

## Whose Plan Is It Anyway?

Using Service Planning to Support  
Personal Recovery and Self-Direction.



## How can service planning support personal recovery and self-direction?

This booklet is designed to help workers in the mental health community sector use planning processes with people that both:

- 1) Promote self-direction and recovery
- 2) Fulfil the requirements of service planning.

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## What is different about working from a recovery orientation?

Most mental health community organisations have named their service frameworks as being recovery orientated. This suggests that the way services are provided and how they work with people has fundamentally shifted enabling people to reclaim a life beyond the impacts of mental illness/distress.

Providing services from a recovery orientation requires services and workers to consider every process of how they deliver services fundamentally differently. This will challenge even the ‘best of services’ as working from a recovery orientation requires services and workers to resist the temptation to fall back into the more familiar traditional ways of working. It is extremely unlikely, if not impossible, for a person to recover, to reclaim a life beyond the impacts of mental illness when they are not in an active position of making decisions, taking control, making meaning, realising their potential and staying connected to life roles and opportunities.

What does this mean in practice? Services that have embraced working from a recovery orientation will be able to demonstrate how they have resisted more traditional ways of working and adopted more recovery oriented ways of working.

The table below highlights some of the practices that services and workers would be embracing when working from a recovery orientation and the practices and processes that they are resisting.



### **RESISTING** Practices of ...

- ✗ Taking an expert role in people's lives.
- ✗ Managing and monitoring people.
- ✗ Being sure.
- ✗ Worker being the author/editor of the person's narrative.
- ✗ Determining what people need and what is best for them.
- ✗ Workers or 'Others' agenda overrides the person's agenda.
- ✗ Focus on goal attainment.
- ✗ Adopting "parent – child" relationships with people.
- ✗ Risk management role.
- ✗ Service responsibility for the person.
- ✗ Support Worker/ Case Manger role.

### **EMBRACING** Practices of...

- ✓ Recognising people as being the expert of their own life.
- ✓ Supporting self-management.
- ✓ Being curious and exploring possibilities.
- ✓ Person being the author of their own narrative.
- ✓ Supporting self-determination and self-direction.
- ✓ Upholding the person's agenda for their change.
- ✓ Focus on self-mastery, learning and citizenship.
- ✓ Adopting adult – adult relationships with people.
- ✓ Supporting people to master areas of vulnerability and risk.
- ✓ Collaboration with the person.
- ✓ Facilitator / Coach.

## Getting Clearer About the Role of Planning

One of the main processes that can help workers to align this practice is through good **service planning processes**.

For so long ‘others’ have done planning ‘on people’ and ‘about people’ and even sometimes without people being involved at any level. These are practices that can no longer be supported within the era of working from a recovery oriented and self-directed framework. Supporting people to self-direct their plans and supports will require organisations and workers to let go of existing ways of service driven planning to develop a bridge towards person driven / self-directed planning processes.

*Self-direction is the process by which a person controls their life.*

*[Scottish Recovery Network]*

When a person drives their own plans it is more likely they are exercising a greater sense of self-direction, self-determination, self-management and have a clear vision of what they want and what role they want you to play in assisting them with that. These are all aspects of personal recovery that recovery focussed services should be creating opportunities for people to engage with.

Mental health workers have traditionally worked with people who access services to design support plans that promote their recovery and manage distress. Generally these plans have been instigated by services and created situations where responsibility for completing plans has leant towards the service provider or at best shared between service provider and person who is requesting the service.

Within the mental health sector there are many terms used to describe the types of planning that are undertaken. You may have heard terms such as case management plans, individual service plans, individual support plans, individual recovery plans, person centred plans, client centred plans, personal wellbeing plans, risk management plans, crisis plans, relapse prevention plans, self-management plans, just to name a few.

This list may give you the impression that all these plans differ from each other in terms of their focus or intention but when we look closely at them they may be much more alike than they are different.

What we call a plan is less important than our understanding of the plans role and how we utilise planning processes to support people to reclaim a life beyond the impacts of mental illness or distress. The planning processes and the conversations we have with people, are far more important than the actual physical plan that is created. The plan is a summary of the conversations we have. Even the most poorly designed form should not stop mental health workers using their skills to have great planning conversations and ultimately develop plans that are both relevant and responsive to the person’s request for assistance.

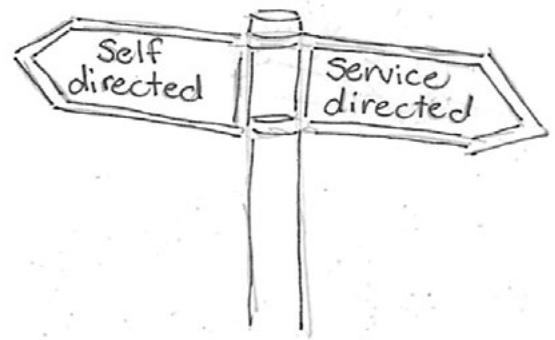


For the purposes of this document we highlight two different **PLANNING PROCESSES**.

Plans can be either:

- I. *Self-directed / person driven, or*
- II. *Service directed and driven*

A person's plan **cannot** be both self-directed and service directed. One must give way to the other. Ideally, within a recovery way of working, services should be trying to resist service directed planning and creating opportunities for people to self-direct their planning processes.



In addition, we distinguish between two different **PLANNING PURPOSES**. If we are involved in providing services, we need to understand the difference between:

- I. **A Personal Plan** and
- II. **A Service Plan**

These are two separate plans where a person's **Personal Plan** should inform the **Service Plan** and where the **Service Plan** should be responsive to the person's request for assistance. The service is not responsible for the attainment of a person's aspirations, dreams and goals. That's right, that work and responsibility belongs to the person. Within a service delivery context a person may elect not to have a personal plan but this does not mean that a service plan should not be developed [refer to later section on developing service plans].

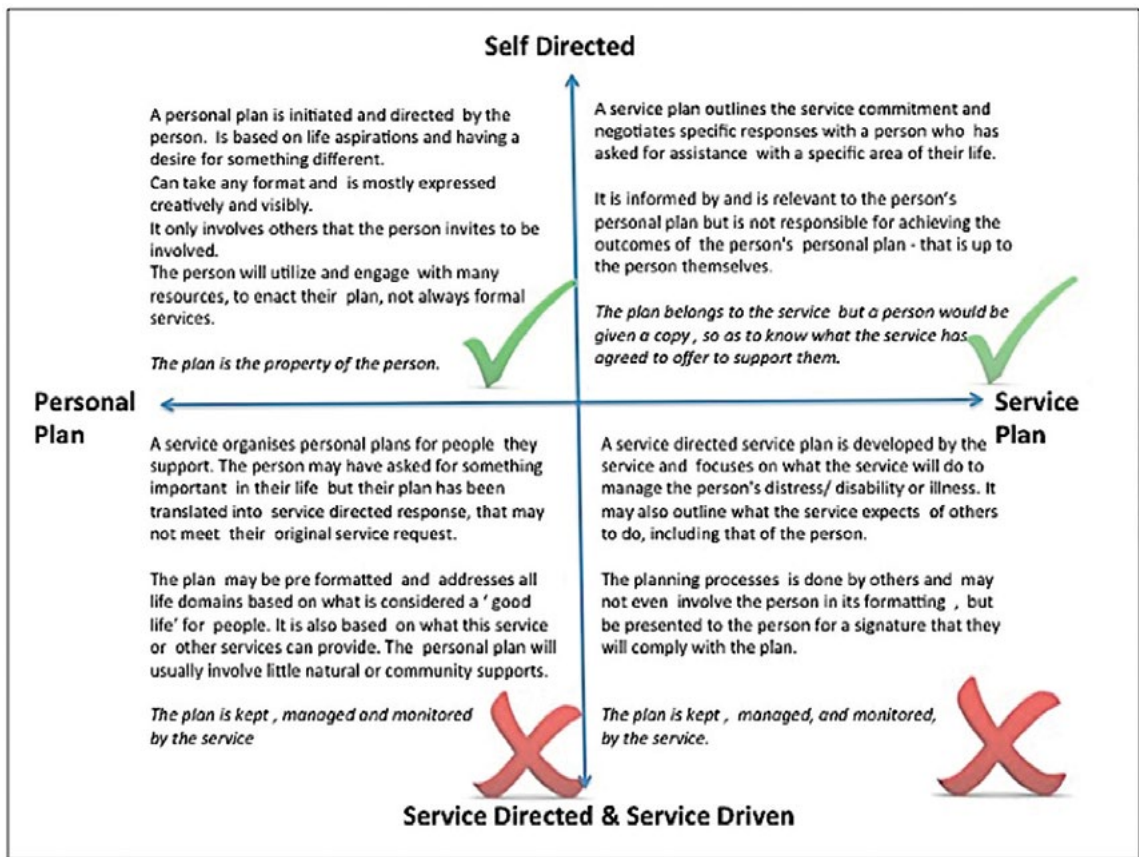
**Personal Plans** are plans that encompass many aspects of a person's life. They are developed by the person and based on their aspirations, dreams and interests. They are usually not about fixing problems. They belong to a person.

**Service Plans** outline and guide the service delivery process. Service plans aim to ensure that everyone is on the same page in terms of their understanding of the nature and direction of the support being provided



## CAUTION

*A service that names their service plans as being a person's Recovery Plan has confused their role and purpose in a person's life. This may also give the message to a person that the service is taking responsibility for ensuring a person's recovery.*



Differences between personal & service plans and self-directed & service directed plans. When you look at the difference between service driven and person driven planning processes you probably desire for people to drive their own planning processes much more than planning be 'service driven and directed'. It is important to support self-directed personal plans and service plans and resist service-directed and driven personal plans and service plans.

### Reasons Not to Undertake Service Driven and Service Directed Planning

- ✗ Unlikely to really match peoples' needs, and risks losing sight of what they originally requested assistance with.
- ✗ Likely that an opportunity to get really clear and focussed on the planned work together will be missed.
- ✗ Likely that the service agenda will lose an opportunity to invite people to self-direction and self-manage (personal recovery)
- ✗ Unlikely that support will be offered in a meaningful way to the person
- ✗ Likely to increase the chances of the plan being coercive in some way
- ✗ Unlikely to be appreciated by the person receiving the support
- ✗ Waste of time and resources for both the service and the person requesting support
- ✗ Unlikely to bring energy and inspiration for both the worker and or the person receiving support
- ✗ Likely to be seen as just a 'necessary task' by the worker, service and person.



## Reasons to Facilitate Self-Directed Planning

- ✓ Is a natural process and a part of ordinary adult life
- ✓ Is likely to result in solutions that are useful to a person
- ✓ Upholds citizenship rights and responsibilities
- ✓ Supports a person's voice to be heard and responded to.
- ✓ Can facilitate a working alliance with people
- ✓ Can be a process to support personal recovery, self-management and ultimately self- mastery
- ✓ Provides a clear understanding for supporters as to what their role is and what their role is not
- ✓ The work of creating a service plan then becomes easier for the worker than trying to determine what should go into a personal plan
- ✓ Provides clear indicators of when the support is working and when it should finish.
- ✓ Reduces the risk of services acting coercively or being controlling in people's lives
- ✓ Resources will most likely not be wasted if they are self-directed



## How Would I Recognize if People's Plans were Service Driven?

- ▶ In simple terms a service driven plan is generated and organised by the support provider or service. Service plans are mostly focussed on managing behaviours, symptoms or ensuring an increase in skill level. The person will be invited by the service to complete a plan, usually at the service entry time.

### EXAMPLE

Worker: as part of you being involved with the service, we need to do a plan with you and map your goals.



- ▶ The planning process usually fits into pre-scripted questions and pre-formatted forms that shape the planning conversation into goals, actions and timelines. The risk is the plan then becomes a monitoring tool of the person's achievements and not a guide to how services have committed to support the person.

### EXAMPLE

Worker: what do you want to achieve, what steps do you think you might need to take, when do you think this can be achieved by.

- ▶ The service driven plan may honour people's individual aspirations, interests and goals within the plan, but makes them the business and responsibility of the service to achieve. The focus on 'end goals' could inadvertently leave a person sitting on the sidelines of their life watching others create it for them. Whilst this action may fulfil the workers needs of being seen to be useful and active, it most likely will not leave a person with a sense of self mastery and self-direction.

#### EXAMPLE

Sarah stated that she enjoyed singing and one day would like to do that as a profession. Without further enquiry the worker planned for Sarah to join a local singing group, organised transport there and back and made sure that the local singing group was aware that she had 'special support needs'. On hearing of her plan, Sarah refused to go and was seen by the service as sabotaging her support, non-compliant and being unmotivated. The team discussed that Sarah may not be ready for recovery and probably not ready to use their service supports at this time.



- ▶ The service driven plan may take into consideration individual aspirations, hopes, dreams etc. but limits the service response around these to what they can provide and what is considered best for the person based on their professional opinion.

#### EXAMPLE

If a person was looking for a boyfriend but mentioned this to a support service as a goal it may be considered outside the service scope and ignored or referred to a service social or support group.

- ▶ The service directed plan usually focuses on eradicating or minimising symptoms or behaviours that are determined not useful or healthy for the person and replacing these with behaviours that are deemed healthier or more appropriate.

#### WORKER:

I think we also need to add some other things to your plan. It is important that you develop the ability to manage your home environment and therefore I think we need to add a focus on cleaning and cooking. How does that sound to you?

- ▶ Service driven plans may become over involved in a person's life and plan services based on all their life needs. Services in an effort to provide a holistic response to people's aspirations could inadvertently become involved in all aspects of their life, creating a 'whole of life service' response. Although the intentions of services are honourable, a whole of life service response does not support working from a recovery orientation. Services are only one of the many resources available to people but should never be considered the whole response to supporting people to reclaim a life beyond the impacts of mental illness/ distress.



**WORKER EXPLAINING THEIR SERVICE TO A NEW CLIENT:**

We see ourselves as a 'one-stop shop' where we can respond to most of your needs. This makes it easier for you. We respond to your emotional, physical, environmental and spiritual needs. People say they feel safer when we provide all the services for them. It is also much easier to keep tabs on what is happening when we also are the main service in your life.

- ▶ The agenda for the plan and service response may not be that of the person. It may be generated by the service itself as to what they think the person will benefit from or by others such as other services or family.

**EXAMPLE:**

John's family think it would be much better if he did not smoke as it is affecting his health and have asked the service to focus on that in their support. John has not mentioned that he is interested in reducing his smoking at this time. The service also agrees that it would be a good goal for John to reduce his smoking habit. As part of John's plan, the service has provided John with Quit smoking information and subtly discourages John from smoking by distracting him when he wants a cigarette as part of his support plan.

- ▶ Usually the plan is cited as needing to be completed as a compliance measure that the service is required to do as part of their service agreement with funders.

**EXAMPLE:**

Worker explaining to a new client We have to do a personal plan with you as our funders require that every person receiving a service will have an individual plan.

- ▶ The service directed plan is kept with the service and becomes part of the organisation's property. It is used in part to monitor the person's progress against the stated goals. A person is usually provided with a copy of their individual plan.

**EXAMPLE WORKER:**

If you wish to access your file you will need to apply through Freedom of Information processes that we have in place.



## How would I recognise if people's plans were self-directed?

Supporting self-direction should be one of the key focuses of services that are committed to fostering environments that promote personal recovery.

**Personal Plans** that are truly self-directed or person driven are initiated, generated, monitored and owned by the person. They are built around what is important to the person, their likes, aspirations and dreams. A person driven plan or self directed plan does not mean that a person must go solo without any support or assistance developing or enacting their plans. A person would engage and negotiate with a range of resources and supports with what they felt useful and relevant in assisting them to meet their needs.

An analogy would be the person, who is self-directing their plan, is the selector of their team. They determine what role they would like others to play, for how long, and have the privilege of being able to change supports as required.

### In an Pure Person Driven Process

▶ A person would have taken time to consider what they want and have established a clear vision of the life they want to lead. Some people find it useful to invite another person to provide some guiding questions to reflect upon to establish a clear vision.

Susan has developed her own personal plan. She has used a workbook she found on the internet to assist her with this. By working through the workbook, she has become much clearer about the things that are important to her. Her aspirations are;

- **To get fit and lose some of the weight:** the medication has caused her to put on.
- **To enrol to finish her schooling:** as it was disrupted due to experiencing a mental illness early in life.
- **To get off the Mental Health Act:** as she is sick of being controlled by what others say. She knows that she can manage things a lot better now.

Eventually she would love to get a real job and not be relying on the pension just to survive. When she was younger she wanted to be a pre-school teacher. She doesn't know if that is still possible. Susan believes if she tells people they will dissuade her and tell her it is being unrealistic. She would like to give it a go anyway. If she doesn't become a pre-school teacher she will become something else. Better than being on the DSP!!!

▶ A person driven plan is owned and directed by the person. It can take any form and most likely will not resemble a service plan format, as we currently know them. Many people who develop person driven plans use graphics, photos, and other creative ways to express their planning ideas and capture what is important to them. PATH is an example of a graphic personal plan. It is used as a visual cue, reminder and inspiration of what is important in people's lives.

More information can be found about PATH and other personal planning tools at [www.inclusionpress.com](http://www.inclusionpress.com)

## Susan's Path



▶ A person developing a person driven plan would be aware of or become aware of some of the boulders or barriers to enacting their aspiration plan. If nothing was stopping them they would be doing it now or have done it. They would not be accessing help if there was nothing in their way. Any support offered should focus on assisting the person to master or influence what is stopping them.



Many of the things in Susan's plan she can do under her own steam, but there are a couple of things she is going to need a bit of help with, such as getting off the mental health act so she can travel and finding better ways to manage her money so she can buy a car to get around. When Susan thinks about why she has difficulty with this, she realises it is not so much any physical limitations caused by her mental illness but more her belief that she can't do it. She also has never tried as her mother and sister have always managed her money for her since she was diagnosed 10 years ago.

▶ A person enacting their self-directed plan would choose the supports that work best for them. They would be the selector of their team. They would be clear about the role they would invite their team to play in their life. They would be aware or become aware of some of the resources and supports available to them to overcome the barriers to reaching their aspirations.

Susan asks a number of people if they would be willing to assist her. She asks her friend Jenny if she would be willing to teach her how to budget her money. Jenny has always been a 'good saver' and Susan thinks she will have some good tips. Jenny also knows what it is like to not have a lot of money as she has been on a pension. She has also asked her mum and sister to take a back seat in managing her money.



She has asked a couple of friends, who she met at the mental health service, if they wanted to exercise together. "We all moan about our weight, but don't seem to be able to do it on our own". Susan and her friends don't have much money for fancy gyms and trainers but decide to go to the park three times a week where the council put on free fitness sessions.

Susan realises that she may need some specialist help in a couple of other areas of her plan and decides to request support from the mental health support service.

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- ▶ A person-driven process may not necessarily include services as part of their supports. If services are invited by the person to assist them, then they probably will coexist with more other self, natural and non-service initiatives.

Susan talks with the support service about her self-directed plan and that she would like some assistance in two things (1) going back to finish school and (2) getting off the mental health act. She mentions the reason she wants this is because she wants to get a 'real job'. She stops short of telling them it is because she wants to be a pre-school teacher. She keeps that to herself for now. She lets them know that she has organised some other supports with friends and family and really only needs assistance in these two areas.

- ▶ Susan talks with the support service about her self-directed plan and that she would like some assistance in two things (1) going back to finish school and (2) getting off the mental health act. She mentions the reason she wants this is because she wants to get a 'real job'. She stops short of telling them it is because she wants to be a pre-school teacher. She keeps that to herself for now. She lets them know that she has organised some other supports with friends and family and really only needs assistance in these two areas.

Susan shared her self-directed plan with the service but did not give them a copy. The service spent a couple of sessions planning with Susan the support options that may assist her regarding finishing school and getting off the mental health act. In the first instance, the service concentrated on helping Susan name what was getting in her way of being able to do these things. Once Susan was clear about these barriers then the service could focus on supporting her to influence and master them.

**Just concentrating on the work of getting off the mental health act...**One of the barriers to getting off the mental health act was that Susan did not know how to raise the possibility of getting off it with her medical team and she was a little afraid to do so in case they said no. She also did not know what they were looking for to be different, so she did not know how she could demonstrate to them that she could do what was required to manage without the mental health act managing her.

The worker considered with Susan a number of support options but Susan chose the weekly 'communication skills group' to attend along with some one on one support where she could practice some challenging conversations with her support worker.

- ▶ A person is not accountable for their performance against their stated goals or aspirations to any of the support providers. People involved in any support provision to the person are not responsible for attaining the person's self-determined goals or aspirations. They have committed to providing the negotiated support to the person to help them attain their aspiration, or mastery over what difficulties they have in meeting their aspiration.

Susan was feeling great. She was in control and also getting the support that she thinks will help. Susan knew that her goals were her goals and that only she could assess how she was going.

Although the worker offered to have a word to the clinical team on her behalf she knew in the long run that this would not be helping her. She knew that she had to learn to do it for herself.

The worker from the support service spent a lot of time with Susan to identify the indicators she would notice if the support offered was useful and support in this area was no longer needed. She also identified the indicators if support was not assisting in the way she hoped. In this case, it would mean that the service supports needed to be reviewed and probably altered. Susan named that she would no longer need support when she didn't get anxious in group settings and when she felt that she could communicate to her medical team without crumbling. Both Susan and the worker had a clear idea of what the support was aiming to assist with.

- ▶ A person driven plan will constantly be modified and tweaked by the person to ensure that it remains relevant to their needs.

Susan, after six months along this journey, made a decision to change her direction. She had attained some of the things on her plan, she was nearly finished her schooling and had continued to stay fit. She was struggling still to survive on the pension and it was frustrating her. She was still working to getting off the mental health act and her medical team was supporting her to do this. Susan was feeling that she had worked hard in the previous six months and was proud of herself for where she was now. She now wanted to move out of home and live more independently from her family.

To make a bold step she had decided to move interstate so that she could start afresh. Although people around her were concerned she was not "ready", she knew that it was her life and that she had the confidence to negotiate the supports she needed to make it happen successfully. After all, look what she had negotiated already.



LEFT:

Susan's Plan that she has pinned to her notice board in her room.

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## What are the practice principles that guide service planning towards being recovery oriented and self-directed?

Establishing principles to guide practice within services are extremely useful. It helps individual workers know that they are honouring the values that are important to uphold in practice. Practice principles should be clear enough to guide workers in what they should be upholding and what they should be resisting in their day-to-day work. Practice principles are useful to guide team reviews, peer reflection, and supervision.

Some of the practice principles that underpin recovery oriented services supporting people towards person driven / self-directed planning should acknowledge that:

### **1. We all have the same human needs.**

No one person has more or less needs than anyone else. We acknowledge that some of the things that cause unmet needs may be due to a lack of access, opportunity and resources and not necessarily as a result of the illness / disability itself. This may be expressed as ‘I don’t want what you want to give me; I want what you have in your life.’

### **2. People who access services want something different in their lives.**

It is important to become clear about what people are looking to master or overcome. We invite people to have conversations around their needs, aspirations and barriers so that we can ensure that what we offer is relevant and appropriate.

### **3. People, prior to coming to any service, have already tried many initiatives to meet their needs.**

A service, such as a mental health service, is useful to people only when it offers something unique that is not available through naturally occurring mechanisms. It is at this point that a service may be contacted to see if they can be of any assistance.

### **4. We recognise people as being experts on their own life especially in terms of what works and what doesn’t.**

We will resist determining what is best for people and any planning and support initiatives that have not been generated with people.

### **5. We support people to direct all decision making processes about their life.**

We are committed to not having any conversations “about people and without them.” We will not shortcut this by participating in any planning or support decisions where the person is not present.

### **6. We recognise the importance of planning in our own lives and develop and utilise our own life plans.**

We resist participating in other people’s planning processes where we have not developed and utilised our own.

**7. We view the person as the team leader of his or her own support team.**

We recognise we are only a chosen member of the person's support team and have been invited to play a specific role for a specific time. We acknowledge that there may be a time where we are no longer selected as a support initiative.



**8. Our service plans are informed by the person's plan so to ensure their relevance and responsiveness.**

Our responsibility to the person is to hear their request for what they have asked assistance to master. A service plan details the service commitment to the person based on the need of the person and what the organisation has the scope and resources to offer. It is not our role, nor is it appropriate to offer support as a whole of life response [see section on service plans].

**9. We will negotiate supports with people** so that we are clear about the nature of the support request, the strategies of support, the desired outcome and the expected timeframes of our involvement. We resist seeing ourselves providing support that does not identify specific outcomes.

**10. When the support offered has not been useful we consider it as a result of the service provision and not of the person.** When we are not clear about the focus of the support offered we will ask the person if they are prepared to help us to become clear again by revisiting the plan. This may eventuate in a new service plan being developed.

**11. We intentionally support people to live, love, work and play in their own community and not within our service.** We support people to utilise and access all of their community resources and consider our service options as a last response. We do not limit our planning and support provision to our service environments.

**12. We acknowledge that on one hand we may be an enabling support to a person but we could also become disabling due to the service environments and limitations that we operate within.** Within the planning process, we have a responsibility to the person to highlight any associated risks that the service may inadvertently cause E.g. increase service dependency, loss of roles, loss of relationships, loss of identity etc.

**13. We value and seek feedback about the services we provide and whether they are relevant to each person's life.** We constantly review, both formally and informally, the supports provided with the person, to check their relevancy and fit. We are committed to refining our service supports so that they remain useful to the person's ability to reclaim a life beyond the impacts of mental illness/ distress.

## What do I have to consider when inviting a person to self-direct?

A person may not have a personal plan or an interest in developing one for a whole lot of reasons. They also may not come to a service with experience, skills or interest to self-direct. This does not excuse the service from negotiating a service plan, guided by principles that promote self-direction and recovery.

Services, when first inviting a person to self-direct the services that will work for them, may face some reluctance from people. For many people the process of driving their own planning is new and can be somewhat daunting. It is unrealistic to expect a person who may have been locked out of their own planning processes for many years, to jump straight into self-directed processes without some guidance and support from others.

It is important to recognise that people may have barriers that create difficulties in engaging with self-directed support. These may include fear, self-stigma, negative experiences with the system, previous low expectations from professionals and lack of self-efficacy. Individuals may need support to tackle these difficulties before being able to engage in self-directed support.

Services can create environments and expectations that support self-directed support through building a support relationship that honours the person's existing efforts of recovery and facilitates their ongoing self-management.

Services need to carefully consider how they create opportunities that invite people to take the reins of self-direction. This could include education on what self-direction is and why it is important that services don't do things "about them without them". Practically, this is evident through promoting individual choice, recognises natural support and creates an expectation of self-determination and the individual's control over their own life.

The role of the service/ worker in supporting self-directed planning processes is much more akin to being a **coach or facilitator** than a support worker or case manager.





## How do I develop a service plan and support self-direction simultaneously?

The experience of having a mental health issue may make it difficult, at times, for an individual to enact their life plan. Therefore, there may be a role for services to be involved in a person's life and to negotiate what supports they can offer a person to help them overcome the obstacles that have made it difficult. Not all of a person's life direction should become the focus of a mental health service, or any service for that matter. It is important that a service does not see its role to take over the person's life plan. The plan that is negotiated between the service and the person about what supports are needed in the individual service plan.



### Establishing "Relevancy and Fit"

*A service plan should not focus on achieving a person's personal plan!*

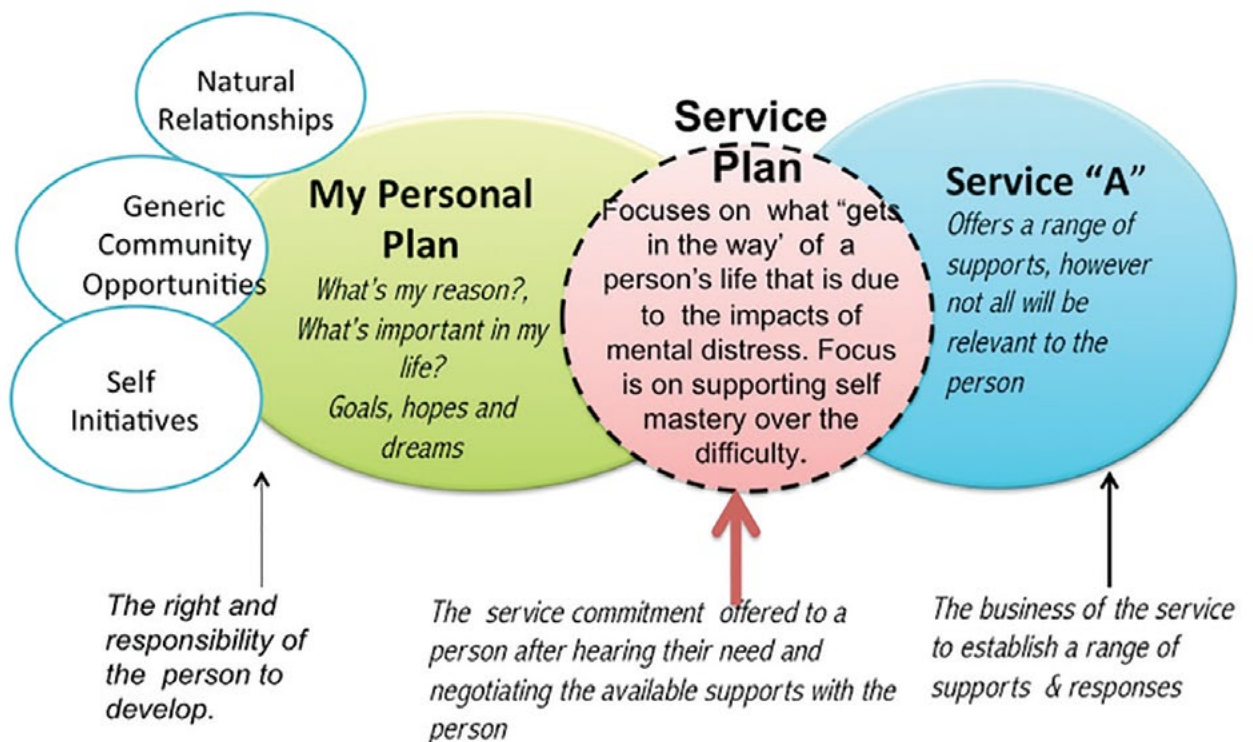


FIGURE 1: Differences between a service plan and personal plan

### Some of the phases of the planning conversation should include:

- ▶ **Prior to initiating service planning**
- ✓ Invite a person to participate in a service planning conversation. Explain that this will be useful to you, as a worker, to get really clear about how best to assist.
- ✓ Supporting the person, prior to any formal planning conversation, to think through what they would like to ask for assistance with and what they think they need to get good at in order to reclaim their life beyond the impacts of mental illness/ distress.



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- ✓ Enquire as to who, if anyone, the person thinks would be helpful to include in the service planning process and who they think would not be helpful.
  - ✓ Ascertain with the person when would be a good time and place to meet that is conducive to a planning meeting and conducive to a relaxed participatory environment. (Service's offices are usually not the best place.) The sharing of food is always a useful way to connect around planning.

▶ ***During the service planning process***

- ✓ Discover from the person what it is that they wish to receive assistance with and/or what they wish to get good at.
- ✓ Why is this important for the person?
- ✓ What would be different about their life if they were able to achieve this?
- ✓ Remember this is their aspiration and does not become part of the service plan. (This part is purely to appreciate the context for the work)  
e.g. – I would like to have some help to get out of my house
- ✓ Get curious about what the challenge or difficulty is for the person. If there were nothing stopping them they would have already done it.
- ✓ Explore what initiatives a person has already undertaken to try and influence their barriers. (Coming to a service will not be their first initiative)
- ✓ Identify other supports that the person is utilising in these areas. This is so not to replicate or replace existing natural relationships.
- ✓ Brainstorm with the person as many natural and service support ideas that would help the situation. Also identify natural and service support ideas that the person recognises may not help. This could be a creative exercise.
- ✓ From the list of identified supports negotiate which ones the service may be able to assist with/ best to assist with. Be clear about the commitment in terms of length of support and frequency of support that can be provided.
- ✓ Enquire with the person as to what will indicate if the support has been useful and when the support is no longer needed. Identify also the indicators that suggest the support has not been useful.
- ✓ Identify any areas or issues that might increase the plans chance of not working.
- ✓ Identify any risks there may be in receiving a support service and how might the service and the person work together to overcome these? (e.g. Increase dependency, loss of roles, loss of relationships, increase stigma, etc.) These are known side effects of service environments and should be discussed openly, honestly and transparently with people.
- ✓ Negotiate with the person when they think it would be a good time to check back in with them to see if the planned supports have been useful or not or whether the plan needs to be tweaked.
- ✓ Confirm with the person what you have heard and the decisions that have been made.
- ✓ Prepare a service plan according to organisational formats and processes. The service plan should only contain the commitment and service supports that the service is able to offer. At this point, it is usual for the worker to discuss the planned service commitment with their supervisor before being able to offer what they have discussed in the service plan to the person.
- ✓ After confirming the service plan with the supervisor, schedule a time to present this to the person. Explain the plan and ascertain whether they wish to proceed with receiving support from the service.

► **Post Service Planning Meeting**

- ✓ Document the planning conversation/s
- ✓ Discuss the service plan with your supervisor.
- ✓ Despite having developed a service plan you are still yet to start to provide any support.
- ✓ Document your work against the commitments you have made to the person in the plan.  
Focus on what you have provided and how it was received. Try to refrain from commenting on the person's progress. It is the person's right to comment on their own progress.

**EXAMPLE:**

As per plan - Worked with Susan on assisting her express her thoughts to others, especially having conversations with health professionals. We role-played this a number of times. I also supported Susan to have conversations with people when she did not know how they would respond – requesting information from people in the street, returning an item she had bought, requesting assistance from someone else. Susan expressed that she found these exercises challenging but useful. We have agreed to try similar exercises next time we meet.)

**EXAMPLE ONLY**

Service Plan			
The service aims to enable an environment that provides opportunities for a person to recognise more of their capacity to self determine and self manage rather than being managed by others.			
Name : Susan Parker	Address 13 Sephamore st, Kentown Phone Contact 09 78567845	Date: 2 <sup>nd</sup> August 2013	Is this an initial plan Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If NO - date of previous plan
What has the person approached the service for support with?	Susan has approached the service with specific help to; 1. Get off the Mental Health Act 2. Finishing School: Susan has finished Grade 10.	<b>Boulder Issue</b> Knowledge	<b>Boulder Issue:</b> Fear and Anxiety
What has been identified as to what gets in their way (boulder) or where this is difficult for the person? (How does a person name their "Boulder/s"?)	1. Getting off the MHA - Susan highlighted that she didn't know what she had to do differently to get off the MHA and that she had great anxiety talking to her medical team about this. She thinks if she knew she could start to work on that. Susan said that she did not know very much about her rights and responsibilities, especially regarding the MHA. She thought she has none.  2. Finishing school. It has been 10 years since Susan finished grade 10. She said she doesn't know the process of going back or whether people would laugh at her if she tried. She is anxious about "not finishing" again. Susan has highlighted that her concentration is proving a problem and it seems to be getting worse. She is also worried that she doesn't have enough money for the course.	<b>Service Commitment</b> Support Susan to access information on the MHA - via service literature and internet. (30 mins - week for 3 weeks - self paced) Introduce Susan to Peer worker who can discuss the process of getting off the MHA and introduce to others who have a lived experience of such. Provide support to Susan to attend the Knowing My Rights and Responsibilities" group. ( 1 x WK , Tuesday 10.00am - 12pm) Provide support Susan to access information from the TAFE regarding enrolling. (2 x 1 hours for 2 weeks)	<b>Service Commitment</b> Support Susan to attend the Communication group facilitated by 'Forum' - a public speaking group women. (Thursday night - 2 hours for 4 weeks)  Provide 1 on 1 session on practising "challenging conversations" in the community and roleplaying conversations with her medical team. 2 hours per week
What co-created ideas / possibilities have been identified that may be helpful in supporting the person address their boulder? (Self directed, natural, community service)	We brainstormed a lot of ideas together Reading the brief version of the MHA Looking on the Internet Talking to Peers who have been on the ACT and got off Practicing conversations Attend the rights and responsibilities group and the assertiveness group Testing her anxiety gradually over time in different places in the community Going to the TAFE to find out about finishing senior and any costs - see if she can talk to some people there who are doing it. Asking others how they did it Getting some assistance with concentration - maybe change the time medication is taken	What will the person and worker recognise if this support has been a success?  What will the person and worker recognise if this support has not been a success?  What are the risks or threats that may get in the way of the success of this plan? Indicators when a service needs to be reviewed	Susan says she will be able to go up to strangers + request something without having a panic attack. She will know about her rights and responsibilities. She will have more confidence in being able to speak to her medical team in asking to get off the MHA. She will be able to access information from different sources.  Susan says the support will not be a success if: --she has more panic attacks. -if she is refusing / or doesn't show up to the sessions -if she is making excuses for not having a go at it  Susan said : - if the service does not follow up on their commitment - " I could get stuck" here and continue programs and courses and not get back to real stuff. - If it becomes too hard I may lose my determination. I might need encouragement about this. - If the medical team doesn't support me to get off the MHA
What personal resources has the person identified that they have to help them?	Self determination and commitment- Susan said " she has a reason to finish school - to get a real job" - this motivates her to have a go. She named courage - she can't keep going with this level of anxiety, so she knows she has to do something about it. She has some really good friends that all support each other.	<b>Check In</b> When have you negotiated with the person to check in regarding this plan?	4 weeks from today 31st August @ 10.00am
Notes	Susan wishes to tackle both needs at once. We talked about providing some initial support around gaining knowledge about the MHA and TAFE but this probably wont need to be an ongoing support once she has gained this knowledge. She thinks the most challenging area is going to be mastering her fear and anxiety. She has asked if we can remind her of ' her reason' for wanting to tackle this if we start to notice her to " drop out" of the support. We have elected to revisit the plan in four weeks as we are wanting to check in that what is being provided is useful.		
Signature of Worker	Teresa Mathews	Approved by Team Leader: Jason Seymour	Date: 3 <sup>rd</sup> August, 2013
Accepted	Susan Parker 4 <sup>th</sup> August		

FIGURE 2: EXAMPLE ONLY. Service Plan for Susan Parker.  
(For full page view refer to resource section)

## Yes But...

By now we imagine you may have some “YES BUT” questions...We have tried to imagine some of them and make some responses.

► ***Is working from a self-direction agenda relevant to everyone?***

Self-directed approaches and planning are relevant for all people. Self-directed planning is not just for people who are identified as being on their ‘journey of recovery’. It is for everyone. It means that no matter where someone is in terms of their ‘wellness’ that they direct their life and decide what services and support that will assist them. This may mean that some people may require and request additional support and assistance. It may also mean that there are some people who need additional advocacy or support to ensure their voice is heard. It is important that people who have limited capacity due to also having a cognitive or other disability are supported to plan and direct their own lives.

“YES,  
BUT...”



► ***But some people may not want to self-direct, what do we do then?***

It is important to recognise that people who may resist self-directed planning may simply feel more comfortable doing things the way that they have always been done because it is familiar, rather than trying something new and risking failure. This uneasy feeling is familiar to all of us. We all resist change even when we acknowledge that the status quo is not working. Acknowledge that change and learning involves risk and trial and error and that we all learn from times when we fail as much as from times when we succeed. It is helpful to ask the person about their concerns and to try and be as explicit as possible. Listen carefully to what they say and discuss together ways to address their concerns.

There is an opportunity at this point to direct people to stories of other people’s experiences and success in using self-direction in their lives. Listening to someone ‘who has been there’ and who may understand their concerns can be important in overcoming the stumbling block of fear that we all face. Peer services are an important resource for people to share experiences and to learn to navigate challenges together.

► ***If someone -can self-direct, maybe they don’t need services?***

Supporting self-direction and personal control should be a core focus of support services and not an indicator that support is no longer required. It is not intended to be a means of putting pressure on the person to self-direct and to excuse responsibility of the service. Importantly, it does not mean that the person does not require support. Further, self-directed planning does not mean that services are not needed or not important.

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However, the role of services will be different. It may involve piloting and refining new ways of working. Services will now be a part of supporting the person to build capacity, skills and confidence to direct and manage their own lives, to live the life they want beyond the role of services. It will require effort and good communication to ensure there is enough time for the service and the person to understand what the person would like support with and how to work on this within a service plan. Services may be challenged to provide support in ways that they had not thought previously possible. It also needs to be acknowledged that services will have a critical role in progressing self-directed approaches and planning.

▶ ***What about people who have high levels of 'risk taking' or 'highly complex' behaviour?***

'It is too risky, something will go wrong' Often concerns are voiced about liability and duty of care and what will happen if the person makes poor choices and is harmed by those choices. Step back and consider where this fear is coming from. Is it possible that the fear is coming from a paternalistic need to take responsibility for that person? Often these fears and feelings are misplaced. In fact, self-direction is a good opportunity to emphasis education about choices and consequences, self-management skills beyond the life of a service and a shared understanding of respect and choice. Individuals can be given tools that assist them to manage their own mental health and to be supported to recognise signs of impending difficulties (examples of tools that may be useful include WRAP , This is Your Life! Creating Your Self-Directed Life Plan and Balancing Safety -see Resources section).

▶ ***Are there any limits on people's ability to self-direct?***

While mental illness may make it difficult for people to participate in self-directed planning at a given time, often there are other factors, such as fear, previous low expectations from services and feelings of hopelessness that make people only appear unable to self-direct. However, people will feel more capable and these barriers can be overcome if people are amply encouraged and supported in developing self-management skills. Consider, is this person feeling a sense of hopelessness? If so, how can I support the person to rediscover a sense of hope and regain a sense of his or her future and potential? When self-direction is presented as an option, it is highly likely the individual who chooses it will be motivated and grow in confidence as they move towards their life direction.

## Summary

Hopefully you have found this short document on supporting self-directed planning useful. Undoubtedly you will have recognised many aspects of supporting self-directed planning that you already uphold in your practice. There are many more resources available to support you in your practice of which we have listed some in the next few pages. We encourage you to keep refining the conversations that you have with people so you and others experience them as life giving experiences.

## Self-Directed Planning Resources

*(Including person centred, recovery oriented and self-directed planning resources)*

There are a vast amount of resources available. Here are a few selected resources that may assist your service in moving towards self-directed planning.

▶ **The Centre on Mental Health Services Research and Policy – The University of Illinois and Chicago**

The Centre provides a series of tools to advance self-determination and person-driven services for use by people with psychiatric disabilities. *Visit Website > <http://www.cmhsrp.uic.edu/nrtc/tools.asp>*

- *Express Yourself! Assessing Self-Determination in your Life*
- *This is Your Life! Creating Your Self-Directed Life Plan*
- *Raising Difficult Issues With Your Service Provider*
- *Seeking Supported Employment: What You Need to Know*
- *Research on Self-Directed Care Fact Sheet*
- *One-Stop Source for Self-Directed Care*

▶ **Person Centred Planning Education Site - Cornell University, USA**

In this site you will find:

- An overview of the person centred planning process
- A self-study course covering the basic processes involved
- A quiz section to help you focus on areas you may need to cover more thoroughly
- A compendium of readings and activities for you to use on your own
- Various links and downloadable resources.

*Visit Website > <http://ilr-edi-r1.ilr.cornell.edu/PCP/>*

▶ **The National Empowerment Centre**

This site has some very good recovery oriented articles which are free to access.

*Visit Website > [www.powwer2u.org](http://www.powwer2u.org)*

▶ **Scottish Recovery Network**

This site has some very good recovery articles and planning ideas around self-direction

*Visit Website > [www.scottishrecovery.net](http://www.scottishrecovery.net)*

▶ **Yale – Program for Recovery & Community Health**

This site has some very good person planning in mental health resources

*Visit Website > <http://www.yale.edu/PRCH>*

▶ **Mary Ellen Copeland**

This website by US consumer advocate has links to lots of recovery resources:

*Visit Website > <http://www.mentalhealthrecovery.com/recovery-resources/articles.php?id=30>*

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▶ **Think about your life**

This website has been developed by cancer survivors and people with chronic health conditions. Although this website focuses on cancer it is very useful for all of us, whatever health issues or distress we may experience.

Visit Website > <http://www.thinkaboutyourlife.org/index.cfm>

▶ **Inclusion Network**

This Inclusion Network has resources and training on PATH, a creative planning tool which starts in the future and works backwards to an outcome of first (beginning) steps that are possible and positive. MAPS is a planning process for people and organizations that begins with a story - the history. And Circles of Friends or Circles of Support have been in every society since the dawn of time. It is about how we take care of each other in families and communities.

Visit Website > <http://inclusion.com/inclusion.html>

▶ **WRAP**

Wellness Recovery Action Planning (WRAP) is a 'self-management' tool used in many countries around the world to help individuals take more control over their own wellbeing and recovery.

Visit Website > <http://www.mentalhealthrecovery.com/recovery-resources/articles.php?id=1>

▶ **Your Life Your Choice**

Queensland Government resource and information website on utilising self-directed supports

Visit Website > <http://www.communities.qld.gov.au/disability/key-projects/your-life-your-choice>

▶ **My Life-My Way**

A booklet has been developed by the Western Australia government as a guide to implementing self-directed support. Essentially it asks, what does self-direction mean for the current service system?

Visit Website > [www.partnershipforum.dpc.wa.gov.au/.../2087\\_MY\\_LIFE\\_MY\\_WAY](http://www.partnershipforum.dpc.wa.gov.au/.../2087_MY_LIFE_MY_WAY)

▶ **Increasing Person Centred Thinking: Improving the Quality of Person Centred Planning: A Manual for Person Centred Planning Facilitators.** By Amado, A. N. and Mc Bride, M. (2001), Minneapolis, Minnesota: University of Minnesota, Institute on Community Integration.

This is a free resource to facilitators of person centred planning processes that guides the worker in the differences between approaches.

Visit Website > <http://rtc.umn.edu/docs/pcpmanual1.pdf>

▶ **Personal Health Workbook**

This workbook is designed to help you develop a Personalised Care Plan/Personal Health Plan. It is divided into three sections. The first section is a series of tools and exercises that can be useful in helping gather information for the plan. The second section is tools and exercises that will help you develop outcomes and then design and plan what your support will look like. The third section is a template of the criteria for what should be in a Personal Health Plan.

Visit Website > <http://www.helensandersonassociates.co.uk/media/43661/personalhealthworkbook.pdf>

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▶ **Social Enhancement Workbook**

This workbook helps you develop your social participation in the community. There is a section on making friendships. There are also tips for supporters.

Visit Website > [http://tucollaborative.org/pdfs/Toolkits\\_Monographs\\_Guidebooks/recreation\\_leisure/Social\\_Enhancement\\_Wrkbk.pdf](http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/recreation_leisure/Social_Enhancement_Wrkbk.pdf)

▶ **Person Centred Reviews**

Most services have regular reviews. A person centred review uses person centred thinking tools to explore what is happening from the person and other people's perspectives, and to agree actions for change. This site provides some good examples on person centred reviews.

Visit Website > <http://www.helensandersonassociates.co.uk/reading-room/how/person-centred-reviews.aspx>

▶ **Balancing Safety**

This document draws on the work of Peter Kinsella on person centred risk assessments balancing safety with happiness.

Visit Website > [http://www.cawt.com/Site/11/Documents/Publications/Disability/POVA/Staying%20Safe%20-%20CD/balancing\\_safety%5B1%5D.pdf](http://www.cawt.com/Site/11/Documents/Publications/Disability/POVA/Staying%20Safe%20-%20CD/balancing_safety%5B1%5D.pdf)



## Planning – Community Online Resources

The following websites may be useful to people in their self-directed resources to find resources and ideas in their local community.

### ▶ **My Community Directory**

My Community Directory is a one-stop online community directory for the public, community organisations and Governments. Its purpose is to improve health and social outcomes by providing open access to quality community information.

My Community Directory is Queensland based and is designed to link local, Council based directories together in a single, simple to use platform. My Community Directory receives around 40,000 unique visitors to its website every month making it a premier source of connection between community services organisations and the public.

Visit Website > <http://www.mycommunitydirectory.com.au>

### ▶ **Access My Community**

1. A visual and map-based search experience designed by and for people with an intellectual disability.
2. Google directions between your location and the service or activity you select
3. Links to additional local information and social infrastructure such as swimming Pools or Wi-Fi hotspots

### ▶ **My Community Diary**

My Community Diary provides a place to find or list local community events, training, interagencies or activities. It will also manage ticketing and invoicing for both free and paid local events.

Visit Website > <http://www.mycommunitydiary.com.au/Events.aspx?Page=1>

### ▶ **Act, Belong, Commit**

A Western Australian community based campaign that encourages people to take action to improve their mental health and wellbeing. It features details of programmes and events, interactive tools and resources.

Visit Website > [www.actbelongcommit.org.au/](http://www.actbelongcommit.org.au/)

EXAMPLE ONLY

Service Plan	
<p>The service aims to enable an environment that provides opportunities for a person to recognise more of their capacity to self determine and self manage rather than being managed by others.</p> <p>Name : Susan Parker Address 13 Sephamore st, Kentown Phone Contact 09 78567845</p>	
<p>Is this an initial plan Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If NO - date of previous plan _____</p>	
<p>What has the person approached the service for support with?</p> <p>What has been identified as to what gets in their way (boulder/or where this is difficult for the person)? (How does a person name their "Boulder/s"?)</p>	<p>Susan has approached the service with specific help to:</p> <p>1. Get off the Mental Health Act 2. Finishing School: Susan has finished Grade 10.</p> <p>1. Getting off the MHA - Susan highlighted that she didn't know what she had to do differently to get off the MHA and that she had great anxiety talking to her medical team about this. She thinks if she knew she could start to work on that. Susan said that she did not know very much about her rights and responsibilities, especially regarding the MHA. She thought she has none.</p> <p>2. Finishing school. It has been 10 years since Susan finished grade 10. She said she doesn't know the process of going back or whether people would laugh at her if she tried. She is anxious about 'not finishing' again. Susan has highlighted that her concentration is proving a problem and it seems to be getting worse. She is also worried that she doesn't have enough money for the course.</p>
<p>What co-created ideas/possibilities have been identified that may be helpful in supporting the person address their boulder? (Self directed, natural, community service)</p>	<p>We brainstormed a lot of ideas together Reading the brief version of the MHA Looking on the internet Talking to Peers who have been on the ACT and got off Practicing conversations Attend the rights and responsibilities group and the assertiveness group Testing her anxiety gradually over time in different places in the community Going to the TAFE to find out about finishing senior and any costs - see if she can talk to some people there who are doing it. Asking others how they did it Getting some assistance with concentration - maybe change the time medication is taken</p>
<p>What personal resources has the person identified that they have to help them?</p> <p>Notes</p>	<p>Self determination and commitment- Susan said " she has a reason to finish school - to get a real job" - this motivates her to have a go. She named courage - she can't keep going with this level of anxiety, so she knows she has to do something about it. She has some really good friends that all support each other.</p> <p>Susan wishes to tackle both needs at once. We talked about providing some initial support around gaining knowledge about the MHA and TAFE but this probably wont need to be an ongoing support once she has gained this knowledge. She thinks the most challenging area is going to be mastering her fear and anxiety. She has asked if we can remind her of 'her reason' for wanting to tackle this if we start to notice her to 'drop out' of the support. We have elected to revisit the plan in four weeks as we are wanting to check in that what is being provided is useful.</p>
<p>Signature of Worker</p>	<p>Teresa Mathews Susan Parker 4<sup>th</sup> August</p>
<p>Accepted</p>	<p>Approved by Team Leader: Jackson Seymour Date: 3<sup>rd</sup> August, 2013</p>
<p>Boulder Issue: Fear and Anxiety</p> <p>Service Commitment Support Susan to attend the Communication group facilitated by 'Forum' - a public speaking group women. (Thursday night - 2 hours for 4 weeks)</p> <p>Provide 1 on 1 session on practising "challenging conversations" in the community and roleplaying conversations with her medical team. 2 hours per week</p>	<p>What will the person and worker recognise if this support has been a success? Susan says she will be able to go up to strangers ; request something without having a panic attack. She will know about her rights and responsibilities. She will have more confidence in being able to speak to her medical team in asking to get off the MHA. She will be able to access information from different sources</p> <p>What will the person and worker recognise if this support has not been a success? -she has more panic attacks. -if she is refusing / or doesn't show up to the sessions - if she is making excuses for not having a go at the sessions</p> <p>What are the risks or threats that may get in the way of the success of this plan? Indicators when a service needs to be reviewed Susan said : - if the service does not follow up on the commitment - "I could get stuck" here and continue programs and courses and not get back to real stuff. - If it becomes too hard I may lose my determination. I might need encouragement about this. - if the medical team doesn't support in getting off the MHA</p> <p>Check In When have you negotiated with the person to check in regarding this plan? 4 weeks from today 31st August @ 10.00am</p>