Ready, Set, Goal: Goal-Setting from Start to Finish

New York City
Family Resource Centers
May 13, 2016
Agenda

- Session I: Uncovering Family Needs
  - Review of March Learning Collaborative
  - Approach
  - Assessment
  - Understanding
  - Prioritization
- Session II: Translating Needs Into Parent/Youth's Vision, and More!
  - Parent/Youth's Vision
  - Strengths and Concerns/Needs
  - SMART Goals
  - Action Plans
  - Outcomes
Effective outreach is a strategic process!

A plan that is the same for every family is not an effective plan; a pitch that is the same for every audience is not an effective pitch.

Select the **right organization**, identify the **right person**, and include the **right content**.

Pitches should be brief, specific, and genuine.

Focus on values, needs, and goals.

Descriptions of programs and services can be found in your folder.
Purpose of the Workshop

- To provide you with the support and tools necessary to assist a family in translating their needs into a concrete vision.
- To learn how to use the overarching parent/youth's vision to plan SMART goals, SMART action steps, and create desired outcomes for families.
How do we make goal-setting meaningful for you and the families you serve?
Key Elements of Person-Centered Recovery Planning

1. Approach
2. Assessment
3. Understanding
4. Prioritization
5. Parent/Youth’s Vision
6. Strengths and Concerns/Needs
7. SMART Goals
8. Action Plans
9. Outcomes

[Diagram of a pyramid with the above elements]
Approach

- Outcomes
- Action Plans
- SMART Goals
- Strengths and Concerns/Needs
- Parent/Youth’s Vision
- Prioritization
- Understanding
- Assessment
- Approach
Principles of the Approach

- Mutual Respect
- Shared Listening
- Wise Decision-making
- Courageous Conversation
3 Methods of Communicating

- 7% - Words
- 38% - Tone, Voice
- 55% - Body Language
The Power of Language

- Language shapes how we see the world.
- The words we choose and the meanings we attach to them influence our feelings, attitudes, and beliefs.
- We choose the words we use to describe ourselves, others, and the world around us.
- These choices have a powerful effect on how we view mental health and people with mental health conditions.
- People-first language means we literally put ourselves and others first in a sentence.
  - Instead of calling someone “mentally ill,” the more appropriate, respectful phrase is “a person living with a mental illness.”
Active Listening

- In the workplace, listening is used at least 3 times as much as speaking, and four to five times as much as reading and writing.
What is the Difference between HEARING and LISTENING?

- Hearing: the physical ability

- Listening: a **skill**. Listening allows one to make sense of and understand what another person is saying. Listening is **active**. It means being alert to and understanding the meaning behind the speaker’s words.
Barriers to Listening

- Noise
- Language differences or accents
- Worry, fear, or anger (our emotional response)
- Lack of attention span
- Talking over the person
- Planning your response
- Bias or judgment
How to put the ACTIVE in Active Listening

1. Pay attention
2. Show that you are listening
3. Provide feedback
4. Defer judgment
5. Respond appropriately
Paying Attention

Give the speaker your undivided attention, and acknowledge the message. Recognize that non-verbal communication also “speaks” loudly.

- Look at the speaker directly.
- Put aside distracting thoughts. Don’t mentally prepare a response.
- Avoid being distracted by your involvement.
- “Listen” to the speaker’s body language.
What does their body language say to you?
Using Body Language

Humans have more than 700,000 forms of body language.
Show that You are Listening

Use your own body language and gestures to show your attention.

- Nod occasionally
- Smile and use other facial expressions
- Note your posture and make sure it is open and inviting
- Encourage the speaker to continue with short verbal comments like ‘yes’, and ‘uh huh’.
Reflective Listening

Our personal filters, assumptions, judgments, and beliefs can distort what we hear. As a listener, your role is to understand what is being said. This may require you to reflect back and ask questions.

- Reflect what has been said by summarizing what the person is saying in your language, “What I’m hearing is…” and “Sounds like you are saying…”
- Ask questions to clarify certain points. “What do you mean when you say…?” or “Is this what you mean…?”
- Summarize the speaker’s comment every so often throughout the conversation.
Focusing Questions

Use focused questions to get a more definitive answer than you would with an open-ended question.

Example:

**Advocate:** “Where do you spend most of your day?”

**Youth/Parent:** “I don’t know – it’s hard to say.”

**Focused question:** “Okay, let’s take yesterday. Was that a regular day for you? What did you do in the morning?”
Focusing Questions #2

- **Advocate:** What would you like to achieve through our work together?
- **Youth/Caregiver:** I don’t really know. I want to do better? I’m just not really sure what you are asking.
- **Advocate:** Being better, if you were “better” tomorrow, what would that look like? How would you know that you are better?
Closed vs. Open-Ended Questions

Close-ended questions invite a yes or no answer. They begin with Do, Does, Did, Is/Are, Was, Has, Have, Could, Would, and Will.

Open-ended questions cannot be answered by yes or no. They begin with: Who, What, When, Where, Why, and How.

Practice:
Do you work?
Do you have any side effects from the medication you are taking?
If you find yourself responding emotionally to what someone has said or is saying, say so.

Ask for more information:
“I may not be understanding you correctly, and I find myself taking what you said personally. What I thought you just said is…; is that what you meant?”
Defer Judgment

Interrupting *can be* a waste of time. It frustrates the speaker and limits full understanding of the message.

- Allow the speaker to finish
- Don’t interrupt with counter arguments
- Sometimes it is appropriate to interrupt in order to refocus the conversation or to clarify what the speaker is saying.
Interrupt to focus:

- Use the person’s name to get their attention, and when he/she pauses, redirect the conversation the issue at hand.
- I really need to ask…
- Let me interrupt you for a just a second…
- I think we need to focus on…
- Can we get back to…
- It would really help me to know more about…
- Any clarifying question: “What do you mean when you say…?” or “Is this what you mean…?”
Respond Appropriately

Active listening is a model for respect and understanding. You are gaining information and perspective. You add nothing by attacking the speaker or otherwise putting them down.

- Be open and honest in your response
- But give these opinions in a respectful way.
- Treat the other person as you would want to be treated
Assessment

Outcomes
Action Plans
SMART Goals
Strengths and Concerns/Needs
Parent/Youth's Vision
Prioritization
Understanding
Assessment
Approach
Telling a Story Through your Documentation

- Each record should tell a story about the care that’s being provided.
- Like any other story, the record has a particular setting and a cast of characters that the “reader” should understand in order to make sense of the record.
- Even when information is “stored” in various parts of the record, the record needs to be consistent.
- The record is a legal document and should be a complete unit of information.
The Assessment Process: What Works?

- What is the purpose of the assessment?
- What do we gain?
- What is included in your assessment?
- How do you approach family members during assessment?
Purpose of the Assessment

- Get information that guides service planning.
- Deepen your understanding of the whole person.
- Identify areas for growth and opportunities for change.
- Identify strengths, talents, and gifts.
- Identify valuable resources and those that haven’t worked.
- Create enthusiasm, confidence, and motivation for goal achievement.
Reason for Seeking Services

- What brings you here today?
- What would you like to change in your life?
- What would you like to see happen as a result of participating in these services?
- What else?
Using the FES as a tool to Assess

- The FES is designed to give you some jumping off points to identify areas that your parent self-identifies as an area of concern/need.
- Allows you to have a conversation about their strengths and resources.
- Addresses many facets of parenting skills and styles.
## Family Empowerment Scale

**Date FES Completed:**

**Name of FRC staff who administered the FES:**

<table>
<thead>
<tr>
<th>ABOUT YOUR FAMILY...</th>
<th>PARENT RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOBRE SU FAMILIA...</strong></td>
<td><strong>NEVER</strong></td>
</tr>
</tbody>
</table>
| 1. When problems arise with my child, I handle them pretty well.  
*Cuando surjan problemas con mi niño/a, los puedo resolver bien.* | | | | | | |
| 2. I feel confident in my ability to help my child grow and develop.  
*Tengo confianza en mi capacidad de ayudar a mi niño/a a crecer y desarrollar.* | | | | | | |
| 3. I know what to do when problems arise with my child.  
*Yo sé qué hacer cuando surjan problemas con mi niño/a.* | | | | | | |
| 4. I feel my family life is under control.  
*Siento que mi vida familiar está bajo control.* | | | | | | |
| 5. I am able to get information to help me better understand my child.  
*Soy capaz de conseguir información para ayudarme a entender mejor a mi niño/a.* | | | | | | |
| 6. I believe I can solve problems with my child when they happen.  
*Creo que puedo resolver los problemas de mi niño/a cuando ocurran.* | | | | | | |
| 7. When I need help with problems in my family, I am able to ask for help from others.  
*Cuando necesito ayuda con los problemas en mi familia, soy capaz de pedirlo a otros.* | | | | | | |
| 8. I make efforts to learn new ways to help my child grow and develop.  
*Yo hago esfuerzos para aprender nuevas maneras de ayudar a mi niño/a a crecer y desarrollar.* | | | | | | |
| 9. When dealing with my child, I focus on the good things as well as the problems.  
*Cuando trato con mi niño/a, me enfoco en las buenas cosas al igual que los problemas.* | | | | | | |
| 10. When faced with a problem involving my child, I decide what to do and then do it.  
*Cuando me enfrento a un problema referente a mi niño/a, decido qué hacer y lo hago.* | | | | | | |
| 11. I have a good understanding of my child’s problems.  
*Yo tengo un buen entendimiento de la enfermedad que padece mi niño/a.* | | | | | | |
| 12. I feel I am a good parent.  
*Me siento que soy un buen padre/una buena madre.* | | | | | | |

**Average FES Score:**
Understanding

Outcomes

Action Plans

SMART Goals

Strengths and Concerns/Needs

Parent/Youth's Vision

Prioritization

Understanding

Assessment

Approach
The Importance of Understanding

- Data collected in an assessment is *by itself* not sufficient for planning – only identifies the “what.”
- Data must be woven together, explored, and interpreted in order to gain an understanding of the person as a whole – identified the “why.”
- True understanding is informed by:
  - The individual’s understanding
  - Your professional opinion
An Example...

- The FES may indicate that the parent (Mrs. Bernard) does not have a good understanding of her child’s problems.
- The summary notes: “Mrs. Bernard does not understand her son’s diagnosis or how the IEP fits in.”
- This does NOT reflect true understanding; it merely re-states the data/facts.
- The task is to try to understand **WHY** Mrs. Bernard does not understand her son’s problems.
- This may take the plan in very different directions.
- Let’s BRAINSTORM…
Mrs. Bernard is concerned that getting an IEP will label her son as “different” from his peers, worsening bullying issues.

- Education on the IEP process, skills training in parent advocacy, youth advocacy services to promote son’s social skills development.

Mrs. Bernard doubts her son’s diagnosis because while he acts up at school, he is cooperative and social at church and in the home.

- Collaboration with faith-based or cultural organizations, education on mental illness, family-based Action Plans.

Mrs. Bernard does not know how to talk to her son about his mental health, fearing that he will feel blamed and stop communicating with her.

- Peer support, communication skills training.
Take it to the Bridge

- Understanding means using the information gained during the assessment process to come to a consensus about the current situation.
- Only by doing this can we determine what should happen next.

“This is how I am seeing you and your situation at this moment. Did I get it right?”
Stages of Change

**Stage 1: Not Ready (Pre-Contemplation)**
- The family member/youth doesn’t see a real need to change even if others do.

**Stage 2: Getting Ready (Contemplation)**
- The family member/youth is beginning to think about and discuss making a change BUT is not completely convinced that change is needed.

**Stage 3: Ready to Take Action (Preparation)**
- The family member/youth understands that his or her issue is doing more harm than good and determines steps to address issue.

**Stage 4: Taking Action (Action)**
- The family member/youth actively works to address issue.

**Stage 5: Ready to Maintain Gains (Maintenance)**
- The family member/youth is ready to take steps to keep from slipping backwards.
Understanding a Family’s Readiness to Change

- Assessing a family’s readiness
  - Establish a rapport with the family
  - Understand if their resistance is internal and/or external

- Meeting the family where they are
  - Understand why a family is not ready to change
  - Ask yourself: How it has served them to stay in this situation?

“People do not change because of logic. People only change when they have an emotionally compelling reason.” — Author Unknown
Understanding Parent/Youth's Vision: A Motivational Interviewing Approach

- Change occurs naturally and Motivational Interviewing (MI) mirrors natural change.
- When behavior change occurs it is usually within the first few weeks.
- Advocates have a significant influence on goal dropout, sticking with the plan, and goal achievement.
- Using empathy regularly with your families improves the family’s ability to change; the absence hinders change.
Understanding Parent/Youth's Vision: An M.I. Approach con’t….

- People who believe that they are likely to achieve their vision do so. When advocates believe in families, families can begin to believe in themselves!

- What people say about change is important. Statements that reflect motivation for and commitment to change do predict achievement of their vision, goals and action plans. Whereas, arguments against change (resistance) produce less change.

- You have the ability to CHANGE the conversation – to replace argument with motivation.
Ambivalence: The Dilemma of Change

- Example: “I want to move closer to my mother and sister so that my children can be close to their family, but I’m afraid that transferring schools would be tough on the kids.”

- For every goal, there are benefits to changing and benefits to NOT changing.

- Use the Decisional Balance Sheet!
Rolling with Resistance

- Worst case scenario is when WE advocate for change while our parent/youth argues against it.

- So, if you don’t argue for change, what do you do?
  - We do not oppose resistance, we roll or flow with it.
  - Remember that ambiguity/resistance is a natural part of goal setting and achievement.
  - Avoid arguing for change.
  - New perspectives are introduced but not forced.
  - Let the family member/youth be the primary resource in finding answers and solutions. At the end of the day, they know their life, themselves, and their situation better than anyone else.
  - If we offer solutions, we become the problem solver and the one responsible for the improvements.
  - Resistance is a signal that you need to respond differently.
Example of Rolling with Resistance

Example:

- Advocate: You haven’t been coming to the parenting class. I’m really concerned about you.
- Parent: I know. The first two classes really helped me. I know what I’m doing now.
- Advocate: It may be that you find the classes take away time from your life and kids. That the time spent on them right now is more important than completing the course and dealing with the consequences with ACS.
- Parent: Well, I don’t know if it’s *that* important. I don’t want to lose custody of my children or deal with any more issues with ACS.
Tips for Staying Empathetic

- Understanding change is hard
- Show warmth and caring
- Try not to argue or be “pushy”
- Show family members that you understand their perspective
- Be optimistic, supportive, and hopeful

Adapted from Jonathan Fader, 2014
Prioritization

Outcomes
Action Plans
SMART Goals
Strengths and Concerns/Needs
Parent/Youth’s Vision
Prioritization
Understanding
Assessment
Approach
Balancing Priorities in the Plan

- People have multiple needs and goals – need to PRIORITIZE.
- Addressing too many things at one time can:
  - Make the plan feel fragmented
  - Dilute efforts
- Need to balance what is important TO the person with what the provider thinks is important FOR the person.
  - Plan must make room for both perspectives.
- Considering time-sensitivity or urgency of different factors can assist in prioritizing efforts.
Finding the Right Balance

Neglect: Let participant do what he/she wants

Control: Get participant to do what I think is needed
Parent/Youth's Vision

- Action Plans
- SMART Goals
- Strengths and Concerns/Needs
- Prioritization
- Understanding
- Assessment
- Approach

Outcomes
Essential Features of Parent/Youth's Vision

- They are broadly stated and reflect the big picture.
  - In the language of your parent/youth
  - Always expressed in person’s words using “I” statements.
  - Is written in the notes.
  - Moves toward the positive – “glass half full”
    - “I want to have a better relationship with my kids.”
  - Achieve rather than reduce – “glass half empty”
    - “I don’t want to argue with my kids.”

- Parent/Youth's vision is linked to “discharge” criteria
  - Identify the desired destination and what the destination looks like.
Where the Vision Goes in eCOMPAS
Vision Development – It’s a Process!

- Not everyone can easily articulate their vision – the process takes time!
- It will unfold through reflective listening that highlights what’s important to the person.
- People are often ambivalent about their vision.
Effective Parent/Youth's Vision

- Meaningful to the individual
- Easily understood by any reader
- Broad enough that all of the work you do together will fit into this idea but not so broad that it will take years to achieve (similar idea as prioritization).
  - Example of Too Broad: “I want my daughter to become an astronaut.”
  - Example: “I want to be able to support my daughter to graduate with her High School Diploma” (still working towards to idea of becoming an astronaut but the first major vision in achieving that overly broad vision).
  - Example of not broad enough: “I want to support my daughter to go to school every day next week”.
Strengths and Concerns/Needs

Outcomes
- Action Plans
- SMART Goals
- Strengths and Concerns/Needs
- Parent/Youth’s Vision
- Prioritization
- Understanding
- Assessment
- Approach
Strengths and Concerns/Needs in eCOMPAS
Strengths and Supports: What Works?

- How do you ask about strengths?
- How do you identify strengths a family member may not know they have?
Active Use of Strengths

- Strengths are not meant to “sit on a shelf”
- How are strengths used in recovery planning? For example:
  - A youth who loves music might benefit from listening to music with headphones as a way to relieve anxiety on the subway.
  - A parent with strong family supports might have family members assist her with grocery shopping and learning to cook healthy meals.
Strengths and Supports

“Tell me about the important people in your life.”

“What are you good at?”

“What activities give you a sense of accomplishment?”

What else could you ask?
Identifying Concerns/Needs: What Works?

- How do you ask about concerns and needs?
Identifying Concerns/Needs

- “What has created challenges in achieving your vision?”
- “What have you tried in the past to address these concerns?”
  - Both what DID and DID NOT work

- Ask yourself: What’s keeping them stuck?
Concerns/Needs

- Challenges/roadblocks experienced as a result of family circumstances.
- What is getting in the way of the person achieving their goal?
  - Why can’t they do it tomorrow?
  - Why can’t they do it themselves?
  - Why haven’t they already done it?
- How are roadblocks getting in the way of identifying and achieving your parent/youth's vision?
Putting it Together

- Capitalizing on strengths and accounting for concerns/needs illuminates **how** you will achieve an identified goal, which leads to...
SMART Goals
SMART Goals in eCOMPAS

Parent/Caregiver Individual Care Plan

Strengths of the Parent

Concerns/needs of the Parent

List of New Goals

<table>
<thead>
<tr>
<th>Description of goal</th>
<th>Action plan to achieve goal</th>
<th>Date Goal Set</th>
<th>Date Goal to be achieved</th>
<th>Was goal achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes Date:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No - Specify Reason:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes Date:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No - Specify Reason:</td>
</tr>
</tbody>
</table>
SMART Goals

S = Simple, straightforward, specific
M = Measurable
A = Attainable, action-oriented
R = Relevant (to goal and stage of change)
T = Time-bound
Effective SMART Goals

- Meaningful to the individual
- Easily understood by any reader
- Effective in tracking progress
- Encourage the person to try new skills
- Contains **ONE** behavior that works toward achieving the vision.
Formula for SMART Goals

Within [amount of time (time-bound)], [insert name] will have improved [insert documented concern/need (relevant)], as evidenced by [insert a meaningful change in functioning or behavior that is related to the vision (measurable and action oriented)].
Measurability

- The intended change should be obvious and readily observed by the individual and the family, as well as the staff.
- It is acceptable to measure change by observation, self-report, and/or completion of an assignment.
- Journals, behavior charts, etc.
SMART Goals Should NOT be Limited to Service Participation

- Ann will attend the parenting class 1x weekly for 12 weeks.
  - This is about service participation. People can participate in services for years and not achieve the intended benefits.
- SMART Goals are what the person hopes to change with the assistance of services. Ask yourself the question: As a result of attending the parenting class, how do you expect the parent’s behavior/quality of life/status to change in a measurable way?
  - Ann will apply communication techniques to reduce instances of arguing with her son to no more than one time per week for four consecutive weeks, as measured by self-report.
Sample SMART Goals

- Over the next 3 months, Kris will reduce his social anxiety by attending at least one social event per week for 30 minutes with a family member, as measured by self-report.
- Over the next 30 days, Kris will experience a decrease in anxiety when talking to people at social events, as evidenced by his tracking of anxiety levels in his mood log.
- Within the next 3 months, Kris will try 3 different types of social events that fit his needs and report progress toward independently meeting new people through his advocate’s monthly report.
Common Mistakes When Writing SMART Goals

- Describing what the advocate is expected to do instead of what the individual is expected to do.
- Including more than one expected behavior in a single SMART Goal.
- Using terms for performance that are subjected to many interpretations, are not action-oriented, and are difficult to measure.
- Writing SMART Goals that do not relate to the vision.
- Cluttering a SMART Goal by including unnecessary information.
- Being too general and not clearly specifying the expected outcome.
- Using general verbs or action words such as “understand” – instead, use concrete verbs such as “demonstrate,” “discuss,” “participate,” etc.
## Detail: SMART Goals

<table>
<thead>
<tr>
<th>Make Goals SMART…</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>SMART Goals are more easily accomplished when they are clearly stated. Answering the 5 W’s – who, what, when, where, and why – is helpful in setting specific goals.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Establishing concrete criteria for measuring progress can help motivate continued effort to achieving the goal. How will we know when the goal is accomplished?</td>
</tr>
<tr>
<td><strong>Attainable</strong></td>
<td>The goal should be reasonable and achievable. Trying to do too much in too little time is not the best way to succeed.</td>
</tr>
<tr>
<td><strong>Realistic</strong></td>
<td>A goal is probably realistic if the person believes that it an be accomplished. To be realistic, a goal must represent something a person is willing and able to do.</td>
</tr>
<tr>
<td><strong>Timely</strong></td>
<td>Goals are more grounded when there is a time frame attached to them. Identifying short-term steps within a longer term goal can help to create hope and momentum.</td>
</tr>
</tbody>
</table>
Practice, Practice, Practice

Turn these 3 Goals into a SMART Goal:

- Gloria will get an IEP for her daughter.
- Erica will argue less with classmates at school.
- Jesse will take a parenting class so that he is closer to his family.

Within [amount of time], [insert name] will have improved [insert documented concern/need], as evidenced by [insert a meaningful change in functioning or behavior that is related to the vision].
Action Plans
# Action Plans in eCOMPAS

![Image of Action Plans in eCOMPAS](image-url)

## Parent/Caregiver Individual Care Plan

- **Strengths of the Parent**

- **Concerns/needs of the Parent**

## List of New Goals

<table>
<thead>
<tr>
<th>Description of goal</th>
<th>Action plan to achieve goal</th>
<th>Date goal set</th>
<th>Date goal to be achieved</th>
<th>Was goal achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Yes Date:**
- **No - Specify Reason:**
- **Yes Date:**
- **No - Specify Reason:**
Action Plans aka Services

- Action Plans serve as a contract for who is responsible for what actions, including the person receiving services and natural supports, that is, supports that they already have in place.

- Action Plans include services which:
  - Describe **medical necessity** by clearly identifying how recommended services can help the individual overcome specific concerns
  - Are tailored to the stage of change/recovery
  - Are connected to a specific objective

- Action Plans from natural supports are **not services**.
A Note from Our Sponsors…

Medical Necessity

“…shall mean payment of part or all of the cost of medically necessary services, as authorized by Medicaid, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant disability and which are furnished to an eligible person in accordance with this title and the regulations of the department.”

What????

In plain English means that your services have to be described in a way that prove they should help your parent/youth achieve their goal while also connecting with the overall vision.
Action Plans aka Services

- Action Plans serve as a contract for who is responsible for what actions, including the person receiving services and natural supports, that is, supports that they already have in place.
- Action Plans include services which:
  - Are tailored to the stage of change/recovery
  - Describe medical necessity by clearly identifying how recommended services can help the individual overcome specific concerns
  - Are connected to a specific objective
- Action Plans from natural supports are not services.
Client’s Vision: “I want to create a better lifestyle for my son and me.”

Goal 1:
Within one month, Celia will improve her chances of getting a full-time job by applying to at least 5 jobs per week, as evidenced by copies of completed and submitted applications to her family advocate.

Action Plan:
Family Advocate will hold 15-minute check-in calls once a week (in addition to regular meetings) for the next month in order to discuss job search, application completion, and provide support.

Goal 2:
Within 3 months, Celia will improve her relationship with her son by identifying at least 3 methods for setting healthy boundaries with her son, as evidenced by report of Family Advocate.

Action Plan:
Celia will attend Emotional Fitness Parenting Class once weekly for the next 12 weeks in order to learn new skills in discipline and boundary-setting.
Activity!

Goal vs. Action Plan
Service Action Plans – 5Ws

- **Must specify:**
  - **WHO** will provide the service, i.e. name and job title
  - **WHAT**: The NAME of the service, e.g., basic living skills training, AND the modality in which the service will be provided, e.g., individual sessions or in group
  - **WHEN**: The SCHEDULE of the service, i.e. the time and day(s)
  - **WHERE** the service is being provided
  - **WHY**: The intent and purpose of the service/intervention
- Read plan from the bottom to the top
- Is it clear why THIS service is being provided in response to THIS SMART Goal that connects to achieving the Parent/Youth’s Vision?
Examples

Examples of Service Action Plans:
- Taking Parenting Class
- Attending Youth Group
- Participating in individual advocacy sessions

Examples of Self-Directed and Natural Support Action Plans:
- Asking trusted family member for assistance with child care
- Gathering all documents and records needed to apply for benefits
Common Documentation Errors

- SMART Goals
  - Don’t support the vision
  - Not measurable or behavioral
  - Action Plans become SMART Goals
  - Not time-framed or generically time-framed

- Action Plans
  - Purpose not included
  - Frequency, intensity, and duration not included
  - Don’t reflect multidisciplinary activity
  - Don’t include natural supports
  - Don’t link to the goal
Quick Review

- Parent/Youth's Vision:
  - What the person would ultimately like to achieve
  - The desired outcome

- SMART Goals:
  - What the person will do, change, or accomplish to achieve Vision
  - Measurable changes the person will make and skills to be gained

- Action Plans:
  - Services and supports that help person achieve Parent/Youth's Vision and SMART Goals
  - Not limited to providers; may include actions by person, family members, and support network

- Remember, services are not SMART Goals!
Outcomes

- Action Plans
- Objectives
- Strengths and Concerns/Needs
- Parent/Youth’s Vision
- Prioritization
- Understanding
- Assessment
- Approach
Outcomes

- Identified and agreed-upon end point for services
- Individual’s needs and likely destination at discharge plays a critical role in determining the anticipated length of stay
  - For example, someone who has just moved into a new apartment might have a shorter length of stay than someone who has not yet identified their options and preferences for housing
- Anticipated discharge or transition shapes the individual’s plan
- Shift from “complete the program” to “achieve Parent/Youth's Vision”
Documenting Progress Over Time

- Provides an opportunity for the family member/youth and advocate to evaluate how things are going on a regular basis and document the continued medical necessity of the services being provided.
- Progress notes can be considered a mini plan review
- Contact notes are *not* progress notes
- Service Plan reviews
Following up on Progress

Questions to ask the family when revisiting Parent/Youth's Vision (Open-ended questions are helpful)

- Why did we set this goal?
- What is keeping you from completing this goal?
- What steps will it take to complete this goal?
- Who can help you?
- How can your FRC staff help you?
Next Learning Collaborative

- We will be reviewing what we learned in this LC.
- Identify areas that were particularly challenging and trouble-shoot as a group.
- Plus: learn how to write effective progress notes (documenting progress or lack of progress over time).
- Practice, Practice, Practice!
  - Documentation and role play practices
Thank you!