

# Los Angeles County – Department of Mental Health

## Care Plan

### Problems:

### Goal(s) (Focus of Treatment)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Improve <b>MOOD</b> regulation | <input type="checkbox"/> Decrease <b>SUICIDAL IDEATIONS</b>  | <input type="checkbox"/> Increase <b>SUPPORT SYSTEM</b>                      | <input type="checkbox"/> Obtain & or stabilize <b>HOUSING</b> |
| <input type="checkbox"/> Manage <b>ANXIETY</b>          | <input type="checkbox"/> Decrease <b>SELF HARM BEHAVIORS</b> | <input type="checkbox"/> Enhance <b>SOCIAL SKILLS</b>                        | <input type="checkbox"/> Obtain & or Keep a <b>JOB</b>        |
| <input type="checkbox"/> Manage <b>HALLUCINATIONS</b>   | <input type="checkbox"/> Improve <b>SELF-ESTEEM</b>          | <input type="checkbox"/> Develop healthier <b>LIFE HABITS</b>                | <input type="checkbox"/> Reduce <b>SUBSTANCE USE</b>          |
| <input type="checkbox"/> Manage <b>STRESS</b>           | <input type="checkbox"/> Improve <b>SLEEP</b>                | <input type="checkbox"/> Improve <b>SCHOOL</b> Performance                   | <input type="checkbox"/> Other:                               |
| <input type="checkbox"/> Manage <b>IMPULSIVITY</b>      | <input type="checkbox"/> Finding a <b>PURPOSE</b>            | <input type="checkbox"/> Attend <b>SCHOOL</b> or <b>EDUCATIONAL</b> facility |   |

### Goal details:

### Planned Intervention:

- |   |  |  |  |                                 |
|---|--|--|--|---------------------------------|
| <input type="checkbox"/> Psychotherapy  | <input type="checkbox"/> Skills Group          | <input type="checkbox"/> Teach Skills (Rehab)        | <input type="checkbox"/> Intensive Home Based Services   | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Medication Management | <input type="checkbox"/> Peer Support                | <input type="checkbox"/> Therapeutic Behavioral Services |                                 |
| <input type="checkbox"/> Group Therapy  | <input type="checkbox"/> Linkage & Referral    | <input type="checkbox"/> Intensive Care Coordination | <input type="checkbox"/> Day Treatment                   |                                 |

### Intervention details:

Client and or family was involved in development of the plan:  Yes

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Provider #:

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