**Introduction to the Documentation of Person-Centered Service Plans**

In considering the entirety of high-quality person-centered planning, it can be helpful to think of it as consisting of 4 component elements.

- **Philosophy**: Believing that people have the fundamental right to maximum self-determination and community inclusion no matter what their disability.

- **Process**: Interacting with persons before, during, and after PCP meetings in a manner that communicates respect and a hopeful vision for the future.

- **Plan**: Translating person-centered philosophy and process into a high-quality written service planning document.

- **Product**: Having high expectations for outcomes across a broad range of quality of life areas.

Section G of this manual will focus heavily on this third “P” of documenting the written service plan. Specifically, it will address a question which is frequently posed by facilitators of person-centered planning, i.e., *Is it possible to write a plan that both honors the person while still satisfying the chart, my supervisor, our funders, etc.?* This documentation section is included in recognition of the fact that many highly skilled PCP facilitators embrace both the philosophy and process of person-centered planning, yet they struggle to reflect this in the context of the written service planning document. Frequently, it is in this step of moving from “process” to “plan” that the quality of PCP breaks down and the written document devolves into one which is both deficit-oriented and professionally-driven rather than staying true to the principles of person-centered planning.

One might be wondering, “Does it really matter? That written plan is NOT something that is a meaningful part of the work… In fact, it gets in the way of the work!” If this is on your mind, you have lots of company! Frequently, the written plan is viewed as simply a technical document that has to be completed to satisfy accrediting or reimbursement bodies, and it is seen as useful neither to the provider nor to the person receiving services. In such cases, the plan is completed and filed in the medical record and it plays little, if any, role in actually guiding the work of the team moving forward. While this may be a widely held perception of service planning documentation, in the person-centered world, the plan of care has the potential, and should be, far more than a paperwork requirement. It is a written contract between a person and his/her network of supporters that outlines a more hopeful vision for the future and how all will work together to achieve it. The pivotal role of the service plan in creating systems transformation was perhaps best described in a landmark document within the mental health arena, the President’s New Freedom Commission Report (2003) which noted that customized plans should be developed in full partnership with consumers as “the plan of care is at the core of the consumer-centered, recovery oriented system.”

Given the centrality of the PCP in driving systems change, it is imperative that facilitators
increase their competency in creating collaboratively developed documents that “honor the person while also satisfying the chart” – Yes, this is possible! But for many, it may take practice and it may differ significantly from traditional styles of service planning documentation. This section is therefore intended to support facilitators in the practical implementation of person-centered planning by presenting a general overview of the core documentation elements along with tips for maximizing the person-centered aspects of each. It is not intended to substitute for the rich discussion of philosophy and process which has preceded this section as the quality of the planning document is only as good as the values and partnership upon which it is based. Put simply, all four “P’s” need to come together for the vision of person-centered planning to become a reality! In addition, this section is not intended to be a “compliance” guide for meeting service planning documentation requirements. These requirements vary widely across State agencies and across particular programs, and as such, a discussion of these is beyond the scope of the current section. Here we will focus on the big picture of “quality” while deferring a more detailed discussion of compliance and program-specific documentation expectations to the appendices.

Core Documentation Elements in Person-Centered Service Plans

The graphic below depicts the core documentation elements of the PCP which will be described in greater detail within this section. These elements include the person-centered goal statement, strengths and barriers, short-term objectives, and action steps/interventions.

![Putting the Pieces Together in a Person-Centered Plan](image)

**Goal Statements**

The creation of the PCP document should begin with, and flow from, a meaningful and motivating goal statement which reflects something the individual would like to achieve. Ideally, the goal is expressed in the focus person’s own words and it is based on the person’s unique interests, preferences, and strengths. Goal statements should be based on the assumption that persons’ with disabilities generally want the exact same things out of life as the rest of us! While this description of what constitutes a quality goal statement may appear obvious from a person-centered perspective, it is actually quite different from the manner in which “goals” are typically documented in professionally-driven service plans. Traditionally, these are focused more narrowly on the amelioration of deficits associated with the disability (e.g., symptoms, behaviors, functional limitations, etc.) thereby losing the focus on personally valued and meaningful goals.
For example, statements such as “remain medication compliant,” “reduce behavioral outbursts,” “maintain stability,” and “increase insight” are extraordinarily common goal statements listed on service plans despite the fact that these things are rarely seen as meaningful and motivating long-term outcomes by persons with disabilities. This is not to say that these things are necessarily negative or undesirable. But, things like reducing symptoms, increasing compliance, staying out of the hospital, etc., are a means to an end and they do not, in and of themselves, equate with the realization of one’s ultimate vision for the future.

Therefore, in supporting individuals to either develop or modify their PCP goals, it is important for PCP facilitators to keep in mind that the goals of the plan should not be limited to clinically-valued or professionally-determined outcomes, but rather, goals should be defined by the person with a focus on attaining the life they envision for themselves in the community. This distinction is captured in the graphic below which contrasts, on the left, goal statements which are frequently accepted as outcomes for persons with disabilities with goal areas, on the right, which are commonly valued by most human beings! A well-written goal statement on a PCP moves past this “us/them” divide and reflects that which is important to the focus person rather than that which is historically prioritized in the professional service system. Most often, this will lead to PCP goal statements which focus on the following types of areas:

- Manage own life
  *I want to control my own money.*

- Work/education
  *I want to finish school.*

- Spiritual issues
  *I want to get back to church.*

- Satisfying relationships
  *I want to see my grandkids.*

- Adequate housing
  *I want to move out of the group home.*

- Social activities
  *I want to join a bowling league.*

- Health/well-being
  *I want to lose weight.*

A few notes about goal statements are in order prior to moving on to a discussion of other plan elements. First, sometimes people articulate multiple goals, sometimes none at all! Each scenario presents different challenges. In the case of the former, it is most effective to help the focus person to prioritize and identify just a few key goal areas on the plan. Having too many goals can make the PCP plan complicated and unwieldy – both for the practitioner to write but most importantly, for the focus person to actually “work” that plan in his/her daily life! In order for the PCP to truly be an effective tool in guiding the recovery journey, it is helpful to limit the goal statements to those that are most salient and motivating to the individual at that given point in time. This does not mean that the focus person does not have goals or challenges in other areas that might ultimately need to be addressed, but it can be helpful to give a certain area dedicated attention over a certain time frame while deferring other goals to a future plan. Just be careful that in the prioritization process, we don’t “table” what is most important to the person while only including that which we think is important from a clinical/professional perspective!

How about the alternative scenario? PCP facilitators often ask, What do I do if the person has NO goals or if they are content with the way things are? First, remember that most people do not live their lives explicitly in terms of “goals,” and the focus person may not be used to being asked
to come prepared to the PCP meeting with these things in mind. Their previous experiences of service planning may involve limited participation - perhaps they were only expected to lend a signature after the written document had already been created! This highlights the shift in roles and responsibilities which occurs in PCP, and underscores the importance of the pre-planning steps detailed earlier in this document and in the PCP tool attached. If PCP is about getting the person in the “driver’s seat” to the maximum extent possible, then some people might benefit from a little “driver’s education” so they can be fully prepared to partner with their team from start to finish. The PCP facilitator plays an important role in this process by maintaining a positive attitude and focusing on the possibilities for the future rather than the challenges. Put simply, facilitators may need to be the “holders of hope” in situations where the focus person is having difficulty expressing goals or a more positive vision for the future. A spirit of hope is communicated in the facilitator’s attitude as well as in the specific tools s/he uses throughout the PCP process. For example, it is essential that facilitators be skilled in the use of strengths-based assessment and motivational enhancement techniques as these can be particularly helpful in supporting individuals to re-discover (or discover for the first time!) goals and dreams which they may have lost along the way.

These goals and dreams frequently will involve the types of statements noted on the previous page, i.e., *I want to go back to church... have a girlfriend... join a bowling league, etc.* PCP facilitators have expressed concern that these written goal statements will not be allowed by internal or external compliance and regulatory bodies as they are not consistent with their mission to provide a particular professional service, e.g., *We are in the mental health business and these goals don’t sound very “mental-health-like!”* This belief that funders will not pay for non-clinical life goals is actually a correct one but not because of the nature of the goal itself but the fact that funders do not pay for goals at all. Rather, funders pay practitioners for the *interventions/professional services* which are provided to help people overcome the disability-related *barriers* which are interfering with their functioning and the attainment of valued person-centered goals. So, for the many PCP practitioners who, by necessity, must also concern themselves with regulatory compliance and “medical necessity,” keep in mind that there will be places within your plan documentation for you to build this “business case.” However, more so than any other part of the plan, the goal statement truly belongs to the individual and it should honor their unique vision for the future.

Having said that, when crafting the goal statements, it is perfectly acceptable, and in fact encouraged, for the PCP facilitator to support the focus person and his/her team to think BIG! A word of caution NOT to become overly concerned with whether or not the goal statement is “realistic” as determining what is realistic (or not) is a slippery slope and often allows unspoken biases or assumptions to come into play. There will be places later in the planning document (most notably the objectives statements) to carve out shorter-term “achievable” first steps, but for the purpose of the goal statement it is most helpful to retain the long-term goal which is most motivating for the focus person. During the initial goal-setting process, the PCP facilitator should therefore remind all team members to refrain from making comments which reflect skepticism or doubt regarding the feasibility of the long-term vision.

**Strengths and Barriers**

**Strengths.**

Focusing solely on deficits/barriers in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to achieve their life goals and dreams. Thus, it is considered a key practice within PCP to thoughtfully consider...
the potential strengths and resources of the focus person as well as his/her family, natural support network, and community at large. This is consistent with the view that recovery is not a solitary process but rather a journey toward interdependence within one’s community of choice.

For this reason, a key role of the PCP facilitator is to support the focus person and his/her team in identifying a diverse range of strengths, interests, and talents while also considering how to actively use these strengths to pursue goals and objectives in the person-centered plan. Put simply, all too often strengths are identified in the assessment and pre-planning process yet they appear nowhere on the final written document! Strengths are not identified to “sit on a shelf.” Rather, the team needs to think creatively about how such to explicitly incorporate them in the various activities within the PCP. For example, if the focus person identifies their faith and spirituality as a cornerstone of their well-being, are these types of activities reflected in their daily personal wellness plan? If the individual has a love of creative writing, is this identified as a positive coping strategy the focus person can use to manage stress or difficult emotions? If the person is an accomplished musician, might s/he work toward volunteering to teach music lessons to others at the local community or senior center?

This emphasis on individual and/or family “strengths” rather than their deficits or problems is sometimes a difficult process for professional service providers as well as the focus person him/herself! It is not uncommon, for example, for individuals to have difficulty identifying their “strengths” as this has not historically been the focus of professional services and assessments and individuals may have also lost sight of their gifts and talents through years of struggles with their disability and recovery. As a result, simply asking the question, “What are your strengths?” is often not enough to solicit information regarding resources and capabilities that can be built upon in the planning process. Guiding principles and sample questions to be used in strengths-based interviewing are provided previously within this document and within the attached PCP tool.

**Barriers.**

While person-centered planning strives to capitalize on the focus person’s strengths, it is also true that the “roadblocks” which interfere with goal attainment often take the shape of disability-related limitations, experiences, or symptoms. These too, have a place in the comprehensive person-centered plan. Barriers should be acknowledged alongside assets and strengths as this is essential not only for the purpose of justifying care and the “medical necessity” of the professional supports we provide, but also because a clear understanding of what is getting in the way informs the various professional interventions and natural supports which might then be offered to the individual in the service of his or her recovery. The difference in a person-centered plan is that the barrier does not become the exclusive and dominant focus of the plan and it only takes on meaning to the extent that it is interfering with the attainment of larger life goals. For example, as noted earlier, within the mental health arena, the reduction of symptoms is not seen as the desired “outcome” (and reflected in the goal statement) but rather such things are noted as “barriers” or challenges that might be addressed in order to help the person, return to work, finish school, be a better parent, pursue a hobby, etc.

In identifying barriers, it is important to be specific. For example, at the individual level, the following types of factors might impede goal attainment:

- Need for skills development
- Intrusive or burdensome symptoms
- Lack of resources
- Need for assistance / supports
- Problems in behavior
- Challenges in taking care of oneself and activities of daily living
- Threats to basic health and safety

Say for example, the focus person’s goal is to someday work with children, preferably in a preschool environment. However, cognitive or social skill deficits (associated with a mental health issue or developmental disability) have made it difficult for the person to achieve their high-school diploma (which is required for most positions in pre-school education). A traditional service plan might note that the goal is to “improve symptoms” or “increase concentration” or even “decrease paranoia.” In a PCP, the goal is simply stated in the person’s own words, i.e., *I want to work with kids someday*, and the following might be noted in the barriers section of the plan: difficulty concentrating due to depression; previously unable to meet attendance requirements due to lack of energy; difficulty remembering/tracking/completing assignments; sometimes very uncomfortable/fearful of other students; high anxiety around taking bus to local GED classes, etc.

In addition, to exploring these individual-level barriers, it is important to note the extent to which external barriers might be interfering with goal attainment. For example, many individuals who wish to pursue their education have difficulty securing financial aid, transportation, child care, or classroom accommodations. A key role of the PCP facilitator is to work with the focus person and his/her team to identify both internal and environmental barriers and to determine strategies and solutions that help the person to move forward.

**Objectives**

Goal statements are useful as they give direction for the overall recovery journey and all that it entails. When writing and implementing the PCP, it is also necessary to identify specific, shorter-term action steps that can help the focus person to move toward his/her unique life goals and dreams. These steps are usually referred to as “objectives” and are best thought of as interim goals that break down longer-term aspirations into meaningful and positive short-term changes. They should reflect a concrete change in functioning, change in behavior, or change in status, that, when achieved, are “proof” that the person is making progress. And, as with all parts of the written PCP, the objectives statement should be arrived after only after a thoughtful dialogue with the focus person about what he/she feels would be a meaningful “step in the right direction.”

The writing of objectives (and also interventions to be discussed next) is the most technical part of the entire PCP documentation process as these plan elements are closely monitored by funders and accrediting bodies, i.e., supporting individuals to make progress toward meaningful objectives is increasingly expected of disability service systems whose mission is to focus on active rehabilitation rather than maintenance of the status quo or “clinical stability.” It is therefore important that objectives be accurate and consistent with each of the characteristics noted below.

- behavioral, i.e., observable actions on the part of the focus person, specific enough so that the team will know when the objective has been achieved
- achievable
- measurable
- time framed with a target date for expected completion
- meaningful and understandable for the person served
There are several methods in the human services field for remembering the technical criteria for well-written intervention. One frequently utilized mnemonic term associated with the writing of objectives is the “S-M-A-R-T” acronym. Specifically, this prompts the PCP plan-writer to ensure that objectives are:

- **Specific**
- **Measurable**
- **Attainable/Achievable**
- **Realistic**
- **Time-framed**

For those that have difficulty achieving these technical criteria when writing objectives, a more simple strategy for checking on the measurability of this plan element is to read the objective out-loud and then ask yourself the question: *As written, will we definitively be able to say, YES or NO, was the objective achieved at the end of the time frame without differences of opinion amongst the team?* This is perhaps the best litmus test for whether or not an objective is truly focused on concrete and measurable behavior change. If the objective statement does not meet this standard, chances are it was somehow too subjective or “soft” on the front end and it should be revised to reflect the criteria noted above.

Objectives should be the most active and dynamic part of the PCP as they reflect the progress that is made toward the specified personal goal. While the longer-term goal statement may remain the same over a period of time, it is important that objectives be crafted in a way that the focus person has a reasonable likelihood of success in achieving them within a shorter frame of time, e.g., within 3 months or 6 months, depending on how often the PCP team is re-convening to review the plan as a whole. Objectives may be written in a sequential manner, i.e., the achievement of one objective may trigger the activation of another. It is also possible that multiple objectives be pursued simultaneously and when closure on all is achieved, this reflects attainment of the goal. In either structure, objectives should describe with some detail/specificity the expected near-term changes needed to meet long-term goals. By dividing larger goals into smaller actions and benchmarks, objectives can provide hope to both the individual and his/her team by taking what can feel like an overwhelming journey and organizing it in a number of steps where progress can be made and success experienced and celebrated.

As much as possible objectives should describe the development of new skills and abilities, including the ability to access needed supports and accommodations. For example, an individual may need to develop an ability to negotiate certain workplace accommodations from his/her employer. A focus on skill building and enhancing self-management goes a long way towards promoting recovery and the person’s vision of the future.

The development of objectives is an area in which the PCP facilitator can make perhaps their most significant contribution in service of the focus person’s recovery. When individuals are feeling overwhelmed by their problems and can see little more than barriers to their goals, the facilitator can use his/her problem solving skills and abilities to build upon the individual’s strengths and resources and identify steps that will help move the person forward. At the same time, objectives should not be broken down to the point where they become trivial. They are not a laundry or “to do” list. Instead, a plan should have two or three objectives (or whatever is most comfortable) for the individual and his/her team to be working on during a particular period of time. Increasingly, national standards determine this period of time, i.e., funders and accrediting bodies often require that service plans be reviewed at minimum every ninety days. Ideally the
time frame for accomplishment of an objective is 90 days or less—and setting even shorter timeframes can communicate a message of positive expectation, confidence, and hope for change.

Perhaps the most frequent problem seen in creating a quality written service plan, is the confusion between objectives and services or interventions. Services are not an objective! Attending a group session is NOT the objective—rather the changes the person can make and the benefit derived from participating in a group is what should be captured and described in the objective statement. For example, it is not uncommon to see a goal such as, I want to have a girlfriend, followed by objectives such as, “Patient will maintain medication compliance, attend social skills group, and meet with his/her therapist, as if participation in these activities will somehow magically equate with the concrete progress and behavior change that will move the person closer to his/her goal of being in a meaningful relationship. Things such as psychiatric medication, social skills groups, and individual therapy may well be a critical part of the PCP, but these are services/interventions not objectives! When crafting the objectives, ask yourself, As a result of attending the social skills group or using medication effectively, what is the hoped-for change in functioning/change in behavior/change in status? For example, will the person be able, within a certain time frame, to…

- Identify 3 local places in the community she/he can go to meet others or identify 3 positive coping strategies to manage anxiety in social situations (known as a “learning” objectives)

- Participate in one preferred social activity outside the group home per week or demonstrate 3 “conversation-starters” in session with clinician or, even actually use those conversation starters to invite someone on a date! (these are known as “behavioral” objectives as they reflect the application of learning to achieve real behavior change, and as such, they are preferred over “learning” objectives wherever possible)

In summary, while the crafting of objectives involves perhaps the most stringent of technical criteria from a documentation perspective, they also present an important opportunity to maximize the person-centered dimensions of the plan as they communicate positive expectations for change while mapping out concrete next steps on the path to recovery and wellness.

Interventions/Services/Supports

Last but not least, we consider the final element of the person-centered service plan, i.e., the interventions section which may also be referred to as the “methods” or “services” section. Traditional treatment plans often limit this section of the planning document to reflect only those treatments which clinical, rehabilitation, medical, and other professionals are paid to deliver to the focus person. This method of documenting the interventions section can lead to PCPs which read as a laundry list of all the “treatments” which are going to be done to (or for) the person while missing out on a key opportunity to capitalize on the resources and talents of other members of the Circle of Support. While professional services are an essential part of the plan, a high-quality, comprehensive PCP also includes within the interventions section any action steps/tasks which will be owned, and acted upon by, unpaid natural supporters or the focus person him/herself. This is consistent with the emphasis which PCP places on maximizing the focus person’s connections to meaningful community activities and natural support relationships (See Section C. above). As with the approach to actively incorporating strengths in the PCP document, when the pre-planning process has uncovered persons within the Circle of Support who are willing, and able, to lend their time, energy, and enthusiasm to the person’s PCP vision, then these contributions should be documented as action steps alongside those services offered by professional providers. Similarly, documenting an action step (which may be as ambitious or as
modest as needed) for the focus person to take primary responsibility for is an important opportunity to build a sense of self-agency and move past the legacy of passivity and low expectations which has unfortunately become common among persons with disabilities involved in professional service systems.

Types of Interventions.

Within the person-centered planning process, the team should explore diverse range of both professional services, alternative strategies, and natural supports to assist the person in realizing their PCP vision. Some examples include:

- Professional clinical interventions such as medications or psychotherapy, including high-fidelity evidence-based practices
- Self-help and peer-support
- Exercise and nutrition guidance
- Rehabilitation and skill-building to enable person to live in least restrictive environment
- Daily maintenance activities and plans for managing symptoms/behaviors before they get worse (e.g., Mary Ellen Copeland’s Wellness Recovery Action Plan)
- Spiritual practices and affiliations
- Homeopathic and naturopathic remedies
- Cultural healing practices/involvement of indigenous healers
- Increased involvement in community activities or connections with natural supporters
- Rehabilitation opportunities such as supported housing, supported education, supported employment, and supported community living.
- Practical assistance in community contexts to address basic human needs for housing, food, work, and connection with the community.

How to ensure interventions are person directed.

It is essential that interventions reflect the choices and preferences of the focus person. While it may seem like common sense to just ask the person what he or she prefers, the “interventions” listed on most treatment plans still typically reflect only what is commonly available within the system/agency and not what the person’s preference for support may be. To make sure the plan is truly person-directed, providers should ask questions about how the person wants to accomplish their hopes, dreams, interests, talents, and skills, and perhaps the most important question—“How can I best be of help to you?” One way to gauge the extent to which interventions promote self-direction and recovery is to consider the following questions:

- Does the person have more or less power as a result of this interaction? (Carling 1995, p. 60)
- Does the person gain power, purpose (valued roles), competence (skills), and/or connections (to people) as a result of this intervention?”
- Does this intervention interfere with the person’s ability to gain power, purpose, competence, and/or connections to others?” (Davidson et al., 2005).

Addressing regulatory and fiscal pressures in writing interventions.

When it comes to documenting services and supports that will be billed to a medical insurer—most commonly Medicaid, it is important that the intervention be recorded in a way that essential information to meet regulatory requirements is included. In order to clearly demonstrate
the medical necessity of a service/support activity, the intervention should include each of the five critical elements and specify the:

- provider and clinical/professional discipline
- staff member’s name (wherever possible, recognizing that in some team-based service models there may be multiple individuals called on to deliver a certain support)
- modality of the intervention or service, e.g. group therapy, case management, rehab services, nutritional counseling, etc.
- frequency (how often?, e.g., 2 times per month) /intensity (how long?, e.g., for 30 minutes) / duration (over what period of time? e.g., for 3 months)
- purpose / intent / impact

The medical necessity of the proposed activity will be clear so long as the purpose of the intervention in helping the individual attain the objective is specified. The clearer the link between the activity and the desired change in the objective, the clearer the case for medical necessity. A helpful strategy for checking to ensure you have maintained the logical link between the objective and the intervention is to read the plan from the “bottom-up” – meaning, read the interventions and then go back and read the objective statement. If the logical link is not apparent, this may have just been an oversight in the documentation and the PCP facilitator can now revise the plan. However, if the purpose of interventions is frequently unclear and/or seemingly unrelated to the attainment of objectives on the PCP, this can be an indication that service recipients are simply assigned to a daily or weekly series of interventions/groups because this is “what we offer here.” This would be an example of a system-centered program design where individuals are fit into the available service menu and then goals are developed after the fact (in essence, the plan jumps right to interventions without adequate attention to goal and objective setting). In a high-quality PCP process, the team works together to design the interventions around the person and not the other way around!

In summary, clearly documenting the intended purpose of the service provided is an opportunity to improve the PCP from a “compliance” perspective. However, it is an equally important opportunity to “connect-the-dots” and to demonstrate to the focus person that the provision of services has stayed true to the goals and objectives on their PCP. For example, are they meeting with the psychiatrist for the purpose of discussing sexual side-effects of medications which is interfering with their goal of getting a girlfriend? Or meeting with the money manager for the purpose of learning skills so they can manage their money as they move out of the group home? Or meeting with the therapist for the purpose of developing communication skills that will help them to be a better parent? When the individualized purpose of the intervention is described in this way, the focus person is far more likely to see the intended benefit as it relates to their personal PCP vision.

**Putting the Pieces Together: A Sample PCP Excerpt**

**Introducing Chase:**

Chase is 22-year old female who dreams of finishing school and becoming a teacher someday. Over the past four years she has received various mental health services, mainly for periods of confusion and hearing voices. The confusion and voices tend to become much worse when she is depressed or “stressed out”. She moved from Texas to Massachusetts one year ago hoping for a fresh start. Against her mother’s advice, she enrolled in college classes and soon felt overwhelmed with the demands of her classes. Her voices became much worse and she was
eventually hospitalized. Chase is referred to your team six-months after this hospitalization, and she seems to enjoy talking with you. After several meetings with Chase, she mentions that she would like to begin to take college classes again. She had a good relationship with her primary academic advisor who was aware of, and supportive around, her mental health issues. However, Chase’s Mom is strongly against her returning to school at this time and she has urged her not to rush things, and to take more time to “get things straight.” Chase does acknowledge that she is still experiencing voices, but she is learning how to cope with them and she does not want to put her dream of finishing school on hold any longer.
**GOAL**

I want to finish college and be a teacher someday.

**Strengths/Resources**

Support of academic advisor around her mental health issues; close relationship with her mother; understands her illness and what tends to trigger an increase in voices; highly motivated to move forward in her education and career; friendly and outgoing personality; connects well with others including staff at the mental health center, and previous classmates and instructors.

**Barriers**

Increase in voices around the stress of attending college; depression that leads to sleep disturbance, making it difficult to get to class on-time; current lack of support from her mother who fears Chase is “rushing” her return to school.

**Objective**

Chase will successfully complete one class with a min. grade of C within the next 6 mos.

**Interventions**

<table>
<thead>
<tr>
<th>Person responsible and Intervention</th>
<th>Intensity</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donna Brick, LCSW, will provide 1:1 cognitive behavioral therapy to assist with stress management and coping with distressing voices.</td>
<td>45 min</td>
<td>1x/wk</td>
<td>6 mos.</td>
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<tr>
<td>Althea Jackson, Supported Education Rehab Coach, to provide skill-building and encouragement around pursuing her educational goal. Ms. Jackson (with Chase’s permission) to coordinate services with advisor and College Disability Services office.</td>
<td>30 min</td>
<td>1x/wk</td>
<td>6 mos.</td>
</tr>
<tr>
<td>Jesse Iwanski, Young Adult Services Peer Specialist, will provide mentoring around dealing with the stressors of returning to class.</td>
<td>30 min</td>
<td>1x/ every two wks.</td>
<td>6 mos.</td>
</tr>
<tr>
<td>Cheryl Anne Bellanic, Case Manager, will provide assistance in locating and completing financial aid and/or scholarships applications</td>
<td>15 min</td>
<td>1x/wk</td>
<td>2 mos.</td>
</tr>
<tr>
<td>With the support of her academic advisor, Chase will identify 1 class that she would like to take at during the upcoming semester.</td>
<td>n/a</td>
<td>1x</td>
<td>Within 3 wks.</td>
</tr>
<tr>
<td>Chase’s mother to participate in NAMI Family-to-Family group to receive support and learn ways to support Chase in her PCP plan.</td>
<td>n/a</td>
<td>2x/month</td>
<td>6 mos.</td>
</tr>
</tbody>
</table>