Handout 1 – Principles of Effective Assessment

Assessment is an ongoing process that helps the worker and the client to plan the best way to:

- Meet the person’s immediate needs
- Assist them to enhance their life and develop in directions that will fulfil their intellectual, physical emotional and social needs.

The principles of Effective Assessment include:

- The person is actively involved in the process of assessment.
- Any decisions made reflect their needs and wishes.
- Exploring the following areas:
  - Crisis needs
  - Economic needs
  - Housing needs
  - Health/medical needs
  - Living skills needs
  - Mobility needs
  - Communication needs
  - Physical support needs
  - Employment needs
  - Educational needs
  - Cultural needs
  - Social needs including sexuality and relationships
  - Emotional needs.

The key tasks in the assessment process are:

- To decide upon the best assessment tools
- To develop or modify existing assessment tools
- To work with the person to determine who will be involved in the assessment process
- To determine which policy and procedures will impact upon the assessment
- To decide how the staff will work with the person
- To gather information about the person, their situation and their resources available to meet current and future needs.

An effective assessment should support the development of an **individual plan**. This plan identifies needs, goals and the strategies to meet needs and achieve goals. It is this document that provides the guidelines to workers who are interacting and providing a service to the person. It also provides a means of accountability for the worker and clearly defines responsibilities for actions. It also identifies time frames for actions to occur.
Handout 2 - Individual Plans for the Person With a Disability

An individual plan provides an outline of:
- The needs and goals of a person (What)
- The strategies/ actions or services that will be required to meet these needs or achieve these goals (How)
- The key people, including the person, workers and significant others that will take responsibility for the strategies
- The timeframe for the strategy to be implemented (When)
- A process for review.

The purpose of planning

Planning should be an empowering process for the person with a disability assisting them to:
- Become more independent
- Meet their needs
- Increase their participation in the community

Planning should:
- Reflect the relevant disability legislation (State and Commonwealth) (if you would like to see a list of the legislation look at the CPCC policy manual) and other government policy, and also International conventions on the rights of people with a disability
- Ensure that a process of accountability to clients and other stakeholders is integral to the plan
- Commonwealth/State Disability Agreement (CSDA)
- International conventions on the rights of people with a disability

An effective plan should comply with standards such as the NSW Disability Service Standards. These standards include:

1. Service Access
   Each person seeking a service has access to a service on the basis of relative need and available resources.

2. Individual Need
   Each person with a disability receives a service that is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

3. Decision Making and Choice
   Each person with a disability has the opportunity to participate as fully as possible in making decisions about events and activities of his or her daily life in relation to the services he or she receives.
4. **Privacy, Dignity and Confidentiality**
Each person’s right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

5. **Participation and Integration**
Each person with a disability is supported and encouraged to participate and be involved in the life of the community.

6. **Valued Status**
Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

7. **Complaints and Disputes**
Each consumer is free to raise and have resolved, any complaint or dispute he or she may have regarding the agency or the service.

8. **Service Management**
Each agency adopts sound management practices that maximise outcomes for consumers.

9. **Family Relationships**
Each person with a disability receives a service which recognises the importance of preserving family relationships and is sensitive to their cultural and linguistic environments.

10. **Protection of Human Rights and Freedom from Abuse**
The agency ensures that legal and human rights of people with a disability are upheld in relation to the prevention of sexual, physical and emotional abuse within the service.

**From:** NSW Carer Resource Centre  
Victorian Government Disability Services Division  
Human Rights and Equal Opportunity Commission  

**Types of plans**

There are a number of different types of individual plans.

1. Personal futures plans
2. Individual services plans
3. Individual education plans
4. Behaviour management plans
5. Case management plans
6. Health care plans.

**Personal futures plans**

This type of plan is used to help the client to achieve their long-term goals. The aim is to enable the person with a disability to consider the ways that the quality of their life can be improved and the ways that they can participate more fully in
the life of the community. This type of plan looks to the long-term goals of the individual.

**Individual service plans**

Individual service plans can be used to ensure that the services received meet identified needs. These may be determined by the person themselves, their advocate, family or workers. The needs are identified and documented through an assessment process.

An individual service plan may incorporate, or lead to, a number of other specific plans such as respite care plans, therapy plans, vocational plans.

This type of plan can also identify the short-term goals that need to be achieved if the longer-term goals described in the personal futures plan are to be viable.

**Individual education plans and individual learning plans**

These plans address the skills needed by the person to achieve the goals identified in their individual service plan. Individual education plans are more commonly used in school settings. Individual learning plans are more common in workplaces, day programs and group homes.

**Behaviour management plans**

This type of plan is developed to respond to challenging behaviours that limit the person's ability to learn skills and to participate in the community. Usually they are developed by people who specialise in this area including psychologists and programming staff. A disability worker would have the responsibility of implementing the plan, documenting data and helping to review the plan.

In this type of plan it is important to:

- Identify the challenging behaviour
- Define the behaviour
- Examine the cause of the behaviour
- Observe the behaviour
- Write and implement a plan to manage the behaviour
- Evaluate the program.

**Case management plans**

A case management plan can provide a flexible and empowering approach to identifying and planning to meet a person's support needs. It is lead by the person themselves who determines who needs to be involved. Often this may only be the case manager.

This model is appropriate where the person has the type of life experience which gives them a clear reference point from which to set realistic goals and determine strategies for the achievement of these goals. People using this model must also be able to communicate their needs.
Health care plans

These plans are developed by health care professionals such as nurses, therapists, dieticians. They are used to ensure that complex medical care needs are managed and reviewed in a timely and coordinated way. Plans can include a broad range of health care procedures that the person requires or may be specifically focused on a particular aspect of their health care eg epilepsy management plans, swallowing and nutrition plans. The disability worker's role would be to implement the plan and record data and report on any difficulties or problems.

Handout 3 - Different Types of Disabilities

A disability is a limitation placed upon an individual's capacity in a particular situation as a result of a physical, sensory (vision and hearing), speech, intellectual, medical, mental, learning/neurological impairment or a chronic health condition.

The World Health Organisation (WHO) defines disability in relation to its consequences for the individual and the impact the environment has on the experience of being disabled. It states that a person may have:

1. An impairment which is some abnormality in their anatomy or function eg a brain injury, loss of limb, loss of sight
2. This may result in a disability which is a loss or reduction in functional ability eg to think, learn, understand, see, hear
3. A handicap is the social or environmental disadvantage that a person may experience as a result for having a disability eg not being able to get into a building because there are no ramps for the person to go up when using a wheelchair, people with a hearing impairment not being able to communicate because other people do not understand their form of communication such as sign language.

Australia's Disability Discrimination Act (1992) defines 'disability' broadly as:
- Permanent or temporary
- Present from birth or be acquired later in life
- Attributed to a person but not exist
- Apparent or hidden
- More or less severe in its impact
- Associated with one or a number of other disabilities
- Associated with a range of different abilities.

It is important to use a plan that best meets the identified support needs of the individual person. The plan will need to incorporate strategies that meet the particular needs of that person. It will also address issues of communication where this is required.

Categories of disability vary considerably and it can be very difficult to make a valid comparison of the needs and impact of disability upon an individual and their families across the disability groups.
Disabilities can be complex. Not all disabilities arise because of the same conditions and not all conditions give rise to the same disabilities. More than one type of limiting condition may also occur simultaneously changing the nature of needs and the priorities or goals for the client.

When deciding on the most appropriate type of plan, a worker must ensure that the person's identified needs can be addressed when the plan is implemented. This would take into consideration the impact of the person's disability on their functioning.

The major categories of disability include:

**Physical:** These types of disability may be acquired before, during or soon after birth. They may also be the result of injury or disease at a later point in life. Having a physical disability affects the physical body including mobility in moving from one place to another. Physical disabilities include:

- Amputation
- Spinal cord injury
- Spina Bifida
- Muscular Dystrophy
- Multiple sclerosis
- Cerebral Palsy
- Stroke.

**Sensory:** This includes conditions that effect the five senses particularly vision and hearing

**Intellectual This includes disabilities where the individual:**

**Has an intellectual quotient (IQ) significantly below average**
This means an IQ of about 70 or less. The IQ score is obtained from a standardised intelligence test.

**Has difficulties with everyday personal, social and living skills**
This may the ability to dress or bath without help; the ability to articulate thoughts; the ability to manage relatively simple life skills such as using public transport, reading writing, the ability to develop and maintain relationships.

**Is assessed to have the above characteristics before the age of 18 years.**


**Other cognitive disabilities**

There are a number of other disabilities that may develop in adulthood because of disease, accident or the aging process which interfere with the cognitive processes,. They include:

- Alzheimers disease
- Dementia
- Brain injury
- Stroke and other organic brain diseases.
Psychiatric disability

Some people can experience disability as a result of having a mental illness. The psychiatric disorder or illness becomes disabling when there are problems in 3 or more areas of major life activity. These areas include:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-sufficiency.

The disability may be caused by the:

- Direct manifestations of the illness eg hearing voices all the time
- Impact of the illness on everyday life and activity
- Additional restrictions placed on the individual by society’s response to the illness
- Side effects of medication.

Mental illness includes a wide range of disorders and is prevalent in the community. The majority of people who experience mental illness do not have a disability. Only a minority of people experiencing mental illness have severe chronically disabling disorders.

Handout 4 - Working With Clients from Culturally Diverse Backgrounds

To ensure the planning process is accessible to people from different cultural backgrounds a worker must respect their diverse needs and:

- Be aware of how the disability is viewed within the person’s own community.
- Be aware of the ways that the person’s community responds to the needs of people with a disability. Make contact with specialist Aboriginal and Torres Strait Islander and CALD services and key people within the community; let them know what service you provide and find out how they work.
- Always obtain the person’s permission before contacting other members of their community on their behalf. They may not want to use their community networks or there may be particular people or groups they do not want to have involved.
- If the person agrees, involve Aboriginal and Torres Strait Islander and CALD workers from other services in the coordination of services.
- If the person’s first language is not English you may need to change the way you are used to communicating. For example do not overload the client with too much information, or do too much talking. Go slowly giving the client plenty of time to think. Find out who the support people are within the person’s own network. Take these people into account when developing a support plan.
• Always ensure the person is involved in support planning and their priorities and needs are being addressed, rather than those of the service.
• Do not pressure the client to carry out these tasks. Be patient and/or offer assistance.
• Use an interpreter.

**Appropriate cultural considerations**

• Support strategies must respect and be responsive to the cultural, linguistic and religious needs of clients. This involves linking the person with ethno-specific services where this serves the interests and meets their wishes.
• The services must be accessible to people from culturally and linguistically diverse backgrounds. This may include having written information in a range of community languages, displaying pictures and posters that reflect a range of cultural groups and languages, having staff that reflect the diversity in the local community.
• All staff need to be trained in cross-cultural awareness and communication
• Staff training should include the use of interpreters and the Telephone Interpreter Service. Staff should be confident in the use of these services.

Where possible a person should be matched with a worker with the same language, or will co-work with a relevant worker from another service (if the person wished). If this is not possible an interpreter service will be used for all meetings.

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**Handout 5 - Individual and Community Benefits of Planning**

An integral part of planning is to enable the person with the disability to participate fully in the life of the community.

For the person with a disability community participation is:

• Is a human right
• Provides the person with experiences which will enhance their growth and development
• Provides the social, economic and human capital that ensures that needs are met
• Provides opportunities for social interaction. This enables networks to be broadened and brings the person with a disability into contact with different workers and service providers. It also enables people in similar situations to relate, share support and work collectively for the achievement of their rights.
• Is necessary for independence
• Provides opportunities for the achievement of life outcomes
• May help to breaks down stereotypes about people with disabilities.
Obstacles to community participation

It is important to remember that the issues facing people with different types of disabilities are not all the same.

For some people with disabilities the obstacles include:

- Many public places are physically inaccessible
- A lack of verbal communication can prevent people forming meaningful relationships
- Limited finances
- Community stereotypes about people with disabilities For example “they are dangerous” “they have unrestrained emotions” “they are vulnerable” “they are child like”
- Poor transport options
- Poorly funded services resulting in staff client ratios that are too high for service to be effective
- The high costs associated with meeting needs eg equipment and medication
- Language, which is often inappropriate and misunderstood by the person
- Lack of training for workers in the disability and community sector in cultural awareness, communication skills and knowledge of kinship systems.
- Lack of awareness the person’s role and responsibilities in being part of a family which may impact on their needs being met.

Handout 6 – Guidelines for Conducting an Assessment

A comprehensive assessment involves finding out about the person with disabilities.

This includes:
- Establishing a rapport and a level of trust in your relationship with the person
- Explaining to the person who you are, the service that you are able to offer
- Explanation of the assessment process including the type of information that will be needed, how it will be collected and stored and who will have access to it, the persons rights and responsibilities and the process for managing complaints
- Listening to the person’s story and respecting their viewpoint and providing advocacy to support their choices.
- Using a problem solving approach to identify the person’s needs, goals and resources, interests and abilities
- Mapping the networks and identifying their informal and formal support as well as their internal and external resources
- Obtaining the permission to seek information from other people including significant others such as family and friends and other services providing assistance to the person
• Ensuring that the process is sensitive to the cultural needs and perspective. This may mean that an interpreter, or signer or other specialist worker is needed to assist with the assessment
• Using previous assessments
• Making using of the agencies assessment checklist. This checklist can also be used as a prompt for areas to be discussed with the person and others involved in the assessment process
• Ensuring the person has access to the information
• Identifying the lead agency and the case manager when a number of different agencies are involved and the case management model is being applied.

Beware

• Of excessive questioning. It is not an interrogation
• Don’t get bogged down. The person is the main concern, not the paperwork
• It is not a therapy session
• Do not overlook possible resources like family and friends.
• Don’t underestimate the person’s existing abilities, talents and personal resources.

Handout 7 - Analysing the Information from the Assessment

The assessment should provide enough information to clearly determine the person’s needs and goals and to determine the most effective possible strategies.

Analysis must consider:

1. The person’s needs

This can be done using:
• The application of the assessment checklist (see the CPCC manual for CAP intake assessment form and the guidelines for developing and individual assessment form). The more general description for this type of assessment is a norm referenced assessment
• Informal discussions with the person, their family and advocates
• Observations of the person’s skills
• Assessments by a multi disciplinary team of people such as therapists, nurses, dieticians, orthotists, psychologist, social workers
• A problem solving approach
• A review of past programs and assessments where available.

2. The person’s goals. Often goals are complex, therefore it is critical to express the goals in clear and measurable terms. An effective goal is:
   • Measurable
   • Achievable
   • Justified
   • Clearly described ie not vague and not too large.

An effective goal is also realistic goal. It accounts for the person’s capacity ie the balance between their needs and their abilities and resources. A realistic goal
also accounts for the capacity of the service that is working with the person as such:

- The service’s staff client ratios
- How much time is needed to work on the need or goal
- How much money is required to fund the resource or service
- The skills of staff.

The goals will also need to be prioritised. The level of priority should be based upon:

- What the person wants
- What resources are available
- How achievable the goals are
- Immediate and long-term needs.

3. **The suitability of the environment and resources that are available.**
   This involves exploring the person’s environment and assessing:
   - Is the environment conducive to the persons needs?
   - Can the goals realistically be achieved within their environment?
   - What program already exist that may assist the person? Where is that program located? Is this the best location for them?
   - What special characteristics does the environment have? For example:
     - Is it a group home?
     - Does it have special physical modifications that will assist the clients?
     - Is there equipment available to assist them?
   - What changes may need to be made to the environment in order to assist the person?
   - It may be necessary to assess a range of environments that the person finds themselves in ie their home, education centre, work environments, social environment. All parts of the environment must be conducive to the client’s needs and goals.

Consider the case of a young man with paraplegia who is keen to return to his office job after his accident. His home has been appropriately modified, he has all the equipment and care he needs to leave his house and can competently care for himself. His office is accessible and his job has been held for him. However he needs to catch a train to the city to work but his local station doesn’t have a ramp or a lift to enable him to access the train.

4. **Agency Guidelines and State Disability Service Standards** (see handout 1).

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**Handout 8: Writing the Individual Plan**

An individual plan must contain:

- The names of the people to be involved
- Information from the previous plan
- The clients views
- The goals
- Resources needs to implement the plan
- Issues which may effect the implementation of the plan.

See the CPCC Policy Manual 2 for guidelines to developing a Support Plan
Carmen Poldis Centre - Individual Support Plan Sheet

Client: Mary Smith
Date of Assessment: 12th June 2002

Planning team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renee Couchman</td>
<td>case manager</td>
</tr>
<tr>
<td>Julie Smith</td>
<td>mother</td>
</tr>
<tr>
<td>Jenny Smart</td>
<td>day program manager</td>
</tr>
<tr>
<td>Geoff Jackson</td>
<td>boyfriend</td>
</tr>
<tr>
<td>Niko Donekian,</td>
<td>worker from group home</td>
</tr>
</tbody>
</table>

Review of Previous Plan:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Assessment of Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare breakfast</td>
<td>Can organise cereal plus make cup of tea On work mornings</td>
</tr>
<tr>
<td>Go to movies with boyfriend</td>
<td>Has been twice with staff; once with Julie</td>
</tr>
<tr>
<td>Travel to work on bus</td>
<td>Morning worker places on bus; picked up By staff member in afternoon</td>
</tr>
</tbody>
</table>

Needs Identified:

Mary would like to go out more with boyfriend by herself
Mary wants to catch bus by herself in the morning
Would like to cook an evening meal

Action Plan:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel to work independently</td>
<td>Learn how to walk to bus stop And identify which bus to catch</td>
<td>Niko</td>
</tr>
<tr>
<td>Go out more with boyfriend</td>
<td>to go to movies each fortnight with Geoff unaccompanied staff to pick up for first 8 weeks</td>
<td>Geoff</td>
</tr>
<tr>
<td>By herself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare a meal for house</td>
<td>learn how to prepare 3 different recipes.</td>
<td>Julie/Niko</td>
</tr>
<tr>
<td>Once a week on weekend</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review Date: 12th October 2002

Copy to be given to the client and one copy to be put in the file.
Handout 9 – Monitoring and Reviewing Individual Plans

It is crucial to implement strategies that continually monitor the person's progress towards meeting their goals. Monitoring processes need to check that strategies are working, and that the person is satisfied with the service they are receiving. Monitoring also enables the worker to evaluate their role in the process. The strategies described in the individual plan is also regularly reviewed to explore ways of getting over barriers, which have arisen. Individual plans are regularly changed to reflect achievements, new priorities, changing goals or abilities. Reviews also consider whether resources are being used effectively. This includes staff, equipment, and funding.

Monitoring is often informal and part of the day-to-day contact between the person and support staff. This is when minor changes or adjustments can occur, in collaboration with the person. In addition to this a formal review process is important for checking the progress being made on the support plan.

Good practice in monitoring and review

The principles of good practice in monitoring and review are:

- Each person is provided with opportunities for ongoing assessment and reassessment of their needs. The assessment may involve family, friends and advocates as well as service providers
- Each person is provided with the opportunity for the monitoring and review of the strategies outlined in their support plan on a regular and timely basis.
- The person is directly involved in the monitoring and review process and is conducted in a way that respects the person's culture.
- If any action needs to take place as a result of a review, responsibilities need to be allocated to workers and time frames determined to ensure that change occurs

Developing a monitoring and review process

The key tasks in developing a monitoring and review process may include:

1. Deciding on the frequency of monitoring/reviewing. When the worker and client meet to develop a support plan, an arrangement should be made to monitor progress. The frequency of monitoring and review will depend upon the client's needs and progress towards meeting goals and will be recorded in the plan.

2. Developing a tool for monitoring/reviewing. Some services may use a review form to review the support plan. An alternative is to make notes on the support plan itself, or make notes in the case notes. Questions to be included on a review checklist may be:

- Have the goals been achieved?
- Have the goals changed?
- Are additional resources required to achieve goals?
- Are different strategies required to achieve goals?
- Should new goals be developed?
- Should the plan be signed off as completed?
All planning processes including review and monitoring need to be included in the organisation’s policies and procedures. These will cover such issues as:

- Frequency of monitoring/review sessions
- Client involvement
- Tools to be used
- Privacy and confidentiality of client information
- State Disability Service Standards.

If there is no progress in working through a support plan arrange a review to look at what is happening and make changes to the support plan if necessary. If you are unsure about what needs to happen, talk to the Coordinator.

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**Handout 10 - The Importance of Good Record Keeping**

Good record keeping will assist in the monitoring and evaluation of the support plan. There are a number of issues that a worker must be aware of in order to effectively manage records.

1. Confidentiality: the support plan and other case notes tell the story of a person’s life and therefore they are private and must be stored in a secure place.

2. Accessibility: Under the new National Privacy Principles, which came into force on 31 December 2001 clients are entitled to:
   - know why their personal information is being collected and how it will be used
   - ask for access to their records
   - correct inaccurate information about themselves
   - know which organisations will be given their personal information
   - ensure organisations only use their information for purposes they have told you about
   - find out what information an organisation holds on them and how they manage it.

3. Language: should be non-judgemental and positive. The client is entitled to read the plan and must not feel insulted or betrayed by the content. Therefore the language must be honest yet respectful of the client and their needs and wishes.

4. Legible: The records should be set out in a clear and readable manner so that other people who need the information can access it easily.

5. Individual Focus: information must be succinct and relevant to the client.

6. Structure: the records should be organised in a systematic and logical way.

7. Accuracy: ensure that anything written down is factual. If it is your perspective or what you believe to be true you must state this.

8. Reflect the client’s views and the views of the significant people in their lives.
Handout 11: Implementing the Plan

Implementation involves considering how the goals in an individual plan will be achieved. It involves:

- Identifying the resources and strategies that must be organised to ensure that the person’s goals are achieved. For example, consider Mary Smith’s goals in Handout 8 to travel to work independently. Remember the actions that needed to be taken included Mary learning to walk to the bus stop and to identify the correct bus to catch. The activities that may now need to be organised by Niko will include:
  - Helping Mary to practice walking the route to the bus stop
  - Teaching Mary the bus number
  - Teaching Mary how to signal to the bus driver to stop the bus
  - Teaching Mary when to signal to the bus driver to stop the bus
  - Helping Mary to practice walking to the day centre after alighting from the bus
  - Giving Mary an alternative strategy if something goes wrong on the way to work and she needs help. For example, organising a homelink phone number and showing her how to find a public phone to call the group home.

- If the goal requires that the person needs to learn a new skill, the task will need to be analysed and broken into smaller steps. When the client practises each step, any difficulties must be noted. For example, in Mary Smith’s case, the following notes may be applicable:

  **Task: Walking to bus stop**

  1. Identify 6 landmarks in order of the walk to bus stop.
     - Difficulties in performing: Had trouble remembering landmarks and the order they would be seen in.

  2. Walk to bus stop noting landmarks.
     - Difficulties in performing: Had some trouble remembering landmark order and became stressed.

  3. Walk to bus stop noting landmarks in correct order using pictures of landmarks put into brag book.
     - Difficulties in performing: Success!!

  4. Walk correct route to bus stop noting landmarks without worker intervening.

  5. Walk to bus stop with worker near by but not with Mary.

  - Identifying the resources that will be needed to implement the strategies for example, the staff and time to help Mary to learn to travel independently to work.
  - Identifying potential barriers to success. Barriers can include:
    - Problems in the physical environment. For example, there may not be a direct bus to Mary’s work; Mary may have to cross a dangerous road; Marty may have to travel on an overcrowded bus that may cause her distress or make her feel unsafe; the bus driver...
may not understand Mary when she speaks and may be rude to
Mary or refuse to sell her a ticket.

- **Time** – there may not be enough time to teach Mary to catch the
  bus in the time or staff may not be available at the time she needs
  to practice catching the bus.

- **Support** – if the worker who is helping Mary to learn to catch a bus
  to work doesn’t believe it is possible for Mary to achieve the goal
  they may tackle the task associated with the goal in a half hearted
  way.

- **Consistency** – sometimes staff shifts can mean that more than one
  worker has to help a client learn the skills needed to achieve their
  goals. This can be a problem if the workers tackle the tasks in
  different ways. If a person is to learn a new skill the approach
  must be consistent.

- **Finance** – unfortunately if there is a lack of money to buy the
  services or equipment needed to realise a goal it may not be
  possible to realistically achieve the goal.

- **Client commitment** – unless the client wants the goals, sees that it
  is desirable and commits to working towards it there is little chance
  that it will be achieved.

- **Staff skills** – unless the staff are available with the required skills to
  assist the client with their desired goal or there are the funds to
  train the staff it may be difficult to achieve the desired goal.
Handout 12 - Evaluating the Plan

Planning the evaluation

While the monitoring and review process should provide enough material to review the support plan sometimes a more formal evaluation will be required. This will need to be carefully planned. When planning an evaluation you will need to consider:

1. What is the purpose of the evaluation? Is it to provide feedback to client or other stakeholders such as family or service providers? Is it to assist in obtaining more resources for the client?

2. Who will conduct the evaluation? Which worker has the skills and time to take responsibility for the evaluation? Or would it be better to get an independent worker?

3. Who will be involved in the evaluation? This is usually the full range of people who were involved in the initial assessment.

4. What is to be evaluated? The strategies used to meet needs and reach goals? The impact the implementation of the strategies had upon the client and other stakeholders? The outcomes ie have the goals been achieved? Efficiency of the plan in terms of costs such as time and money?

4. How will the evaluation be conducted? Talking to clients and others about the processes, impacts and outcomes? Observations? Case records?

5. The cost of the evaluation is time, money, staff and effort.