

# Being a Planner with a Person with Disability and Complex Support Needs: Planning resource kit

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# BEING A PLANNER WITH A PERSON WITH DISABILITY AND COMPLEX SUPPORT NEEDS

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Planning resource kit

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The Intellectual Disability Behaviour Support Program, UNSW, project team comprised: Dr Susan Collings, Dr Angela Dew and Associate Professor Leanne Dowse.

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## About the Planning Resource Kit

This Planning Resource Kit is intended to strengthen existing good practice and to provide guidance for engaging a person with complex support needs in planning. The kit is aimed at workers in planning or related roles, such as case managers or service coordinators, who engage with people with complex support needs.

The term 'complex support needs' captures the sense of multiple interlocking experiences and factors that span disability, health, behavioural and social issues over the life course<sup>1</sup>. Individuals with complex support needs face significant vulnerability to marginalisation and disadvantage within the service system and in the community<sup>2</sup>. 'Complexity' is a product of individual life situations and the failure of support structures to respond appropriately over time. In recognition of these overlapping factors, an ecological approach is applied in the kit, taking into consideration person, service and system level domains.

The development of the kit is in response to recognition that people with complex support needs are likely to require more intensive and coordinated support for a longer duration than other people with disability. Planning is an important element in effective responses to complex support needs however many people with complex support needs will also require ongoing case management and/or service coordination to achieve their goals. The Planning Resource Kit focuses on the planning process and does not address the issue of who, other than a planner, may be responsible for the implementation and sustainability of a plan.

**As described in this resource kit, planning is envisaged as a three-stage process:**

- » Stage 1: Pre-planning
- » Stage 2: Planning conversations
- » Stage 3: Plan-to-action

Each of these stages is described in this kit with explanatory notes and a case study example to assist the user to apply the concepts to their planning role. The Planning Resource Kit is designed to be used in conjunction with other planning tools and resources appropriate to the person, the planner, the service sector and the broader context in which the planning is undertaken.

<sup>1</sup> Rankin & Regan, 2004 (2004). *Meeting complex needs: The future of social care*. London: United Kingdom: The Institute for Public Policy Research.

<sup>2</sup> Dowse, Cumming, Strnadová, Lee, & Trofimovs, (2014). Young people with complex needs in the criminal justice system. *Research and Practice in Intellectual and Developmental Disabilities*, 1, 174–185. doi:10.1080/23297018.2014.953671

Being a planner with a person with disability  
and complex support needs (CSN): Planning resource kit

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# Stage 1: Pre-planning

The purpose of Stage 1 is to guide the planner on the steps taken to gather information about the person and prepare for a meeting.

## Stage 1: Pre-planning

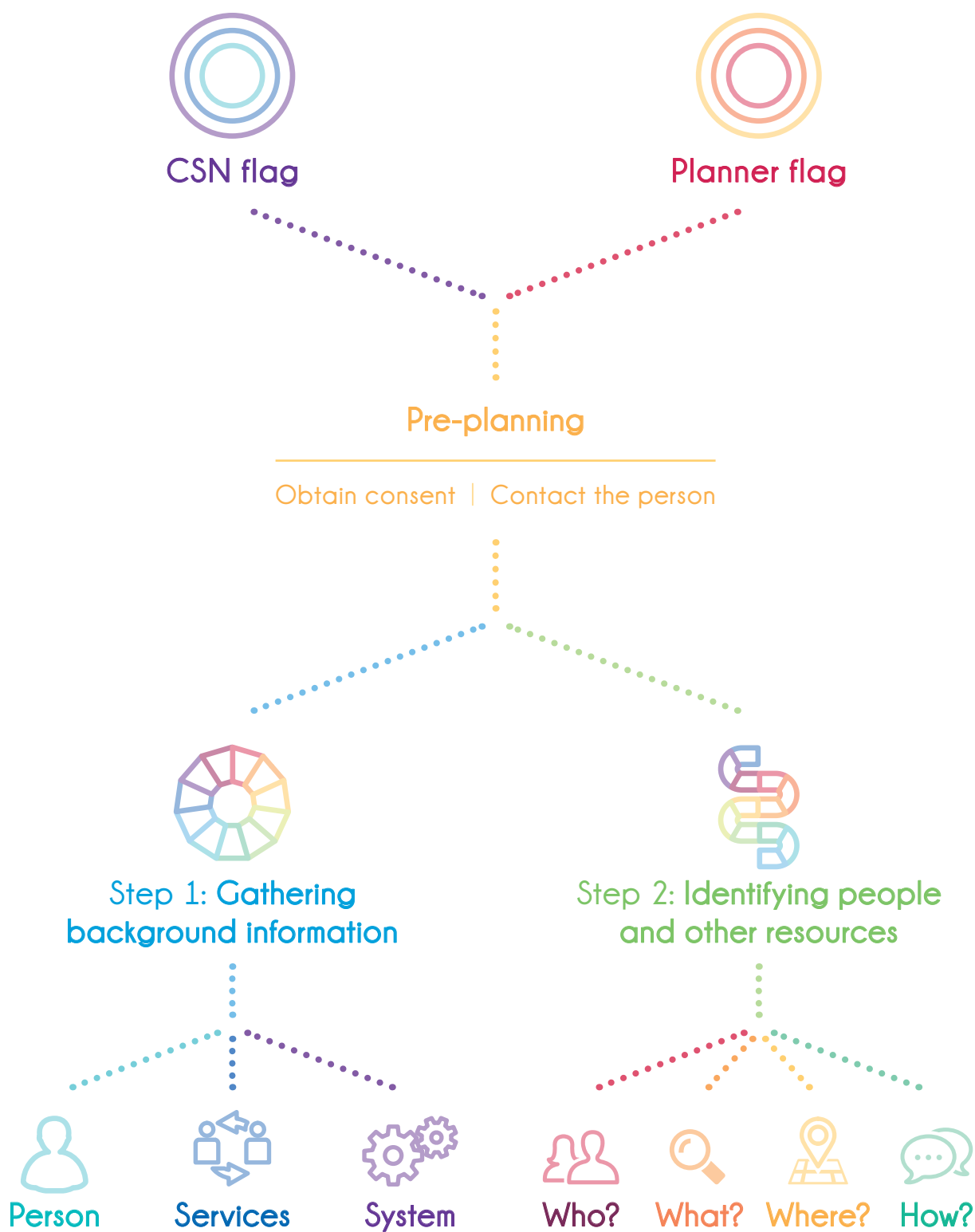
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# Overview

The Pre-planning overview diagram is a visual table of contents for preparing for the planning conversations.

**Stage 1** is broken down into 'Step 1: Gathering background information' and 'Step 2: Identifying people and other resources'.

## What is in Stage 1?



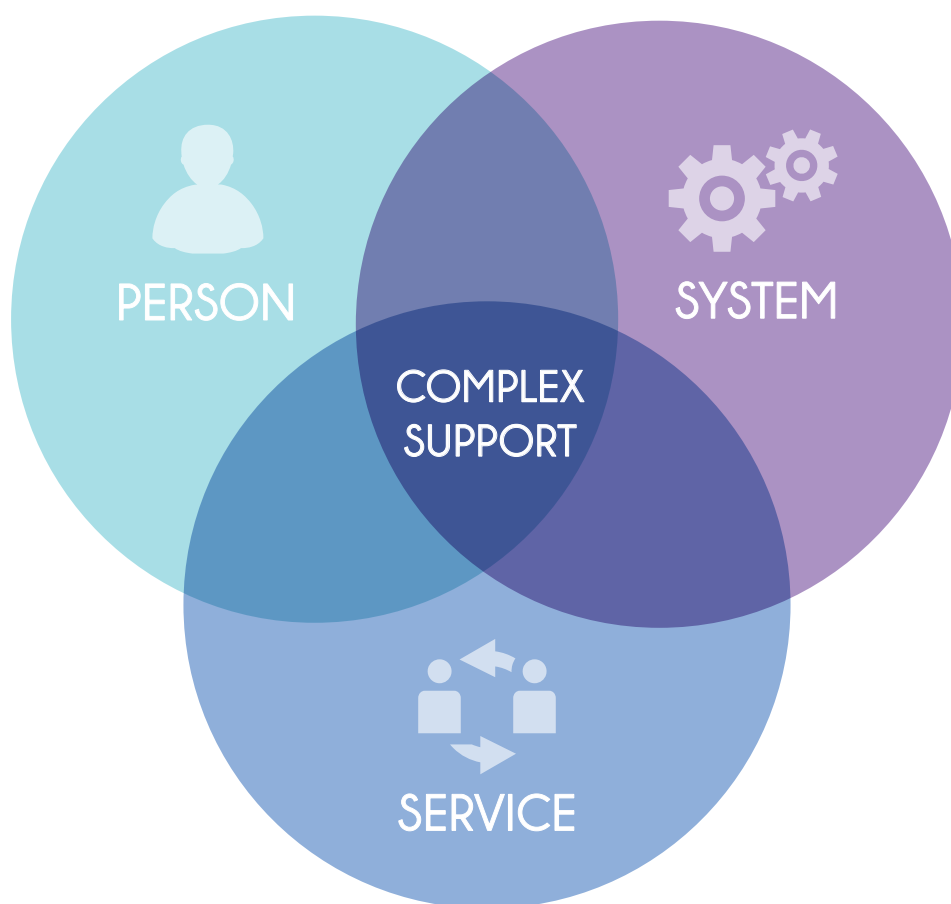
Stage 1: Pre-planning

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# Complex support needs: Person, service, system

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## Complex support needs: Person, service, system



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**Person level** refers to the domains of the person with complex support needs, such as mental illness, challenging behaviour, and substance misuse.

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**Service level** refers to the domains of the service system such as health, housing, and criminal justice.

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**System level** refers to the overall funding and policy context for services to address complex support needs, and includes the design, delivery and effectiveness of interventions to address complex support needs.



## Stage 1: Using the CSN flag

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# Does this person have complex support needs?

Before engaging in the planning process, it is necessary to determine if the person has complex support needs. The Complex Support Needs flag will help with this.

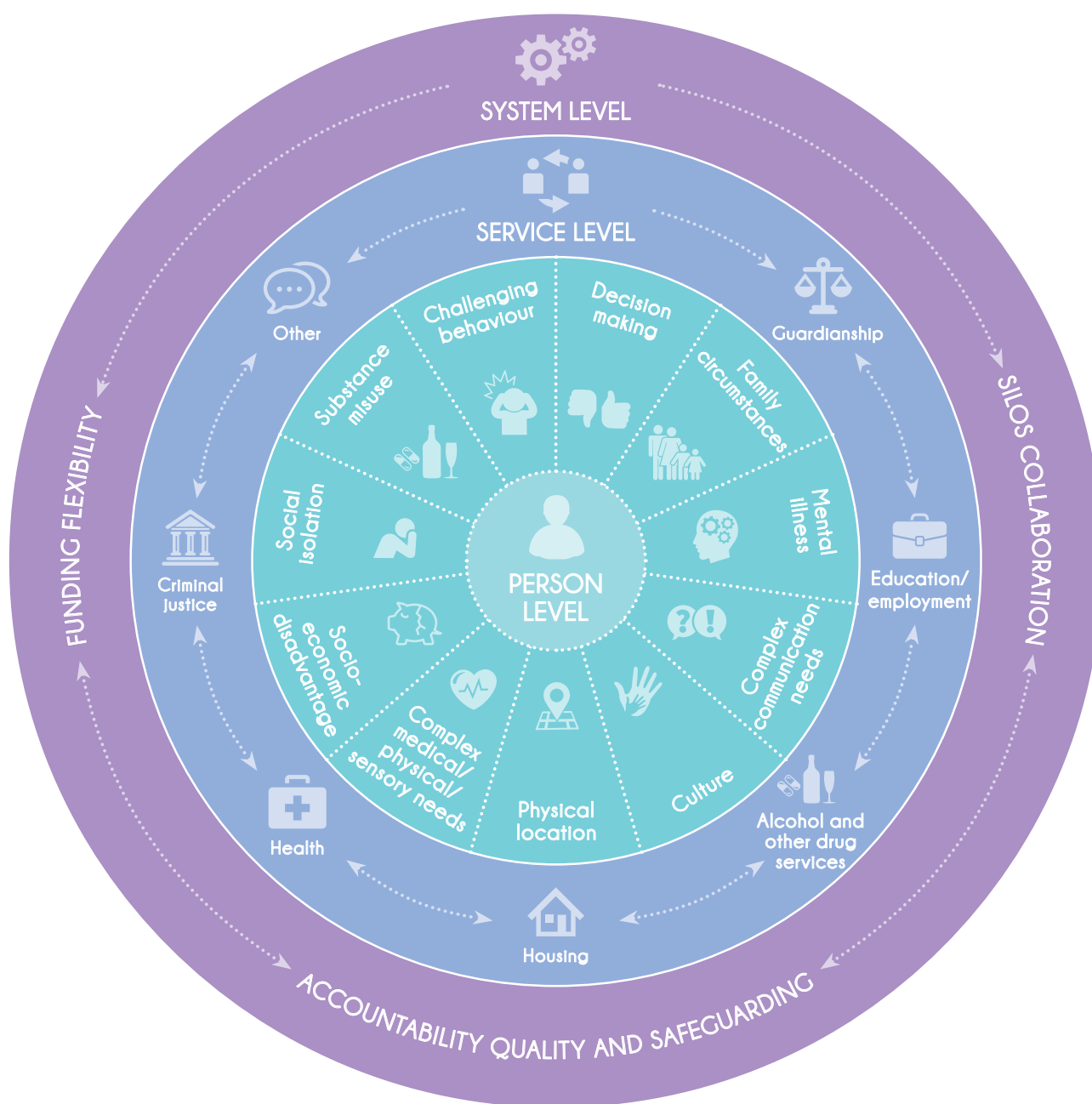
The Complex Support Needs (CSN) flag is designed to assist support planners to identify whether a person with disability has complex support needs which require additional and/or different planning responses.

The CSN flag is a prompt NOT a checklist – representing the intersection of complexity at person, service and system levels. The domains are not prescriptive and there may be additional domains relevant for an individual with whom you are engaged.

- Complex support needs in the life of the person (at the core) are represented as segments of the inner ring.
- Complex support needs compounded by the person's interaction with services are represented by the middle ring.
- Complex support needs compounded by features of the system are represented by the outer ring.

Put a flag  in the relevant segment to denote this is an issue for the person. If there are flags in multiple rings or multiple flags in a particular segment, it is likely that a person has complex support needs.

## CSN flag: Does this person with disability have complex support needs?



**Person level** refers to the circumstances of an individual with disability that contribute to complex support needs. This can include co-existing disability, such as mental illness or complex physical/sensory/medical needs, substance misuse and challenging behaviour. Environmental factors such as social isolation, physical location or family circumstances interact with personal attributes to compound complexity.

**Service level** refers to the government, non-government, private and for-profit organisations that provide mainstream, community and specialist services and supports. Services can compound complexity by not adequately meeting individual needs. The following service sectors have been identified as key for people with complex support needs: Alcohol and other drugs, criminal justice, education/employment, guardianship, health, and housing.

**System level** refers to the overarching legislative and policy context in which services are framed, resourced and delivered. This includes funding arrangements, e.g. block or individual funding; silos, e.g. lack of interagency collaboration; and accountability, e.g. quality, safeguarding and equity.



Stage 1: Using the CSN flag

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# Definitions of person level complex support needs



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## Complex support needs as referred to on the CSN flag (*inner ring*)



**Challenging behaviour:** intense, frequent or persistent behaviour that threaten the quality of life and/or physical safety of the individual or others and is likely to lead to restrictive or exclusionary responses. Positive behaviour support is an approach that seeks to understand the relationships between the person's behaviour and his/her ecology from a biological, psychological and social perspective.



**Decision making** is a fundamental human right involving the act of choosing between two or more courses of action. Some people, including those with intellectual disability, require additional assistance (e.g., communication aids, different formats, longer timeframes, reminders of previous decisions, greater explanation of implications) to make and express choices.



**Family circumstances:** refers to the social, cultural and economic factors that impact on family relationships. For example, on the coping or stress levels of carers.



**Mental illness:** is a general term for a group of illnesses affecting thinking, emotions and/or behaviour. A mental illness can be mild or severe, temporary or prolonged.



**Complex communication needs:** communication involves the exchange of information between two or more people. People with complex communication needs may have communication problems associated with a wide range of physical, sensory, cognitive and environmental causes which restrict or limit the person's ability to participate independently in society. People with complex communication may need significant support from their communication partners for their messages to be understood. Augmentative and alternative communication strategies may be used (e.g., alphabet boards, sign language, voice generating devices.)



**Physical location:** relates to the interplay between an individual and their physical environment that creates disadvantage. Geography can create access barriers, such as in rural and remote locations, and social barriers, such as lack of opportunity or social capital. Physical location includes poor living conditions, such as overcrowding or squalor, and placements at risk of breakdown.



**Complex medical/physical/sensory needs:** includes profound, severe or long term physical or medical impairment or sensory disability that requires continuous support, high cost equipment and access to various mainstream services. The complexity of need may relate more to the complexity of services and systems than the complexity of an individual's disability.



**Socio-economic disadvantage:** refers to hardship or inequality in a person's standard of living, well-being, capabilities or other life opportunities. Socio-economic disadvantage is considered to be broader than poverty, as it reflects multiple types of social inequality.



**Social isolation:** refers to a person's lack of meaningful, extended relationships and intimacy leading to feelings of having no one to turn to during a crisis. The risk of social isolation is increased by family violence, ill-health and disability, living alone, unemployment, ageing and lack of transport.



**Substance misuse:** refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Substance misuse may cause an individual to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption, and/or dependence.



## Stage 1: Using the Planner flag

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# What skills does the planner need?

The Planner flag is designed to assist support planners to identify attributes, skills and knowledge they need to work effectively with a person with disability and complex support needs.

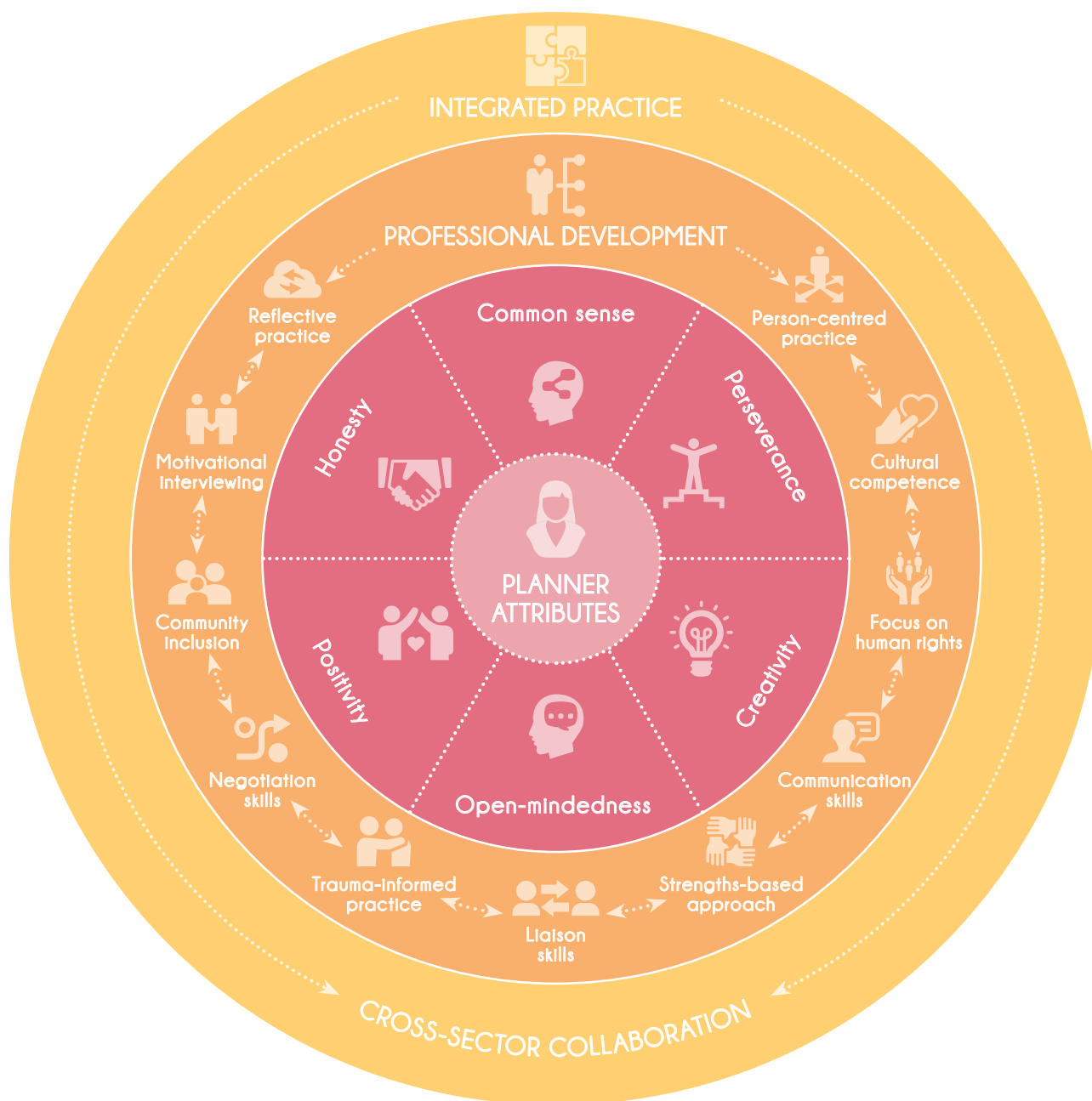
Like the Complex Support Needs flag, the Planner flag is a prompt NOT a checklist and there may be other skills and training needed to engage with a particular individual with complex support needs.

Planners will draw upon particular skills at different times depending on an individual's circumstances. As it is not always possible to know in advance what particular skill

will be called upon, planners need to be highly skilled across a broad range of areas and know how to access specialist expertise when needed.

- Planner needs related to personal qualities are included in the inner ring.
- Planner needs that are addressed at the service level through organisational support for training and professional development are included in the middle ring.
- Planner needs can be met (or not) by systems that promote integrated practice and cross-sector collaboration, as represented by the outer ring.

## The Planner flag: What skills does the planner need to engage with the person with complex support needs?



The **planner** level refers to the attributes of the planner including personal attributes and values. The planner needs these attributes to engage effectively with a person with complex support needs.

The **professional development** level refers to the skills and competencies the planner will need to develop to work effectively with a person with complex support needs. Professional development relies on organisational mechanisms such as training, supervision, mentoring and networking.

The **integrated practice** level refers to systemic conditions that impact on the ability of the planner to work effectively with a person with complex support needs. Although the planner may not have control over these conditions, they will need to be aware of them.



Stage 1: Using the Planner flag

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# Definitions of planner competencies



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## Competencies that planners gain through professional development, as referred to on the Planner flag (*second ring*)



**Focus on human rights:** to understand the needs of participation, equity, access and rights for vulnerable people.



**Community inclusion:** to foster inclusive and welcoming communities for people with disability.



**Communication skills** include active listening, use of plain English, and understanding of augmentative communication supports.



**Strengths based approach** recognises the resilience of individuals and focuses on their strengths, interests, abilities and knowledge rather than their limitations.



**Liaison skills:** to identify when tertiary expertise is required, and which professions can provide specialist information or are appropriate referral avenues. This takes extensive knowledge of how the service system works.



**Cultural competence:** to identify and challenge one's own cultural assumptions, values and beliefs and gain cultural knowledge and skills. This enables the person to work cross-culturally including with people from culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander peoples.



**Trauma-informed practice:** to understand the individualised nature of trauma and its impact on the person's life, and ensure that services do not inflict additional trauma, but help the person rebuild a sense of control.



**Negotiation skills:** to take a solutions-focused approach to obstacles and to work toward an achievable compromise.



**Motivational interviewing:** to facilitate and engage the intrinsic motivation of a person to change unhelpful behaviours.



**Reflective practice:** to reflect on action and the values that inform it, so as to engage in a process of continuous learning.



**Person-centred practice:** a set of practices that assist people with disability to plan the supports they need to live a good life on their terms.

## Stage 1: Pre-planning

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# Step 1: Gathering background information about the person

The following two diagrams in Step 1 provide questions to focus the planner's thinking around particular issues that may be present for the person he or she has been asked to engage in planning with. The planner will do this thinking at both the person and service level.

## Step 1: Gathering background information about the person

Think about this in terms of the person



Stage 1: Pre-planning

---

# Step 1: Gathering background information about services

## Step 1: Gathering background information about services

Think about this in terms of services



# Step 2: Identifying people and other resources

The initial meeting is an important event in the planning process, as it is likely to be the first time the planner and the person with complex support needs meet. To adequately prepare for this meeting it is necessary for the planner to ask her/himself a series of questions and answer them based on preliminary knowledge of the person and their situation.

Questions may include:

- **Who**, in addition to the person with disability, needs to be at this meeting and what skills and knowledge will they bring? For example, what is the nature of the person's family relationships and friendships?
- **What**, if any, planning has the person done previously and what goals have they set.
- **Where** will the meeting occur, taking into account the person's preferences, risks to the planner's safety and practical considerations. For example, finding a quiet or public venue, or somewhere suitable if the person is homeless.
- **How** to create a conducive environment taking into account planner's demeanour, informality and access supports. For example, communication aids.

## Step 2: Identifying people and other resources





Being a planner with a person with disability  
and complex support needs (CSN): Planning resource kit

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# Stage 2:

# Planning conversations



## Stage 2: Planning conversations

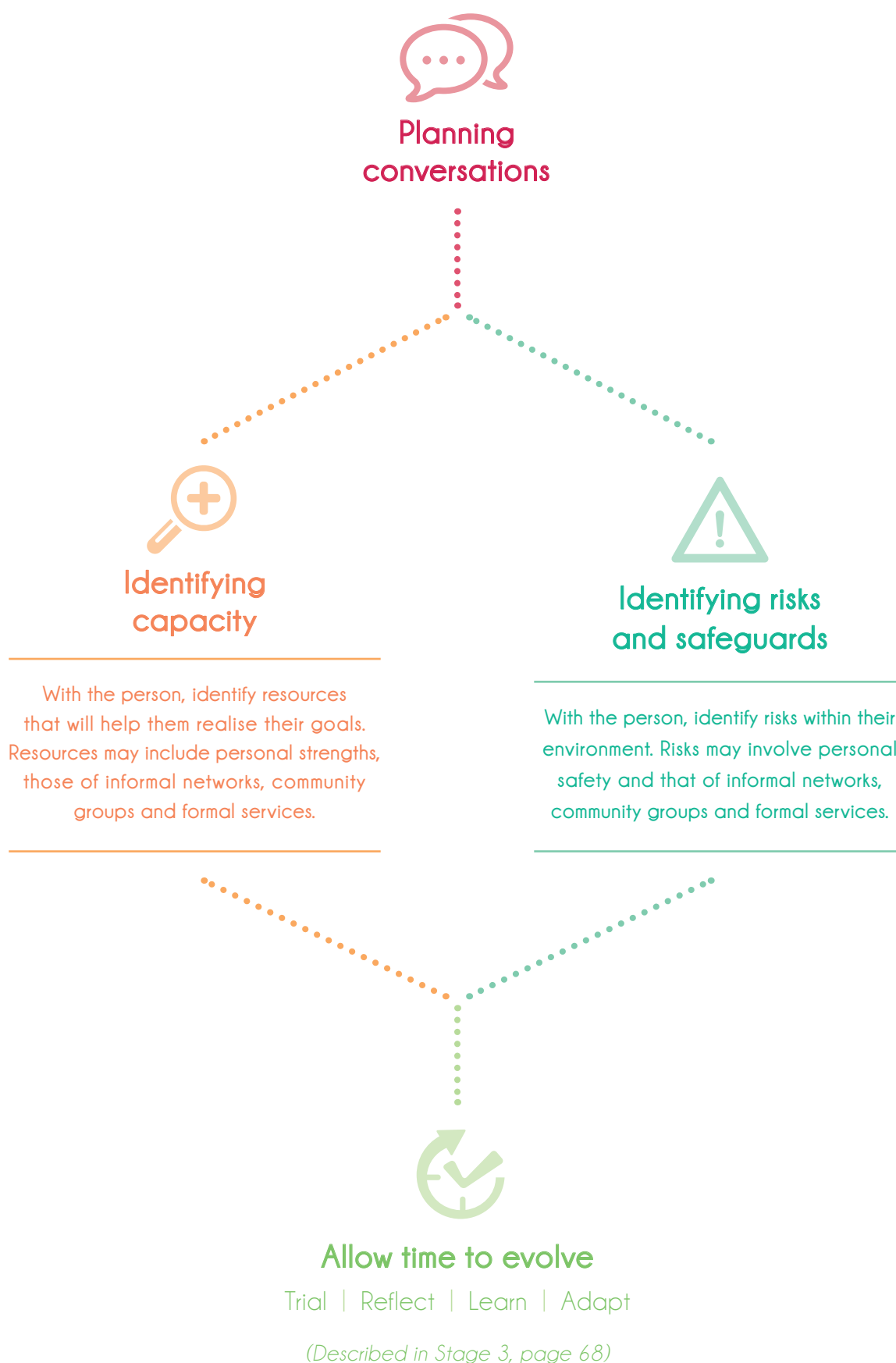
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# Overview

Planning conversations are discussions that a planner has with a person with complex support needs and, if available, their informal supports. The purpose of these conversations is to develop a plan that incorporates the person's future goals and reflects their wishes and preferences about the services

that can help to achieve them. This section details a process for approaching planning conversations with a person with complex support needs that includes practical steps, a case study example and prompt questions to assist the planner to develop a plan that is attainable and sustainable.

## What is in Stage 2?





## Stage 2: Planning conversations

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# What are planning conversations and what makes them work?

This is what we heard from people with disability and people in planning-related roles who we talked to about planning conversations.

## Planning conversations: what are they and what makes them work?

### What do people with disability say makes a good planning conversation?

"To find out information from us because you can't know unless you've walked a mile in our shoes"

"Unless you know us really well ... you can't understand us very well"

"That's what I love the most the trust. I worship that stuff"

"You have to know the person and trust them"

"Get connected with people who have gone before you"

"It's also about your comfort zone and you have to be pushed out of it"

"You come up with a compromise"

"I hate it when they talk to my mum and won't talk to me"

"Communication is crucial"

"You have to be able to change your plans"

### What do planners say makes a good planning conversation?

"You'd try and set the scene for them to be as comfortable as possible to sit and communicate with you and help make the plan rather than do anything to agitate them, that's important"

"Try to make it informal and as less scary as possible because if he's resistant to services you don't want to be another service that he resists"

"A planner should meet with this person and their supports numerous occasions prior to the plan"

"You've got to go with a good spirit"

"It's really difficult to work with someone about their drug use if they've just been thrown out of their house"

"Let people talk about what's worrying them and try and listen to them"

"Set it up quickly and it's doomed to failure"

"You've got to like people"



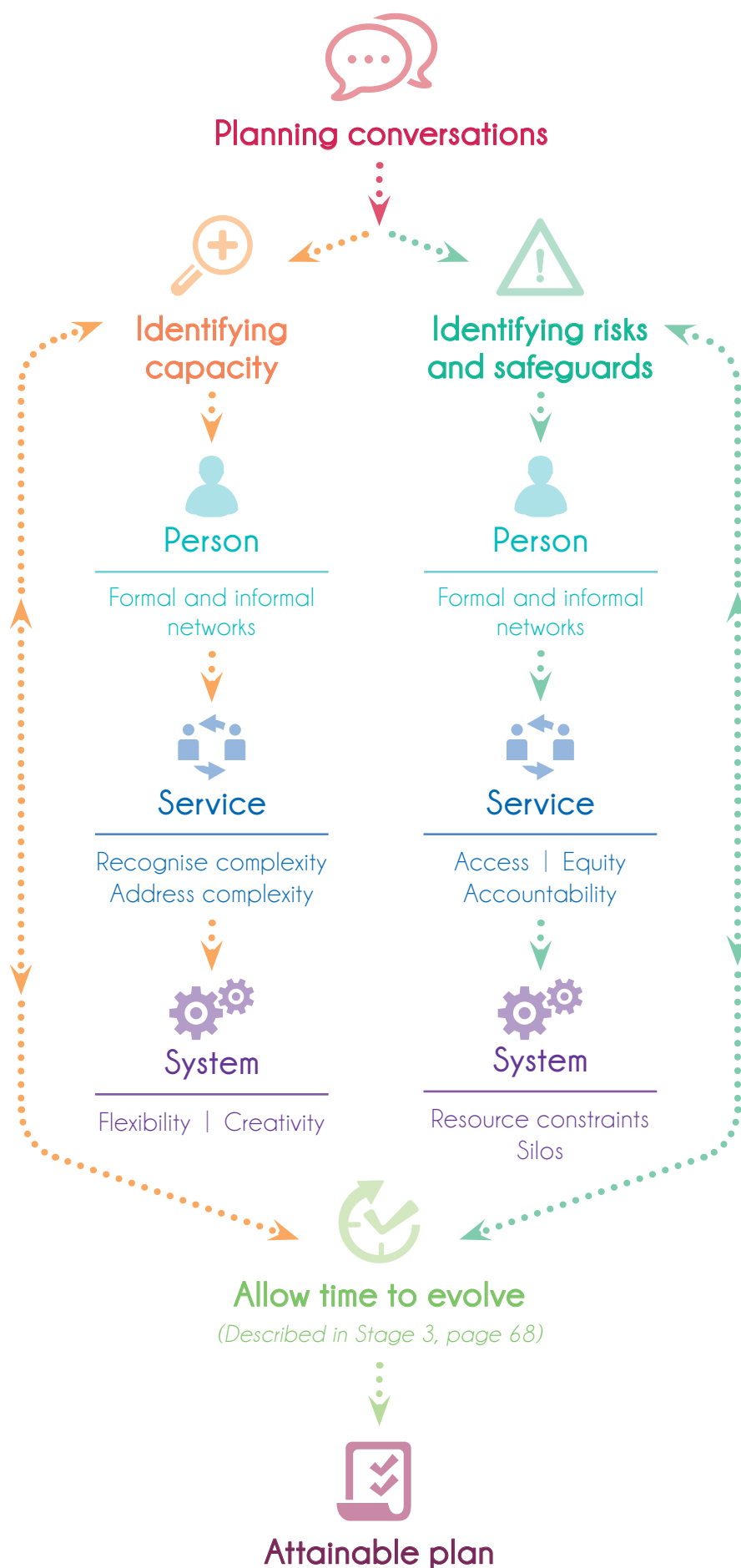
## Stage 2: Planning conversations

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# Approaching planning conversations

This stage guides the planner to approach a planning conversation with a person with complex support needs. This stage will take you through the steps to identify capacity, risks and safeguards. This information is intended to complement other general planning practices and tools.

## Stage 2: Planning conversation process





## Stage 2: Planning conversations

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# Case study: Mitch

The following case study is used to work through some of the issues that a planner may need to consider when approaching planning conversations with a person with complex support needs.

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## Case study: Mitch



Mitch is a 30 year old Aboriginal man with an intellectual disability and a mental illness. He has poor physical health, difficulty with verbal communication and low literacy. Mitch lives alone in public housing and finds it hard to look after the house and himself. Although family has always been important to Mitch, due to intergenerational trauma, he is currently estranged from them and has no informal support networks. Mitch is allowed supervised visits with his two children who are in out-of-home-care, but he has not seen them regularly. Mitch has spent time in jail for drug-related offences and is on community orders requiring him to take methadone and medication to manage schizophrenia. Although Mitch is committed to remaining drug-free, his former drug-taking friends live nearby and are his only social contacts. Mitch wants to find work to become more connected to his community and earn money so he can resume former interests such as going to football matches. Mitch has reluctant engagement with multiple services and systems such as corrective services, community mental health, housing and child protection but receives no disability-related support.

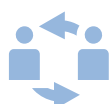
In Stages 2 and 3 we will refer to the case study of Mitch as an example of how to engage in planning with a person with complex support needs

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To approach the planning conversation with Mitch, what aspects of the current situation would you need to take into account in terms of identifying capacity for the:



Person?



Service?



System?

To approach the planning conversation with Mitch, what aspects of the current situation would you need to consider in terms of identifying risks and safeguards for the:



Person?



Service?



System?



## Stage 2: Planning conversation process

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# Identifying the capacity of the person

Think about the current capacity of the person, including informal supports, that might support his/her plan. For a person with more severe cognitive or communication impairment it is important to involve the person's family and informal supports. If you are talking to a proxy, make sure you are employing strategies to ensure the voice of the person is heard.



**This icon signifies general questions you might ask yourself about a person with whom you are planning.**

---

## Identifying the capacity of the person





Stage 2: Planning conversation process

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# Identifying the capacity of services

Think about the current capacity of services that might support the person's plan. Services include mainstream, community and specialist.



This icon signifies general questions you might ask yourself about a person with whom you are planning.

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## Identifying the capacity of services





Stage 2: Planning conversation process

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# Identifying the capacity of systems

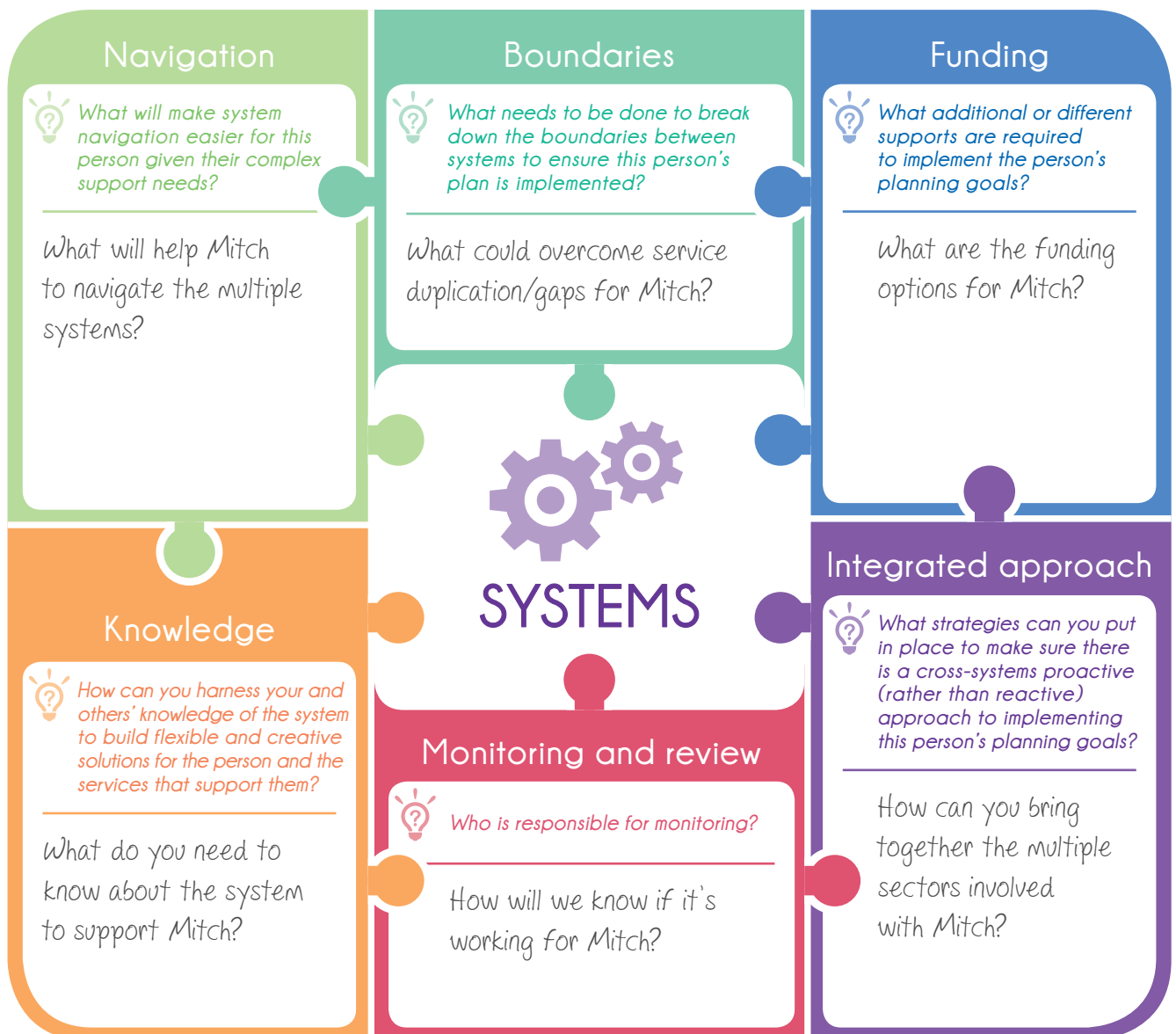
Think about the current capacity of systems that might support the person's plan.



This icon signifies general questions you might ask yourself about a person with whom you are planning.

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## Identifying the capacity of systems





## Stage 2: Planning conversation process

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# Identifying risks and safeguards with the person

How would you identify current risks and safeguards with the person?

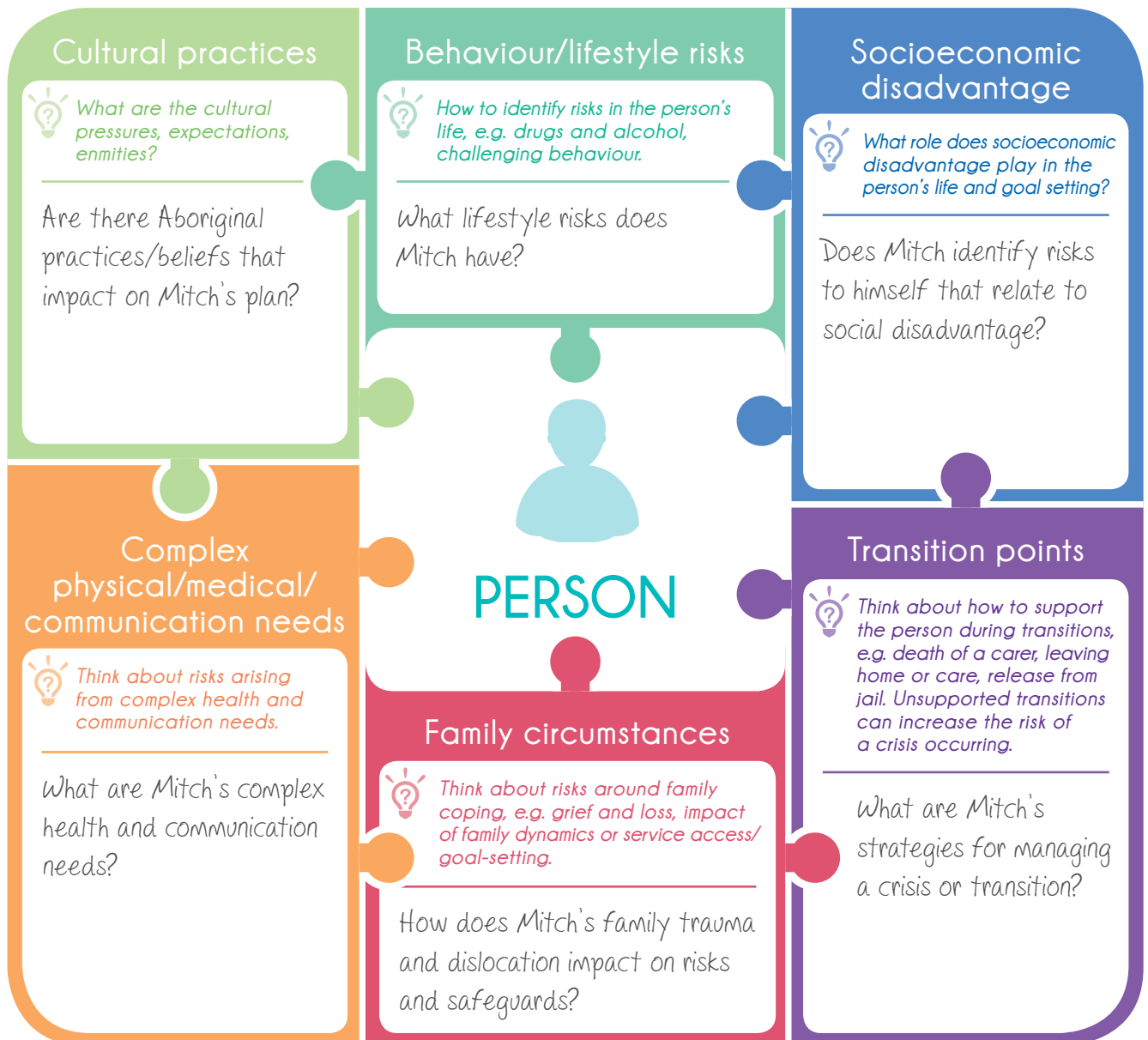
This is not a risk assessment tool and should be used in conjunction with prescribed assessment documentation.



This icon signifies general questions you might ask yourself about a person with whom you are planning.

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## Identifying risks and safeguards with the person





Stage 2: Planning conversations process

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# Identifying risks and safeguards for services

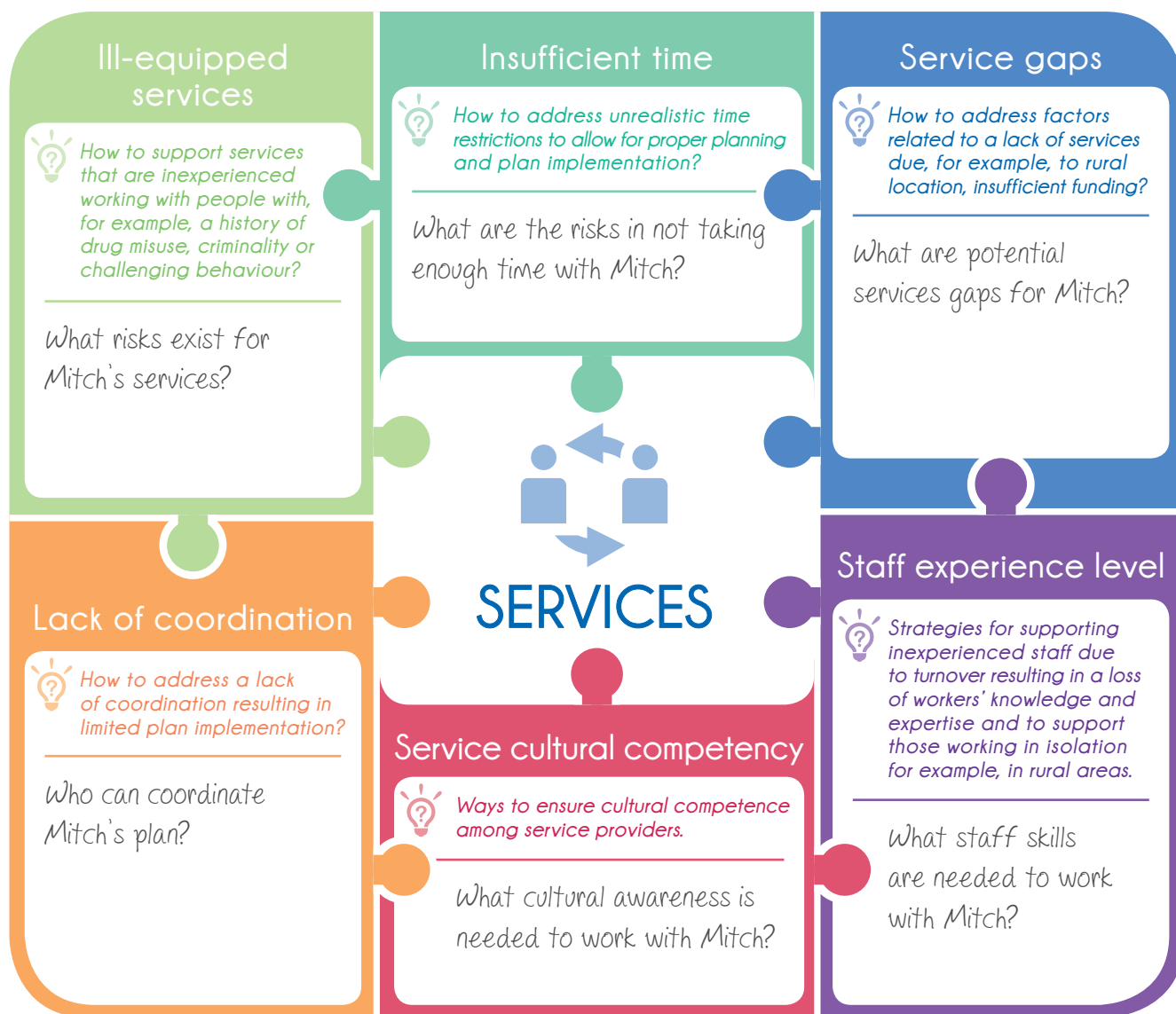
Think about the current risks and safeguards that services might need to consider to support the person's plan. Services include mainstream, community and specialist.



This icon signifies general questions you might ask yourself about a person with whom you are planning.

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## Identifying risks and safeguards for services





Stage 2: Planning conversations process

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# Identifying risks and safeguards for systems

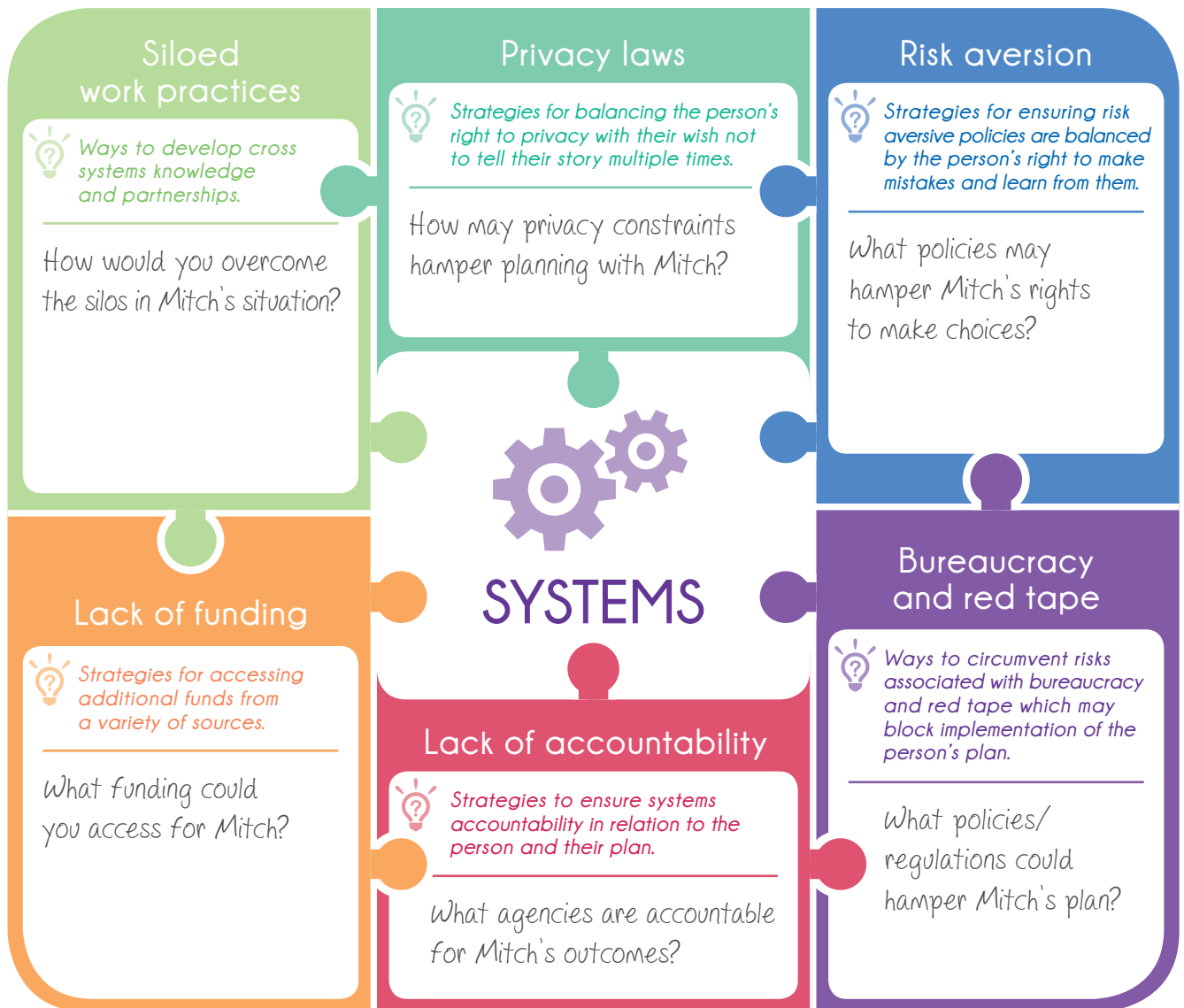
Think about the current risks and safeguards within systems that might support the person's plan.



This icon signifies general questions you might ask yourself about a person with whom you are planning.

---

## Identifying risks and safeguards for systems



## Notes

### Risk assessment tools

Remember, to complete the necessary risk assessment protocols, as required by your organisation or funding body.

Being a planner with a person with disability  
and complex support needs (CSN): Planning resource kit

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# Stage 3: Plan-to-action



## Stage 3: Plan-to-action

---

# Overview

As the planner, you have now gathered together the information you need for a comprehensive picture of the individual's current capacity and risks. This includes the strengths and challenges, such as gaps in formal and informal supports. It also includes the risks in their current circumstances that may jeopardise the plan, such as the absence of supports and services that match the person's preferences.

Stage 3: Plan-to-action, builds on this foundation by detailing a process for building capacity and addressing risks through appropriate safeguards.

Stage 3: Plan-to-action is about implementing the plan that has been developed in conversations with the person with complex support needs about their goals, aspirations and support needs. This section details a process for drawing on the capacity of the person and overcoming tangible and perceived safety (and other) risks that may stand in the way of implementing a sustainable plan.

## What is in stage 3?





## Stage 3: Plan-to-action

---

# What makes a plan work?

This is what we heard from people with an intellectual disability and people in planning-related roles who we talked to about implementing a plan.

### What do people with disability think makes a good planner?

"Your planner is meant to listen to you so that it is all about you and your life"

"[Someone] who understands me and knows how to communicate"

"Planners need to research and do their homework"

"A partner"

"My planner is a good person because he understands me from my level"

"They need to be able to have walked in our shoes basically"

"A good planner should have some knowledge about what's out there"

### What do planners think is important for implementing a plan?

"Ask the right questions at the right time to challenge their [family/carer] beliefs without challenging them"

"You have to be knowledgeable about what's available and how you can use the system"

"You've got to be a bit creative ...because there will always be some constraint"

"[To take into account that] a person's reputation may mean they get a lot of wrong doors"

"[The person] may have burnt bridges with everybody..."

"Fix the things the person wants fixed first"

"Make sure to plan for when crises happen or the wheels fall off"



## Stage 3: Building capacity

---

# Creating a circle of support

### What is a circle of support?

Circles of support are often used in person-centred planning with people with disability. A circle of support is an intentional group made up of people with a shared interest in supporting the person to achieve his or her goals. Conventionally, a circle of support is an informal (as opposed to formal/paid) network of people who supplement family resources.

Many people with CSN have little or no informal support or contact with family and

social isolation contributes to their complex support needs. The planning process should build a person's capacity to achieve his or her goals through development of a sustainable plan. A primary way to develop a sustainable plan is to help the person create a circle of support that harnesses available people resources, which may, due to the lack of informal support, include service providers. Wherever possible, the circle will extend to (re)integrate members of the person's family and community.

---

## How does the planner assist the person to create a circle of support?

Use the CSN flag to think about the person's supports and the Planner flag to think about the skills you will use to help build a circle of support with an individual (e.g. cultural competence, motivational interviewing

and so on). For practical purposes, we focus on some of the skills needed to work with Mitch. This is not to imply that other skills are not important and useful.



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**Use the CSN flag** (page 11) to identify significant person-level domains and services, representatives of which are important to engage in the circle of support. Representatives who are invited to join the circle of support must be known to, and trusted by, the person.

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**Use the planner flag** (page 15) to identify the competencies needed to engage with the person to create a circle of support. This includes training to develop communication and negotiation skills, cultural competence and other skills as relevant for the individual.

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## Stage 3: Building capacity

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# Case study: Mitch

Remember Mitch from the case study that was introduced in Stage 2? Consider the attributes and skills a planner may need to implement his plan and the ways that the planner can help Mitch to build capacity and address risks and safeguards.

The planner will need to be creative, open-minded and resourceful, drawing upon skills such as cultural competence and person-centredness.

Mitch's circle of support will help him to achieve the goals he identified in his planning conversations and to pre-empt problems that may arise.

## Case study: Mitch



Mitch is a 30 year old Aboriginal man with an intellectual disability and a mental illness. He has poor physical health, difficulty with verbal communication and low literacy. Mitch lives alone in public housing and finds it hard to look after the house and himself. Although family has always been important to Mitch, due to intergenerational trauma, he is currently estranged from them and has no informal support networks. Mitch is allowed supervised visits with his two children who are in out-of-home-care, but he has not seen them regularly. Mitch has spent time in jail for drug-related offences and is on community orders requiring him to take methadone and medication to manage schizophrenia. Although Mitch is committed to remaining drug-free, his former drug-taking friends live nearby and are his only social contacts. Mitch wants to find work to become more connected to his community and earn money so he can resume former interests such as going to football matches. Mitch has reluctant engagement with multiple services and systems such as corrective services, community mental health, housing and child protection but receives no disability-related support.



To build a circle of support the planner assists Mitch to:

- ✓ Identify people in his life whom he trusts
- ✓ Find potential new sources of support, e.g. cultural groups
- ✓ Reconnect with family members



*Is there an Aboriginal led organisation in the local area?*



*Would Mitch feel more comfortable with an Aboriginal and/or male worker?*



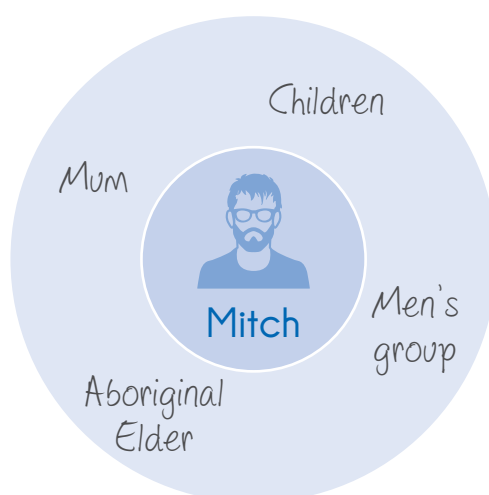
*Is there a suitable service available in the local area?*



*What would it take for Mitch to reconnect with his mother and children?*



*What avenues are there for Mitch to meet new people?*





## Stage 3: Addressing risks and safeguards

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# Pre-empting problems

### Planners need to pre-empt potential problems in implementing a plan by:

- Matching the service to the person (i.e. not vice versa) to give the plan the best chance of success, e.g., finding the right service/s and working with them to overcome perceived risks.
- Using systemic advocacy and education to overcome the perceived risks related to working with a person with complex support needs.
- Building a 'Plan B' for times of crisis or transition.
- Brokering a compromise to attain success e.g., person agrees to modify plan to enable the 'right' service/s to be put in place;
- Building relationships with specialist and direct services to foster understanding, flexibility and willingness to engage with a person with CSN;
- Finding the 'go to' person in an organisation who can help you broker solutions;
- Knowing how the service system works so you can avoid roadblocks or find hidden exits.

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## How does the planner pre-empt problems?

Use the CSN flag to think about the person's supports and the Planner flag to think about the skills the planner will use to help pre-empt problems with an individual, e.g. cultural competence, motivational interviewing

and so on). For practical purposes, we focus on some of the skills needed to work with Mitch. This is not to imply that other skills are not important and useful.



---

**Use the CSN flag** (*page 11*) to identify potential person-level risks that may present barriers to implementing a plan and potential service-level safeguards that may be used to address these risks.

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**Use the planner flag** (*page 15*) to identify personal attributes and competencies the planner will need to be able to work effectively with a person with complex support needs.

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## Stage 3: Addressing risks and safeguards

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# Using the CSN flag to pre-empt problems

This section relates to the case study of Mitch. Here we consider potential barriers to his plan being implemented and offer some suggested solutions the planner may consider. We have focused on just a few person-level domains from the CSN flag that are likely to present risks to Mitch's plan but this does not mean these are the only important domains. For other individuals, different domains will be relevant.

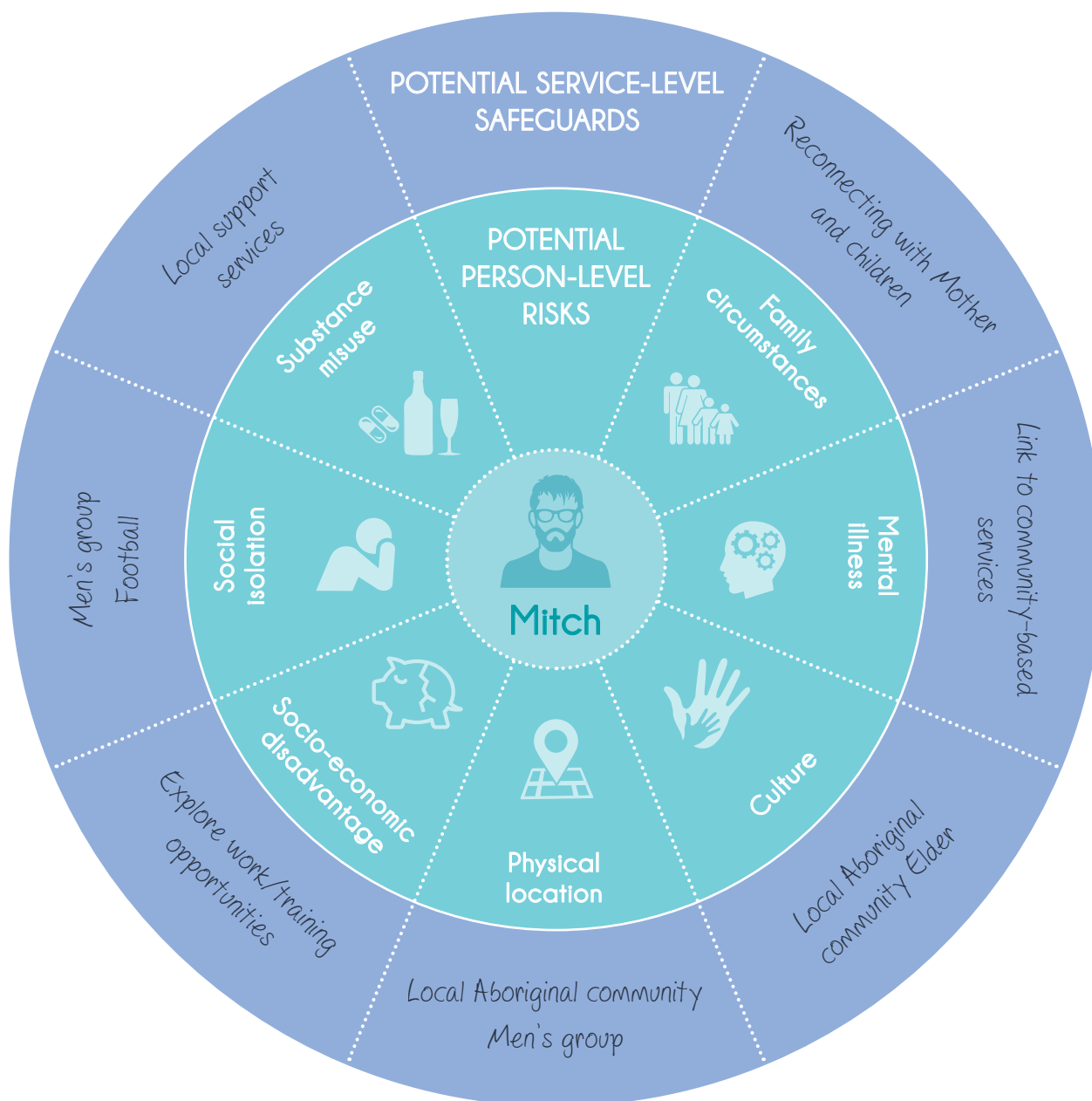
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Use the **person-level domains** in the CSN flag (*page 11*) to identify the risks that are present and the safeguards to address them.

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## Using the CSN flag to pre-empt problems



There are a number of areas highlighted on the CSN person flag as posing potential risks to Mitch's plan such as relapsing into substance misuse, breakdown in family relationships, mental ill health, cultural disconnection, temptations to use drugs due to his physical location, lack of money and social isolation. Using the CSN person flag to identify potential risks will help Mitch and the planner to identify safeguards.



## Stage 3: Addressing risks and safeguards

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# Using the Planner flag to pre-empt problems

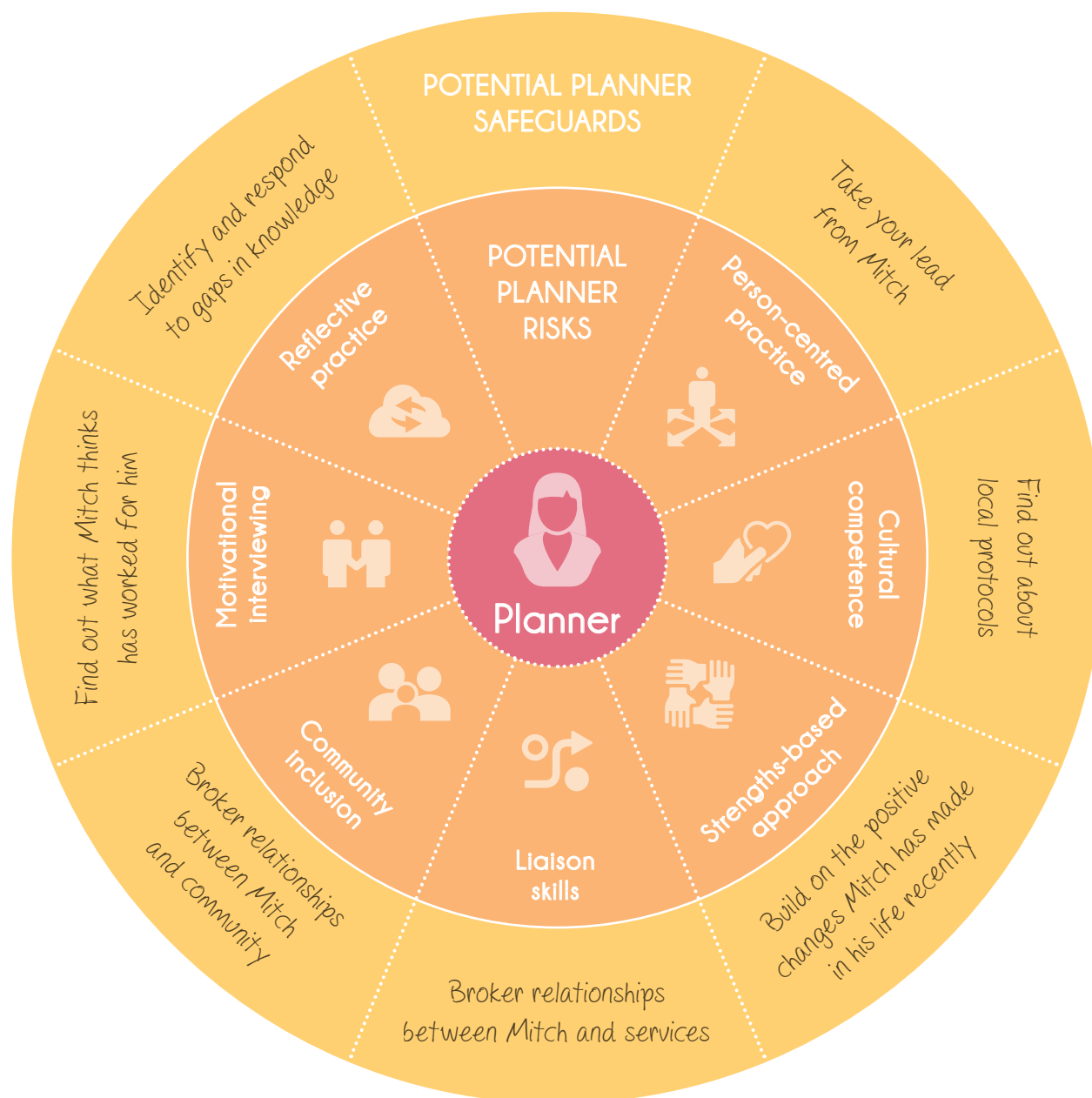
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Use the **Planner flag** (page 15) to identify the competencies needed to put in place workable safeguards e.g. clear boundary-setting.

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## Using the Planner flag to pre-empt problems



The Planner flag highlights potential risks to a planner working with Mitch to identify barriers and safeguards in his plan. The outer circle proposes some of the competency-based strategies a planner could use. For example, cultural competence to engage effectively with Aboriginal people and services and person-centredness to ensure Mitch leads the process and does not disconnect.



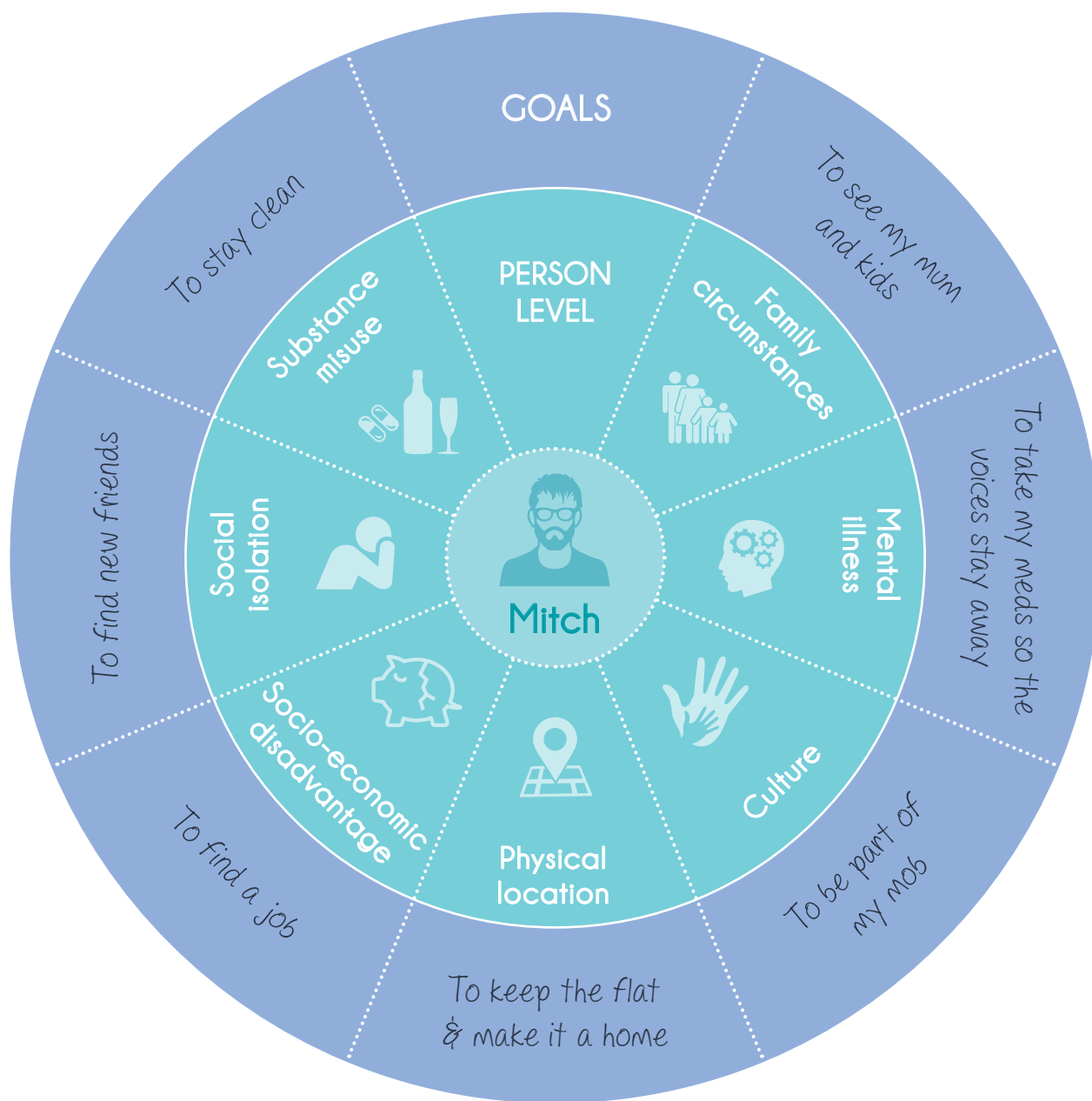
## Stage 3: Capacity and safeguards working together

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# Mitch's goals

This section brings together building capacity and pre-empting problems to address risks and develop safeguards. The example of Mitch is used to illustrate how the person and planner together think through the opportunities at both the person and service levels to achieve the person's goals. Mitch and the planner together identified seven goals related to person-level issues. Goals should be written in the first person and, as much as possible, in the person's own words.

## Mitch's goals





## Stage 3: Capacity and safeguards working together

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# Working together: The person

The first diagram (*page 65*) aligns Mitch's capacity to achieve his goals with the planner's skills. The second diagram (*page 67*) identifies the services that may be involved in helping Mitch achieve his goals.

## Stage 3: Capacity and safeguards working together for the person





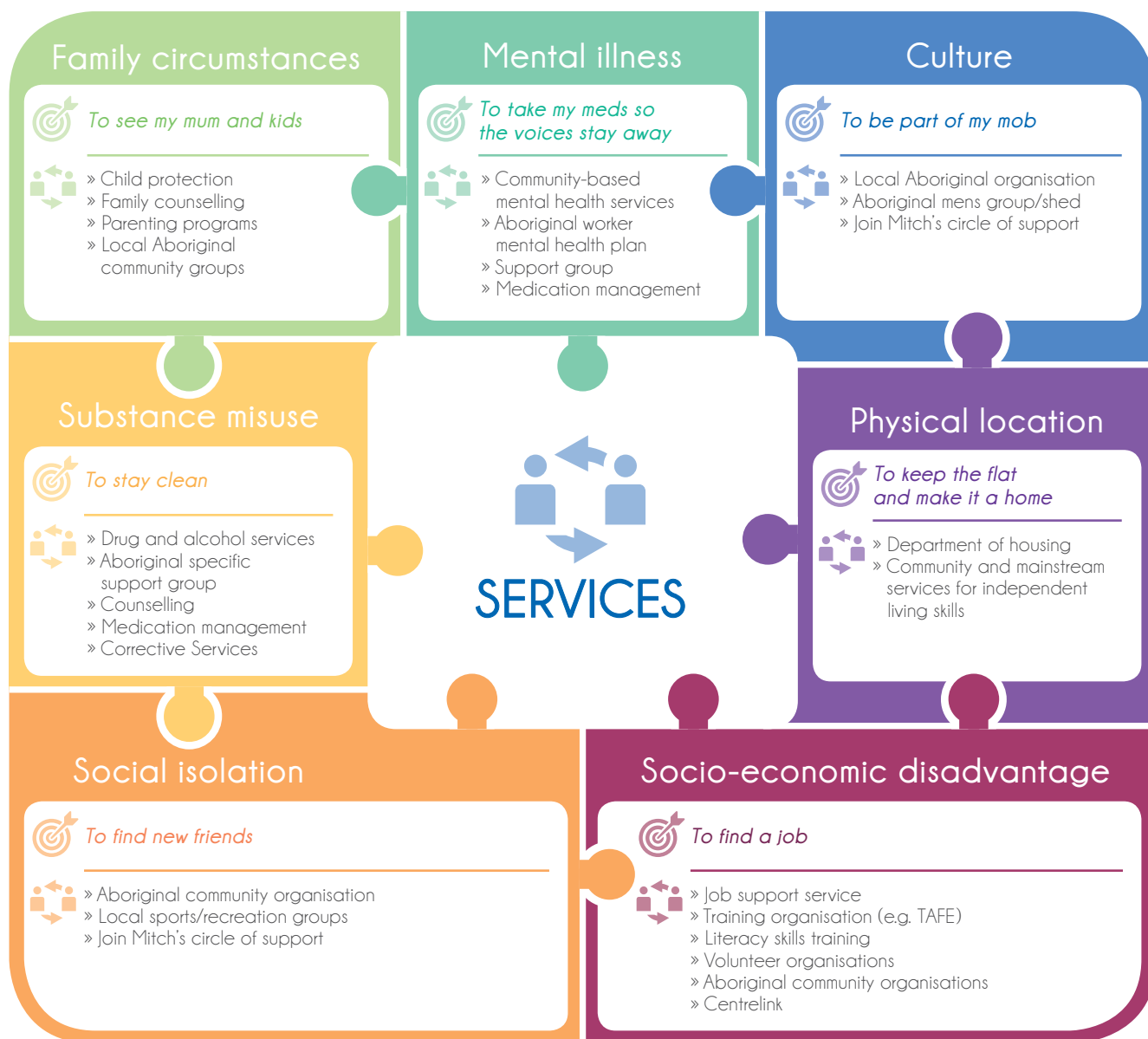
Stage 3: Capacity and safeguards working together

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# Working together: The services

At this point, the planner will need to involve coordination or case management supports to undertake referrals for services and supports.

## Stage 3: Capacity and safeguards working together for the services





## Stage 3: Allow time to evolve

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# Trial, reflect, learn, adapt

This final section highlights the importance of allowing time to trial, reflect, learn and adapt throughout the planning process. It suggests strategies the planner and person may use to ensure the sustainability of the plan.

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## Allow time to evolve: Trial, reflect, learn, adapt

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- » Planning with a person with CSN is a longer, more intensive process
  - » The person and planner are equal partners on the planning journey
  - » All people learn best through trial and error.
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- » Pre-empting problems and identifying safeguards will help to avoid the cycle of continuous disruptions that occur over the life course for people with CSN
  - » A sustainable plan sets up regular reviews and identifies the key people accountable for its success, e.g. circle of support and services.
- 



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- » The person and planner spend time reflecting on what worked well and what they would do differently.
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- 
- » The person gains skills and confidence to respond to life challenges
  - » The planner gains skills and knowledge to engage with a person with CSN.
-







For more information and further resources visit:  
[arts.unsw.edu.au/idbs/support-planning](https://arts.unsw.edu.au/idbs/support-planning)