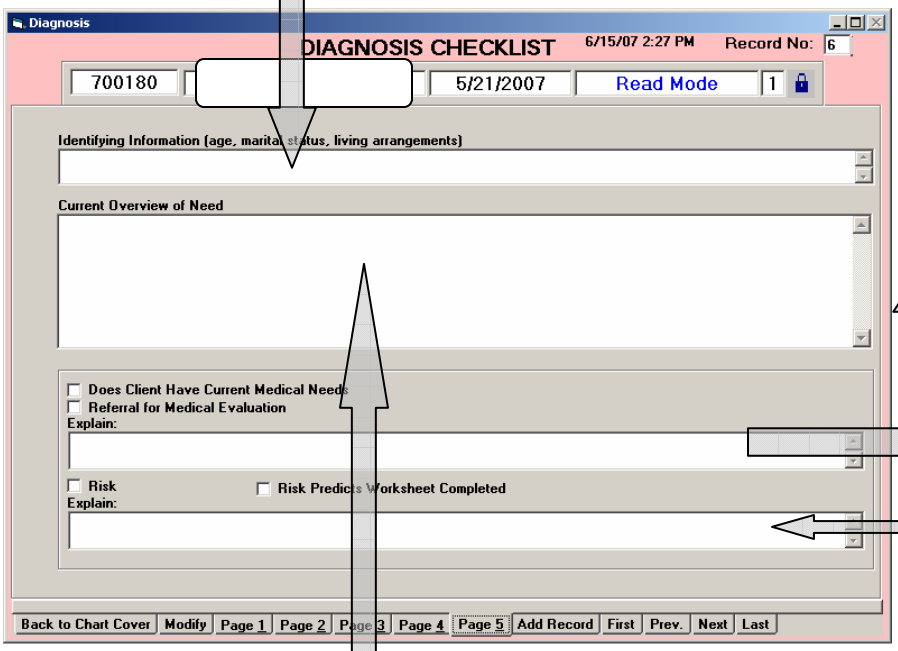
Incorporating Person-Centered Planning
Elements into Treatment Plans

The following information should be included in the Diag forms on page 5 (and should be updated whenever a Recovery Plan Review is completed:

1. Identifying Information:
include gender, age, birthday, current living situation, family composition (when appropriate), ethnicity, and other relevant identifying information.



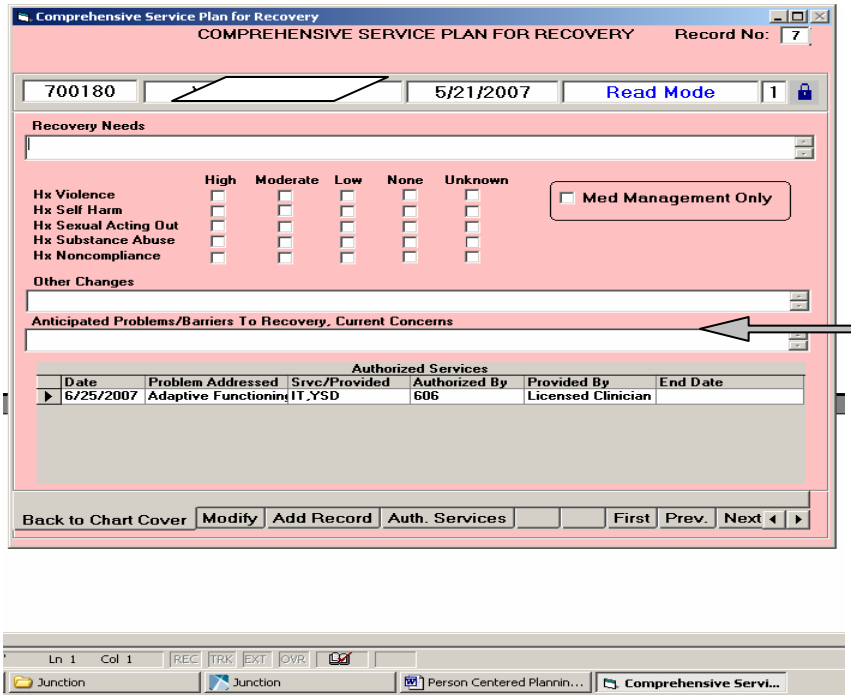
3. Medical Needs
Check either appropriate box. Explain mental health medical needs PLUS any outside medical needs and or referrals

4. Risk
Check the Risk box and explain the concern (such as: suicidality, violence, sexual behaviors, truancy, unstable housing, criminal behavior, etc…)

2. Current Overview of Need:

1. Include the ***reason*** that the individual and/or family is seeking services in their own words.

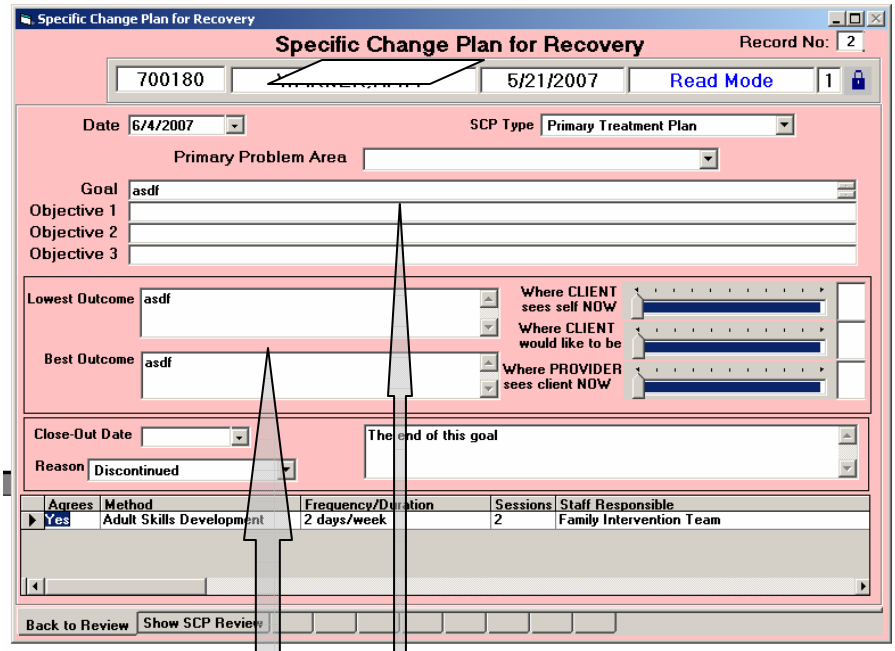
2. Assess and describe the following:
   - Clients readiness to change using the client's (or parents, or both if working with an older child or youth) own words.
   - Client strengths that will help them to achieve their goals.
   - Family or other natural/informal supports and how they can help client to achieve goal
   - Anticipated difficulties/barriers from the client's point of view.
   - Cultural factors affecting the family or treatment process.



Anticipated Problems/Barriers to Recovery, Current Concerns:

Describe the current significant barriers, stressors, and clinical issues that are affecting the client (and his/her family if applicable)

The information included in the SCP needs to be entered initially and then updated every time the SCP is reviewed!



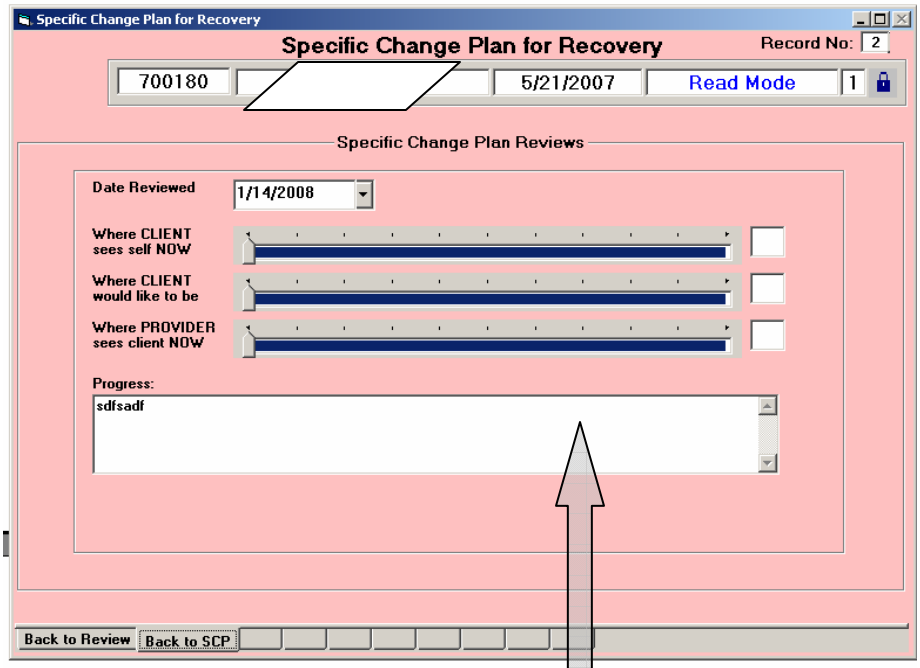
SCP Instructions:

1. The **GOAL** is the overarching treatment goal written in the clients own words that is tied to the Primary Problem Area

2. The **OBJECTIVES** are the specific changes expected in measurable and behavior terms (can be written in the clinicians words).

Lowest and Best Outcomes:

3. Lowest Outcome: In the client or family's words, "What is the smallest amount of change that would indicate to you that you have made progress on your goal?"
4. Best Outcome: Describe changes in the individual/family's current needs and circumstances that will need to occur for them to be succeed in discharge or transition. Also, describe the discharge/transitional setting in terms of location, level of care, length of stay, and service needs for discharge. This statement may be different on the different SCP's (discharge from Case Management could be different than from a residential or outpatient setting for the same client…) "[Client name] will be discharged when describe the above information"



In Progress Box:

Specifically address each of the goal areas and objectives.

Include OQ/YOQ data showing progress or increased distress/symptoms and relevance to changes in Recovery plan.