Recovery Roadmap

Tips for Recognizing a Good Person-Centered Plan

The following tool can help you to reflect on the extent to which your plan documentation reflects certain person-centered practices and content. The list of items is not exhaustive (i.e., there may be additional ways in which you reflect person-centeredness in your documentation) and not all items may be possible or relevant for all individuals or in all contexts. This tool is meant to stimulate your thinking and to help you identify both strengths as well as things that you might like to improve.

Item #	Practice	Notes/Observations
1	The plan uses "person-first" language (e.g., a person living with *schizophrenia* NOT a *schizophrenic*) and/or the individual's name throughout the document.	
2	The goal statements on the plan are about having a meaningful life in the community not only symptom reduction or compliance.	
3	The goal statements are written in positive terms. For example, instead of "I just want to be less depressed," consider "I want to feel good enough to take care of my daughter."	
4	Goal statements are written in the individual's own words.	
5	A diverse range of strengths are identified in the plan (e.g., skills, interests, natural supports, previous successes, faith-based resources, motivation for change, etc.).	
6	The plan actively incorporates the person's identified strengths into the goals, objectives, or interventions/ action steps.	

7	The plan makes clear how barriers are relevant in interfering with identified goals (e.g., depression and excessive sleep have led to chronic absenteeism at work).	
8	Barriers included go beyond diagnosis to describe the individual's unique experience of symptoms and distress.	
9	It is clear in the plan how functional impairments relate to mental health/addictions related issues (e.g., not simply "poor budgeting" but cognitive/concentration issues associated with psychosis interfere with budgeting tasks).	
10	Plan objectives are logically linked to reducing/removing a barrier (i.e., it should be clear which documented MH or SA barrier you are working on overcoming to achieve the short-term objective).	
11	Objectives are understandable/meaningful to the person served.	
12	Objectives meet the SMART criteria. They are written *simply* (understandable to the reader), are *measurable* (they happened or not, "as evidenced by…"), are *achievable*, *relevant*, and *time limited.* Ask yourself, is the objective concrete enough to know definitively (yes/no,) was it achieved or not at the end of the time frame?	
13	The target dates of short-term objectives on the plan are individualized rather than all objectives defaulting to a standard update cycle (e.g., every 90 days).	
14	Does the objective go beyond service participation? In other words, is it only about "will attend X,Y,Z services" or does it capture a positive/meaningful change in behavior/change in functioning/change in status? For example, instead of framing the objective as "Client will regularly attend Dialectical Behavior Therapy," focus on the desired behavior change associated with that treatment intervention, such as "Jane will use mindfulness skills to improve regulation of emotions as evidenced by having no more than two incidents of self-injurious cutting per week for the next 30 days."	

15	Professional interventions meet the criteria of the key Ws: **who** is providing the service (staff member), **what** (billable service), **when** (frequency and duration), and **why** (purpose and intent).	
16	The plan goes beyond professional clinical/rehab interventions to include at least one self-directed action step and at least one action step by natural supporters, as available. (Note: These are typically identified within the assessment process and build upon the person's strengths.)	
17	Self-directed actions focus on personal, strengths-based activities the person will do in support of their plan and NOT only on the act of attending professional services.	
18	The plan describes attempts to help the person to connect with chosen activities in the community rather than the plan being carried out solely within the context of agency-based MH services.	
19	The plan/plan update is developed collaboratively and there is evidence of direct input from the person (e.g., includes quotes from the individual and/or statements such as "Jose stated...").	
20	There is evidence in the record that the person was offered a copy of their plan. (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)	
21	The plan is written so that the person can understand it. Clinical or medical terminology is explained to the person as needed.	