



# Recovery Roadmap

## Tips for Recognizing a Good Person-Centered Plan

The Recovery Roadmap is designed to educate you about person-centered planning so that you can be an active participant and feel respected in the process. The following tool will help you to reflect on whether or not you are receiving good person-centered planning. You can use this tool to identify things that are going well as well as things that might need to be improved. We encourage you to discuss your feedback with your team or individual service provider. In Unit 4 you received the first half of our tips to recognize what a good person-centered planning meeting looks like. This second section below offers you some tips for recognizing what a good person-centered PLAN might look like in the actual document itself.

### SECTION B: IS MY PLANNING DOCUMENT PERSON-CENTERED?

This second section reviews ways in which we hope good person-centered process will show up in the actual service PLAN itself (i.e., the written documentation).

Item #	Response	Yes	No	I Don't Know/ NA
B1	My plan uses “person-first” language, for example, it refers to me as “a person with” a mental health issue and does not define me by a label such as “a schizophrenic” or “a bipolar.”			
B2	My plan has goals (hopes and dreams) that are important to me and they are about more than just symptom management or treatment compliance. My plan focuses on things like making friends, getting a job, and pursuing new interests			
B3	The goal statements are written in positive terms. For example, instead of “I just want to be less depressed,” my plan might say: “I want to feel good enough to take care of my daughter.”			
B4	My plan goals are written as quotes in my own words.			
B5	My plan makes note of a wide range of my strengths (e.g., my skills, interests, natural supports, previous successes, faith-based resources, motivation for change, etc.)			

<b>B6</b>	I can see in my plan how my strengths are used. For example, if I love animals, but get nervous making friends, I might walk my dog at the dog park to meet new people.			
<b>B7</b>	The plan makes clear how barriers get in the way of goals that are important to me (e.g., I want to get my job back, but depression and excessive sleep have led to have a lot of absences).			
<b>B8</b>	The barriers listed describe my individualized experience of symptoms. They don't just list a mental health diagnosis.			
<b>B9</b>	It is clear in the plan how difficulties I am having might be tied to my experience of mental health issues (e.g., I may be struggling with budgeting because I have anxiety which makes it difficult for me to concentrate).			
<b>B10</b>	The plan includes short-term objectives that explain how I will overcome a barrier to take a next positive step in my recovery.			
<b>B11</b>	The objectives are understandable/meaningful to me.			
<b>B12</b>	Objectives meet the SMART criteria. They are written <i>simply</i> (understandable to the reader), are <i>measurable</i> (they happened or not, "as evidenced by..."), are <i>achievable, relevant</i> , and <i>time limited</i> . Ask yourself, is the objective concrete enough to know definitively (yes/no,) was it achieved or not at the end of the time frame?			
<b>B13</b>	The time frame or target date of the objectives are individualized and vary if appropriate (e.g., some might take me six months to achieve, other positive changes might happen faster).			
<b>B14</b>	The objectives are about more than just service participation. The objectives reflect positive changes in my life I can look forward to.			

<b>B15</b>	It is clear to me in the interventions/services section of the plan what my providers are offering, on what timeline, and for what reason.			
<b>B16</b>	If I have agreed to have friends or family involved, my plan outlines the things they agree to do to help.			
<b>B17</b>	As part of the plan, I have tasks/activities that I am responsible for doing on my own that will help me achieve my goals.			
<b>B18</b>	My plan helps me get back involved in my community, not just in places that provide services for people with mental illness.			
<b>B19</b>	There is evidence in the plan documentation of my involvement (e.g., the plan includes my quotes and/or statements such as "Jose stated...")			
<b>B20</b>	There is evidence in the record that I was offered a copy of my plan. (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)			
<b>B21</b>	My plan is written so that I can understand it. Words that I don't understand are explained to me.			