happen prior to the planning meeting so that information is available when planning. Or it may be an activity included as part of the plan, provided a mechanism is in place to assure the necessary supports are addressed before the new support situation begins.

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PLANNING FOR RISK

A Safety Nets Planning Tool Developed By
The Maryland Self Determination Initiative

1. In order to protect people's health, safety, and consequently freedom, it is necessary to identify health and safety risk factors and create supports (and back-up plans) to minimize risk.

2. It is important to develop trust. Risk should be addressed not by limiting freedom or automatically suggesting the person stop an activity, but by helping the person look at ways to be safe within the choices they have made. A person may chose to take a risk without safeguards. If the risk does not overly jeopardize the person's health or safety, the person's choice should be honored.

3. Situations which present a high level of risk and serious consequences for health or safety should not be supported if adequate safety nets cannot be identified. Groups of people planning with the person need to figure those situations out. Continued work should happen to at some point sufficiently reduce risk so the person can proceed. (There is an obligation to use state funds for support in a way that does not promote harm to the person.)

GUIDELINE FOR ASSESSING RISK AND PLANNING SAFETY NETS
For each of the following
1. Can the person do this on their own or do they need support? If they need
2. support, do they want to learn to be more independent in this area?
3. Specify who will support for each thing (family, neighbors, friends, paid support, etc.)
4. What accommodations or adaptations can be made to minimize risk? Consider strategies or items to support as well as people.
5. Be sure all necessary people have a listing of safety nets planned.

HEALTH CARE
- Can the person give medical consent (if not, who?)
- Can the person take medication on their own?
    - if not self-medicating, who is available to help (neighbor, family, etc.)?
    - how is it monitored to assure person receives medication?
    - log at home reviewed weekly by a person in monitoring role
    - if a serious problem, should there be closer monitoring, e.g. a phone call confirmation to designated person?
- Can the person arrange medical care?
    - can the person explain medical needs to involved support and health care providers?
        - who will make medical appointments and arrange transportation?
    - who will provide information to the physician about medication prescribed?

- who will keep a list of all physicians that are seen and their phone numbers'
- who will keep the insurance information and procedures?
- if unable to identify illness, will the person receive an annual exam to help identify issues? Will support people know how the person indicates illness?
- Can the person arrange to receive follow up care needed?
  - including replacing old medications with current
  - someone e.g. pharmacist to verify medications will not poorly interact
  - arrange repairs e.g. wheelchair, obtain hearing aid batteries, etc.
- Does the person have knowledge of basic first aid and response to medical emergency?
- Can the person plan their diet and nutrition needs?
  - follow plan to address dietary needs
  - consider lifestyle, opportunities and ways to support the person (e.g. if don't know how to cook or feel it is a hassle to prepare a nutritious meal for one, perhaps support staff can assist to cook and freeze individual portions for on weekends.)
- If medical or other technology is relied upon and it failed, would the person be safe
- Is there a backup? (e.g. telephone by a bed if hoyer lift is used)
- If a diabetic or similar health concern, does the person wear a medic-alert?
- Look at all medical issues, rate of clinician involvement for those things, and who will help for what to assure sufficient plan of support
- Do medical needs require that one designated person monitor all medical information?

EMERGENCIES

- Does the person know or always carry his/her address and telephone number?
- If something happens, who can the person call? who can the family call? (see attached list)
- Does the person also have telephone numbers of back up people?
- Does the person know those telephone numbers or carry them with them?
- Do involved community members have a number to call if they have a concern?
- (In the end, it is the friend in the community who may act on behalf of the person David Schwartz)
- Does the person carry necessary emergency information (name, emergency con person, allergies, etc.) in the event of incapacitating accident
- Does he/she know how to access emergency medical/fire/police services (e.g. dial 911)?
- Does the person know how to respond in case of fire, crime, eviction notice?
- Does he/she know what to do in the event of a household systems failure (electric, plumbing, telephone, gas, heat, etc.)
- If a support person does not show up when they are scheduled, does the person know who to contact and their phone number?

COMPETENCIES

- Observe skill ability, e.g. can person cook on a stove, cross street on his/her own
- What supports are needed by a person who is learning a new skill but does not have skill yet?
- Assessment of competencies by someone who knows person well (see sample.)
- Assess personal safety awareness and strategies, for example:
  - safe sex and prevention of sexually transmitted diseases
  - sexual vulnerability and exploitation
  - awareness of unsafe situations such as being out late in some places, etc.
- Is the person aware of the risk of door-to-door salesman and phone solicitors and how they can be talked out of money, etc.

ENVIRONMENT

- Is the person aware of locks on doors and windows and how they are used?
- Do they have keys and know where spare keys are located? Does someone else (family, staff, neighbor) have a spare key?
- Is there a security system in the home? Does the person know how to use it and who to call if it is set off?
- Are there grab rails in the bathroom if needed?
- Is there a non-skid bath mat in the bathtub?
- Is hot water set at a reasonable temperature or is the person able to safely adjust
- the water temperature? Are there scald guards installed throughout the home if needed?
- Is the home wheelchair accessible to all areas if needed?
- Is the telephone programmable if needed and a list of all programmed numbers by the phone?
- Is the person familiar with any necessary restrictions about using the stove or microwave oven and are accommodations planned?
- Are there smoke detectors and fire extinguishers and does the person know how to use them?
- Can the person secure his or her valuables to the extent desired?

FINANCIAL

- What help if any does the person need to take care of the day-to-day financial matters, e.g. ATM cards, charge cards, cashing checks at the bank.
- Does the person need help in preparing or following a budget that matches income expenses?
- Does the person need help with paying of the bills, e.g. rent, medical etc.?
- What checks and balances are in place to protect the person's financial resources?
- What would happen if the person sharing their home and expenses leaves?
- What would happen if an increase in the person's income causes loss of Section 8, but did not cover expenses?
- Does the person need assistance if there is a change in income or loss of employment?

COMMUNICATION
- If there are several support people involved, what information needs to be shared and how will it be shared?
- If the person communicates in ways other than verbally, describe what is known about their communication style, e.g. when the person does ___ we think it means ___ and should happen. Or use 'Listen To Me' or other tools.

LIFE CYCLE CHANGES
- If the person is planning to move to a new place, how will they deal with the stress of moving and change?
- What would happen if there were a change in the health (or death) of a parent
- What would happen if the person becomes pregnant? Begin menopause?
- What would happen if the person decides to get married; how would that affect their benefits?
- What would happen there were cultural changes in the person's life.

AMOUNT OF SUPPORT HOURS NEEDED
- Identify what the person needs in terms of support hours: day, evening, weekdays, weekends and who will assess. Will there be more support needed at the onset?
- Address any needs related to daily living skills: meal planning, shopping, budgeting, personal care.
- Does the person have other family, friends or neighbors who could help out when there is a need
- Always be prepared when the situation changes. Can the person easily access additional support if needed?

TRAINING OF PAID SUPPORT
- Get input from family and significant others, as well as the person, to help get support people in working well with the person.
- Look at important key issues for individual. Build individualized job description and training. What role does the person want to play in training their staff?
- Identify how to foster a non-"staff" relationship. Teach about invisible support.
- Teach how to assess and plan for risk following principles listed at the beginning
- Minimize turnover.
    - pay well; build in incentives to meeting outcomes associated with individuals plan e.g. finding a job, having new relationships with others in the community, with the rewarded outcomes changing with each year's plan.
- Consider video taping essential training/information about the person in the event of turnover.

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CONFLICT SETTLING TOOLS

Some tension in a meeting may take place. This is not always a bad thing. But some types of tension turn into conflict that takes place out in the open.

This is not a good thing.

When you are helping everyone participate in the planning meeting it is good for you to know some simple conflict settling tips. Here are a few you can use and the times you may want to use them:

- "Broken CD Technique": When a person wants to take over the meeting and talk about things the consumer does not want talked about, you can use this tool. Repeat what you say, with no changes, over and over until you get the other person's attention.

Speaker: I want to talk about Jim's smoking.

Facilitator: Jim does not want to talk about smoking at his meeting.

Speaker: But Jim shouldn't smoke!

Facilitator: Jim does not want to talk about smoking at his meeting.

- "Soft versus Loud": A person may raise his voice to overpower your role as gatekeeper and take over the meeting. Capital letters are shouting and small letters are your response as you get softer and softer until the other person catches on and has to lower his voice to hear you.

Speaker: But JiM WILL GET CANCER IF HE DOESN'T STOP!

Facilitator: I understand you are worried about that. But Jim is an adult and does not want to stop smoking.

You can add broken CD tool if you need to so the message gets across.

Prepared words to say: You may become upset or angry yourself in a conflict with someone else. It is a good idea to know what your limit is and use a tool to end a conflict before it gets out of hand. You can prepare a set of things to say in certain situations, such as:

Angry: I know that you are angry and I do not blame you. But anger is less helpful than talking things out calmly. We are here to talk about _____.

Sad: It sounds like you are sad right now. Let's take a time to get ourselves together and then move on.

Unhappy with a decision made by the group: I'm sorry you feel that way. The rest of the group has decided that issue. Let's move on and talk about something else now.

L:\Presentations\CONFLICT SETTLING TOOLS FOR IPOS (PCP) TRAINING.doc

CONFLICT RESOLUTION STYLES

TYPE	FAVORITE PHRASE	BEHAVIOR
COMPETITOR	"Do it my way." "I'm always right."	Tries to win, usually making another lose. In this style, a person defends his/her position or pursues his/her goals without regard to the needs of the other person. *Traits:* dominates, dictates, seek revenge, insults, berates others.
ACCOMMODATOR	"I'm sorry." "You're right, I'm wrong."	Puts aside one's own needs to satisfy the needs of another. *Traits:* self-sacrificing, appeaser, abdicator, takes the blame.
AVOIDER	"Let's talk about this later." "Forget it."	Refuses to deal with conflict. *Traits:* withdraws, ignores, isolates.
COMPROMISER	"Let's split the difference." "Let's compromise."	Gives up something in order to get something. Attempts to reach middle ground. *Traits:* bargains to find compromise.
COLLABORATOR	"Let's find a fair solution for both of us." "We're both right."	Assumes that both people can get their needs met. *Traits:* harmonizer, problem solver, seeks satisfaction for all.

Active Listening Techniques

1. Finding out more information
Examples

"What are you concerned about?"
"When did this begin?"
"How long have you known each other?"
"Where did you last see your books?"
"How much money do you think it was worth?"

2. Repeating back the information
Examples

"So you would like her to stop giving you dirty looks."
"You're saying that you don't know when you first noticed it happening."
"So you feel like he owes you $9.00."
"So you would still like to be her friend if she wants to be yours."

3. Repeating back the feelings
Examples

"You seem angry about all of this."
"I get the feeling that you are sad about what has taken place."
"You seem frightened about what is going to happen."
"You seem mad about the situation."

4. Encourage the party to speak
Examples

"Please go on."
"Thanks for taking the time to explain this to us. We appreciate your patience."
"Tell me more, I really want to make sure that I understand what you want."
"You are really working hard to resolve this. Thanks."

5. Summarizing what the party says
Examples

"So you are saying that you are concerned about these three things: the money, your friendship, and getting your books back."
"So overall you seem to be saying that you like her, but you don't really want to be friends anymore."
"The things that you want from him are . . ."
"You're saying that the problems you want to talk about here today are . . ."

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I-MESSAGE

Speaking So Others Can Listen

When we have strong feelings in a conflict, especially anger, we often use "you messages". These are statements that start with "you" and that accuse, blame, or belittle the other person.

Strong feelings can be expressed without making the conflict worse, by using "I-Messages". In using "I-Messages", the speaker states his or her feelings about the situation without accusing or blaming. "I-Messages" are a good opening to problem solving.
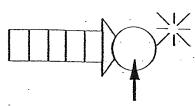
Key Components:
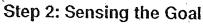
I feel _____
            (use feeling words)

when _____
            (describe the behavior non-judgmental)

because _____
            (describe what effect the behavior has on you, again non-judgmental)

And what I'd like is... or
Please _____
            (give a positive outcome of what you would like)
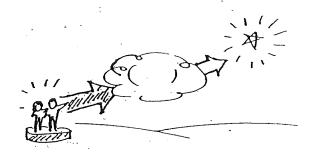
I-Messages are only a non-threatening opening to communication. It is most effective to spend time in advance composing the I-Message that most accurately states the speaker's feelings and needs.

Step 2: Sensing the Goal

The Dream is an expression of identity and orientation. It gives direction. However, the Dream is not the pathfinder's goal. The goal helps the pathfinder realize and deepen understanding of some of the values expressed in the dream. Identifying your goal for your *Path* depends on having a vivid, colorful, multi-sensory image of the results of what effective work toward the dream would look like. The more specific the images of these "results" the better. To describe the sense of success, the pathfinder uses the thinking tool of looking backward. The pathfinder vividly and concretely imagines that success has already happened and describes the changes that have resulted as if they are real. This process of trying on the future can seem awkward at first, but it can be clarifying.

Invite the pathfinder to travel forward in time in order to vividly imagine what they want to create
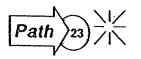
🗨? Do you think that you could accomplish some important results in a year's time? [If not, try 18 months, 2 years]. When the pathfinder agrees on a time frame, ask the date by which you will have some important results (today plus one or more years). Write the date on the record. Be sure they write the correct future year. The ideal time frame is something that is "just beyond your grasp". If you already have a one year plan, push beyond it into uncertainty - but not too far. Just enough to create some tension...

🗨? "Imagine that today is [the future date above]. You are taking time out to reflect on how far you have come since [today's date]. You have done an incredible amount of hard work over the last months. There were ups and downs and

When we dream alone
It is only a dream,

But when we
dream together

It is the beginning
of reality.

-Dom Helder Camera

Path 23

times when you felt lost, and there is still much to do. But when you look back and see how far you have come since [today's date], you feel a real sense of accomplishment and pride. Your dream is even more clear now because of what you have been able to do."
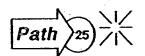
- "Tell us what has happened. What, specifically, can you point to as the signs of what you have created? What you have done?" For example, if a school team "remembered" that the Grade 10 class planned a trip together and everyone went, push them to remember the details. "Where did you go? Who was on the committee? What was the funniest incident? Who was involved?"

- Keep asking for specific details: "Help us to see, and hear, and smell, and taste, and touch (remember) what you have created/done."

- Let the pathfinder describe whatever accomplishments seem significant. There may be accomplishments in a number of different areas. Record them all.

- If this step yields accomplishments in a variety of different areas, invite the pathfinder to focus on the area of accomplishment that seems most important to explore now. It usually works better to do more than one meeting than it does to explore several paths at the same time.

⬜(?) Ask the pathfinder to quietly review the record of accomplishment, add anything they want, and then share some feeling words associated with the accomplishments (Add the feeling words to the record).

The facilitator finishes this step by summarizing the pathfinder's sense of success and getting confirmation that the summary is accurate.

Maori Wisdom:

  Wishing

  never filled

  a game bag.

  the wall

at Uncle Whitu's

Lake Taupo, NZ

Step 6: Charting Action for the Next Few Months

The pathfinder cannot find a way through a complex situation without taking action (Do It) and learning from it (Reflect). The pathfinder needs to chart the main actions for the first few months of their work.
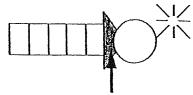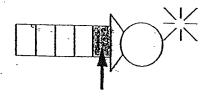
Invite the pathfinder to chart their next three months action:

⬜? Go back and briefly review your image of what you want to create (step 2). Think about the next three months. This should be time enough to take some important action toward what you want to create. What are the most important steps to take in the next three months? (Ask the pathfinder to be concrete and specific in describing each step.)

⬜? Check to see that the pathfinder has considered each aspect of the area they have highlighted for focus. The pathfinder may decide that they will not take action on a particular aspect of what they want to create, but they should decide explicitly to wait before taking action.

⬜? Ask the pathfinder to take a minute to check and make sure that the actions they have chosen are consistent with their dream (step 1). If the pathfinder identifies actions that don't uphold the values expressed in the dream, take time to make revisions.

⬜? Ask the pathfinder to highlight the actions that seem possible to do without any additional resources.

• If the pathfinder has selected a longer term goal (say 2 years), they may prefer to chart action for 6 months or a year.

• The facilitator finishes this step by summarizing the pathfinder's ideas about how to build strength and getting confirmation that the summary is accurate.

Step 7: Planning the Next Month's Work

Specifying who will do what by when during the upcoming month clearly focuses the process on action.

Invite the pathfinder to plan the next month:

☐⟨?⟩ If you are going to accomplish what you want in the next six months, you will have to take actions now...
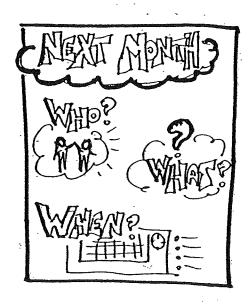
... exactly what will you have to do, and
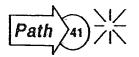
... by what day in the next month

... who, does what, when

☐⟨?⟩ Check to make sure that the pathfinder plans, or schedules a time to plan, for each of the areas they charted for the next three months (step 6).

The facilitator finishes this step by summarizing the pathfinder's plan for the next month and getting confirmation that the summary is accurate.

Path 41

THRIVING* IN MY COMMUNITY

3. PLAN TO SUPPORT MY PERSONAL VISION STATEMENT

What We Will Do Now

Name: _____ Date: _____

ONE OF THESE FORMS WILL BE COMPLETED FOR EACH PART OF THE VISION TO BE ACHIEVED, I.E. EACH OUTCOME OR GOAL
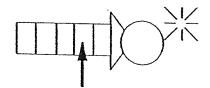
PARTS OF MY VISION TO BE ACHIEVED DESIRED OUTCOMES	NEW EXPERIENCES, ACTIVITIES, GOALS AND/OR ACTIONS CHOSEN	WHO WILL		REVIEW	WHEN	
		MAKE IT HAPPEN	REVIEW PROGRESS	DATE	BEGIN	COMPLETE

*Thrive: To make steady progress, to prosper, to grow vigorously, flourish.
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APPENDIX I Page 12

Step 8: Committing to the First Step

Moving from thinking to action requires commitment to a clear first step. The size of the step matters less than specific pledges to take action by a close and definite time. Breaking the grasp of inertia is critical...

Invite the pathfinder to commit to a specific first step:

creating what you want?

⮕(?) What is the biggest barrier to taking this step?

⮕(?) Who, specifically, will support you in this step?

⮕(?) How will you enlist their support?

The facilitator finishes this step by summarizing the pathfinder's first step and getting confirmation that the summary is accurate.

In committing to the first step, there are three elements:

Support

Change is inevitable;
Growth is optional

Marsha & Jack

• identifying a first step
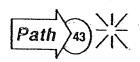
• identifying people to support your first step

• checking for "blocks" to action

In many situations, people can identify a first step with ease. However, from lifelong habits, they might neglect to begin their journey with a new essential step – asking for support. Thus, ensure that no one takes their first step on the new journey alone.

Barrier

The extent of support may be simple – but the new habit is vital. It could be as simple as asking a colleague to phone at noon and ask if you have made your "first step" call yet. In effect, give them "permission", an invitation to bug you. Giving

permission to someone to be involved is a very important kind of invitation to add to your new repertoire.

In other instances, people may seem to be blocked from a first step. This is vital information and must be treated delicately. It is a good practice to talk about blocks with every group because we all encounter them from time to time. However, if the pathfinders are genuinely struggling with "first step" kinds of issues, chances are it is a deeper issue and it should be teased out. A good question:
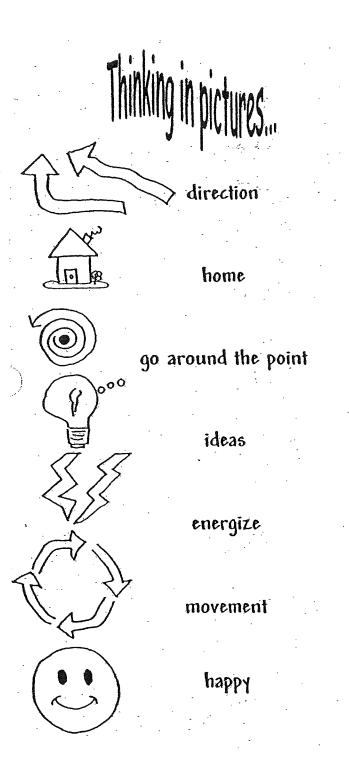
❏❓ Is there anything blocking?

❏❓ Is there anything that isn't on the *Path* that needs to be there? Is there anything missing?

One possibility that explains "stalls" is that people got into the process and suddenly realized that success is achievable, if they are willing to make a commitment and work hard. This can be very unnerving since it means they actually must decide if they are willing to make an adequate commitment. Some people choose not to proceed, but the process makes this a conscious choice and so it can be difficult to face.

Alternatively, there may well be an underlying unresolved issue which has been ignored, avoided, or simply forgotten – until now. In some instances, that can be sorted out on the spot. In others, it may well be that until that issue is resolved, the whole *Path* process is put on hold. Some might think this is a terrible waste, but if the process does nothing but strip away the layers to reveal a central underlying issue, this could be enormously helpful – if people choose to work with it and through it.

Thinking in pictures...
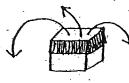
Be creative at your next meeting!
a great way to put participants at ease...

direction

home

go around the point

ideas

energize

movement

happy

learning

get out of the box

together

gifts

love

dream

money

PRE-PLAN / PERSON CENTERED PLANNING MEETING VISITATION

Individual's name _____]Date / Pre-Plan _____
Complete Address _____]Participants _____
Parent/Gdn. _____]_____
Home Provider _____]_____
Visitor/recorder _____]_____
Location _____ Time _____]Date / PCP _____

POSITIVE PROFILE   ]People / Rel. I=invited A=att.
_____   ]_____
_____   ]_____
_____   ]_____
_____   ]_____

DREAMS / WISHES (Whose?)   ]_____
_____   ]_____
_____   ]_____
_____   ]_____
_____   ]_____

FEARS / BARRIERS   ]_____
_____   ]_____
_____   ]_____
_____   ]_____
                                                   ]_____

ACCOMMODATIONS / TRAINING SERVICE/ TECHNOLOGY NEEDED
_____
_____
_____
_____

GOAL(S)
_____
_____
_____
_____

OBJECTIVES / TIMES/ RESPONSIBLE PARTY
_____
_____
_____

COMMENTS
_____
_____
_____

Listen to Me Communicate

This part of the workbook is designed to support people who do not use words to talk, or who have difficulty in communicating with words. This section is also useful for people who do use words to talk but are difficult to understand and as a way of recording how we communicate with people who have difficulty in understanding what we say.

The heading **what is happening** describes the circumstances that seem to affect what the person does. For example, it could be the place, the people around, or the activity that affect someone's behavior. The headings **and (person's name) does** describes what the person does in terms that are clear to a reader who has not seen it and would still recognize it. For people where it is something hard to describe (e.g., a facial expression), a picture or even a video recording may be preferred. The heading **we think it means** describes the meaning that people think is present. It is not uncommon for there to be more than one meaning for a single behavior. Where this is the case, all of the meanings should be listed. The heading **and we should** describes what those who provide support are to do in response to what the person is saying with their behavior. The responses under this heading give a careful reviewer a great deal of insight into how the person is perceived and supported.

What is happening _____ does	We think it means	And we should

Person Centered Pre-Planning Meeting

Name:_____ Date:_____

Supports Coordinator/Case Manager/Primary Caseholder:_____

THE SUPPORTS COORDINATOR/CASE MANAGER/PRIMARY CASEHOLDER HAS:

1) Explained Person-Centered Planning (PCP) to me and/or my principal representative: ☐ Yes ☐ No

2) Provided the brochure on Independent Facilitation and explained the option of asking for an Independent Facilitator: ☐ Yes ☐ No

3) I can understand (☐Yes ☐No) and speak or answer for myself (☐Yes ☐No), or have the assistance of an individual who knows me well and has a positive outlook for me. Person's name: _____ Relationship:_____

4) Family, friends and others in my life are:_____

_____

_____

5) Of this group, I would like the following to attend my Plan of Service meeting:_____

_____

6) I *do not* want these people to attend:_____

_____

7) I want this person to facilitate my Plan of Service meeting *(Myself, Friend, Supports Coordinator, Independent Facilitator)*:

_____

8) I would like _____ to record the meeting, and I prefer this method (wall charts, note taker, Index cards, worksheets, mini-chart, etc...) _____

9) When and where I would like to have my Plan of Service meeting to assure attendance of chosen people:

   Day: _____ Date: _____ Time: _____ Location:_____

10) Topics I would like to discuss at my Plan of Service meeting are *(Including Hopes, Dreams, Desires and Plans for the Future)*:_____

_____

_____

_____

11) Topics I do not want to discuss or want to address at a different time are:_____

_____

_____ And with whom? _____

_____

12) How family and/or friends will be involved in the planning process and fulfilling my plan

_____

_____

_____

_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

PROPOSED FRAMEWORK for PCP / IPOS FORM
CONFORMING TO ELEMENTS OF PCP PRACTICE GUIDELINES & REVIEW PROTOCOLS

Prepared by Bea Russell, PCP Consultant
Sanilac Co. CMH

Key to references
[C:#] *PHP Review Protocol*
{I.A#.a} Revised Practice Guidelines

SECTION I

A. IDENTIFIERS / PCP MTG. INFO

1. Identify Individual

2. Meeting Date, Time, LOCATION   {III,A,5,d,e}
   Where/when pcp

3. Treating Professional & FACILITATOR   {III,A,4}
   Who invited

B. PERSONAL PROFILE

1. LIST OF PEOPLE IN PERSON'S LIFE
   Name of individual _____ Did he/she attend meeting? If no, why?   {III,A,7,c}
   Choice not gdns.

   Indicate level of participation & how plan will be communicated.   {III,A,7,a}   [C.1.5]
   Acc. Comm   Pre-pl.   [C.2.7]
   Comm.

   Names & Relationships , invited to PCP / attended (checkboxes)   {III,A,5,c}
   Who invited

2. STRENGTHS, SKILLS, POSITIVE CHARACTERISTICS   {II,A,C}   [C.2.2]
   Str / Gifts   Strngth.   [C.2.8]
   ADD Cult. Hx

3. PERSON'S WISHES, DREAMS, ASPIRATIONS, DESIRES   *Domains*   {II,B,C,D}   [C.2.1]   [C.2.5]
   Choice,gifts,ind.   Dreams   Hlth / sft

   Wishes of others for the person.

SECTION II

A. **BARRIERS**   *Domains* (ADD <u>Community</u> to domains)

1. Why individual is seeking services.   [C.2.9]
                                                                         Community

                                    {III,B, B,1-3}
                                    Req serv

2. Diagnosis, and how it affects achievement of desires.

3. Health and safety needs, related to or apart from personal desires.   {III,A,6,a,b,}   [C.2.5]
                                                                         H&s, crisis plan   Hlth / sft

B. **TREATMENT, SUPPORTS, TRAINING, ACCOMMODATIONS NEEDED**
   to achieve dreams, safety & health.   {III,6,a,b,c}   [C.2.3]   [C.2.5]
                                                                         H&s, crisis plan, Serv / Sup   Hlth / sft
                                                                         Amt, scope, dur   Amt, scope, dur.

1. **ASSESSMENTS** as needed

2. **DOMAINS** <u>checklist</u>just to determine coverage of all areas.   {II,D}   [C.2.9]
   (ADD <u>Community</u> to domains)   Max ind / comm.   Comm.

   Maybe "concern / not a concern" / "see goal # _____." (ask for each domain)

SECTION III

A. SUMMARY (maybe landscape format with CODE column for Self / Natural Supports / Generic Community / Coop Agency / CMH Service (including dev. of Nat Sup).

1. DREAM / GOALS / OUTCOMES
   {III.B,6}   [C.2.4]   [C.2.10]   [C.2.4]
   Amt, scope, dur   Nat Sup   Ongoing input   Nat supp
                                                   [C.2.12]
                                                   Mngfl. act

2. OBJECTIVES / WHO / DOES WHAT / WHEN / CODE
   {III,B,6 a-d}   { II, C}   [C.2.3]   [C.2.4]   [C.2.8]   [C.2.11]   [C.1.12]
   S & S   S & S   S & S   Nat. sup.   Cult. iss.   Fam Foc S&S   Mngfl. Act.
   Amt, scope, dur.   Amt, scope, dur

3. DIAGNOSIS / Continuing eligibility / start, ↑,↓, change services

4. DESIRED FREQUENTY OF PLAN REVIEW &
   {III,B,6,c}   [C.2.3]   [C.2.14]   [C.2.15]
                      S&S   Freq. Rev.   Ongoing feedback
                      Amt, scope, dur.   Amt, scope, dur.

5. DURATION OF TREATMENT   [C.2.3]
                                   S&S, Amt, scope, dur.

6. PLAN GOES INTO EFFECT
   COPY OF PLAN SENT TO CONS / GUARDIAN _____   {III,A,9} {III,A,6,c} [C.3]
                                                     Copy   Eff. date   Copy / Eff. date

7. PROGRESS SHALL BE RECORDED / CHANGES IN PLAN MADE PER NEED OR CONSUMER REQUEST.
   Progress reviewed as scheduled or requested.
   {III,A,8}   {IV,B,6}   [C.5]   [C.4]
   Fd bk   Prog./rev./modify   Rev.   Assuring Serv.