|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

|  |
| --- |
| 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 BehaviorsInternalizing BehaviorsPositive BehaviorsMore TargetsOther | Mood rating will increase / decrease… |
| *Practice Elements for Treatment Target (select 1 practice element per column – up to 3 total)* |
| Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther | Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther | Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther |
| *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… |

|  |  |
| --- | --- |
| **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:* |
| 1.
 | 1.
 | 1.
 |
| *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)
 |

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