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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Youth:** Name | | | **CRN:** 123456 | **DOB:** m/d/yy | | **Age:** #y #m | | **Gender Identity:** select | | | |
| **School:** XYZ Elementary | | | | **Grade:** # | | | | **Education Status:** select | | | |
| **Guardian(s):** Name | | | **Care Coordinator:** Name | | | | | **FGC:** select | | | |
| **Therapist:** Name | | | **Provider Agency:** Org Name & Service | | | | | | **Admission / Start Date:** select | | |
| **Diagnoses:** From CMP / CSP / Referral Materials (Name of Evaluator, Date of evaluation) | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Date of Plan:** select | Initial Plan  Updated Plan | | | |  | | | |  | | |
| **Youth & Family Information** | | | | | | | | | | | |
| 1. Description   Youth is a… | | | | | | | | | | | |
| 1. Strengths   Parent and teachers report… | | | | | | | | | | | |
| 1. Barriers to Treatment & Plans to Address Barriers   History of elopement… | | | | | | | | | | | |
| **Treatment Plan** | | | | | | | | | | |
| 1. Anticipated Treatment Format, Sessions Per Week, Hours Per Session, and Provider(s) | | | | | | | | | | |
| *Intervention Format* | | *Sessions per week* | | | | | *Hours (Units) per session* | | | *Provider(s)* |
| 1. select (describe if necessary) | | select / week | | | | | select / session | | | Name |
| Additional Comments… | | | | | | | | | | |

1. Treatment Focus Areas, Targets, and Practice Elements / Strategies

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| --- | --- | --- | --- | --- | --- | --- |
| 1. (from CMP or Referral Form) | | | | | | |
| *How will this be addressed in the milieu:* (for out-of-home services only) | | | | | | |
| * 1. *Treatment Target (select 1)* | *Measurable Goal / Outcome* | | | | | |
| Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  More Targets  Other | Mood rating will increase / decrease… | | | | | |
| *Practice Elements for Treatment Target (select 1 practice element per column – up to 3 total)* | | | | | | |
| Behavior Management  Coping/Self-Control  Core Practices  More Practices  Other | | | Behavior Management  Coping/Self-Control  Core Practices  More Practices  Other | | Behavior Management  Coping/Self-Control  Core Practices  More Practices  Other | |
| *Status:* select | | *Start Date:* select | | *Projected End Date:* select | | *End Date:* select |
| *Updates:* Comments / Progress Updates | | | | | | |

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| 1. Important Indicators / Criteria for Discharge   Youth and family… | | |
| 1. Anticipated Barriers to Discharge   Work schedule, childcare needs… | | |
| 1. Recommended Continued Services – Preferred Option | *Probable Timeframe:* select | |
| *CAMHD Services:* | | *Services Outside CAMHD:* |
| ABI FEP FFT IIH IILS IOH MST TSS  CBR HBR TFH TRH  Case Mgmt Kaeru Kealahou Med Mgmt PSS | | AMHD CCS OP Med Mgmt  OP Therapy SBBH Other  Other Other Other |
| Additional Comments… | | |
| 1. Recommended Continued Services – Alternative Option | *Probable Timeframe:* select | |
| *CAMHD Services:* | | *Services Outside CAMHD:* |
| ABI FEP FFT IIH IILS IOH MST TSS  CBR HBR TFH TRH  Case Mgmt Kaeru Kealahou Med Mgmt PSS | | AMHD CCS OP Med Mgmt  OP Therapy SBBH Other  Other Other Other |
| *Reason(s) alternative might be utilized:* If situation worsens… | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Youth:** Name | | | | | | | **Date:** select | |
| *PROBLEM BEHAVIORS – These are behaviors I sometimes show, especially when I’m stressed:* | | | | | | | | |
| Losing control | Assaulting people | | Feeling suicidal | | Running away | | | Using other drugs |
| Injuring myself | Attempting suicide | | Threatening others | | Using alcohol | | | Feeling unsafe |
| Other | Other | | Other | | Other | | | Other |
| *TRIGGERS – When these things happen, I am more likely to feel unsafe and upset:* | | | | | | | | |
| Not being listened to | Feeling pressured | | Being touched | | Lack of privacy | | | People yelling |
| Loud noises | Feeling lonely | | Arguments | | Not having control | | | Being isolated |
| Darkness | Being stared at | | Being teased | | Contact with family | | | Time of day: Specify |
| Time of year: Specify | Particular person: Name | | | | Other | | | Other |
| *WARNING SIGNS – These are things other people may notice me doing if I begin to lose control:* | | | | | | | | |
| Sweating | Breathing hard | | Racing heart | | Clenching teeth | | | Clenching fists |
| Red faced | Wringing hands | | Loud voice | | Sleeping a lot | | | Sleeping less |
| Acting hyper | Swearing | | Bouncing legs | | Rocking | | | Can’t sit still |
| Being Rude | Pacing | | Crying | | Squatting | | | Hurting things |
| Eating more | Eating less | | Not taking care of myself | | Isolating / avoiding people | | | Laughing loudly / giddy |
| Singing inappropriately | Other | | Other | | Other | | | Other |
| *INTERVENTIONS – These are things that might help me calm down and keep myself safe when I’m feeling upset:*  *Check off what you know works; star things you might like to try in the future* | | | | | | | | |
| Time out in my room | Listening to music | | Reading a book | | Sitting with staff | | | Pacing |
| Talking with friends | Talking with an adult | | Coloring | | Molding clay | | | Humor |
| Exercising | A cold cloth on face | | Writing in a journal | | Punching a pillow | | | Hugging a stuffed animal |
| Taking a hot shower | Taking a cold shower | | Playing cards | | Video Games | | | Lying down |
| Ripping paper | Screaming into pillow | | Holding ice in my hand | | Getting a hug | | | Using the gym |
| Bouncing a ball | Male staff support | | Female staff support | | Deep breathing | | | Speaking w/ my therapist |
| Drawing | Being read a story | | Making a collage | | Crying | | | Snapping bubble wrap |
| Being around others | Doing chores / jobs | | Cold water on hands | | Drinking hot herb tea | | | Using a rocking chair |
| Calling a family member: Name | | | Other | | Other | | | Other |
| *THINGS THAT MAKE IT WORSE – These are things that do NOT help me calm down or stay safe:* | | | | | | | | |
| Being alone | Being around people | | Humor | | Not being listened to | | | Peers teasing |
| Being disrespected | Loud tone of voice | | Being ignored | | Having staff support | | | Talking to an adult |
| Being reminded of rules | Being touched | | Other | | Other | | | Other |
| *Crisis Prevention Plan* | | | | | | | | |
| 1. *I will try to notice the following warning signs and triggers:*   Describe… | | | | | | | | |
| 1. *I’d like staff / my family to notice the following warning signs:*   Describe… | | | | | | | | |
| 1. *When I notice these triggers or warning signs, I will take action to prevent a crisis from developing by doing the following:*   Describe… | | | | | | | | |
| 1. *When staff / my family notice that I’m getting upset, I’d like them to help me prevent a crisis by doing the following:*   Describe… | | | | | | | | |
| *Crisis Intervention Plan (if the prevention supports above are not effective)* | | | | | | | | |
| *SIGNS THAT I MAY NOT BE ABLE TO STAY SAFE – Thoughts, feelings, and/or actions that indicate loss of control:* | | | | | | | | |
|  | |  | | | |  | | |
| *SUPPORT PEOPLE – People I can call or have someone call when I have these thoughts, feelings, or actions:* | | | | | | | | |
| 1. Name | | Relationship to youth | | | | Phone | | |
| *\* If you cannot reach the first person, go down the list until you reach someone.* | | | | | | | | |
| *HELP STATEMENT – This is my clear and specific statement to let my support person know what I need:* | | | | | | | | |
| I feel out of control… | | | | | | | | |
| *CRISIS SUPPORT – If all of my coping strategies have not worked and I cannot reach a support person, contact crisis support:* | | | | | | | | |
| * Crisis Line: 832-3100 (Oahu) / 1-800-753-6879 (Neighbor Islands) * Crisis Text Line: 741741 (Text: ALOHA) * Suicide Prevention Line: 1-800-273-TALK (8255) * Dial 911 or go to the Emergency Room | | | | TELL THE CRISIS WORKER:   1. If you plan to harm yourself / someone else or already have - BE SPECIFIC 2. How long you will be able to remain safe 3. Where you are and with whom (if anyone) | | | | |

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| *Name* | | | *Role* | | *Signature* | | *Date* | |
|  | Name |  | Client |  |  |  |  |  |
|  | Name |  | Parent / Guardian |  |  |  |  |  |
|  | Name |  | Therapist |  |  |  |  |  |
|  | Name |  | Care Coordinator |  |  |  |  |  |
|  | Name |  | Role |  |  |  |  |  |