

*The Yourell Plan Format for  
Psychotherapy & Case Management,  
(YPF V.1.1)*

Dear Clinician,

This is a format for conducting and writing up a clinical assessment and plan that works well with the ***Yourell Self-Planner: Getting There from Here*** form for clients. Although it is presented as a format, this is most importantly a state of mind and resulting protocol that could be active in any intake and planning process in mental health and social work, including case management.

**Purpose:** This format is intended for general assessments in which the client's perceptions, case management, diagnosis, and the accountability of all persons involved, should be specified and logically tied to clearly stated goals and objectives. This format and the *Getting There from Here* form may be of value to social work and mental health professionals who are not necessarily performing psychotherapy or counseling. The assessor would simply do the steps from the perspective of their existing responsibilities and scope.

This format can also assist with tracking progress, because it is short and includes self-rating. Clients benefit from palpable evidence of improved functioning, because they often underestimate their level of improvement without a comparison, and professionals with whom you must negotiate a plan can be persuaded most effectively with baselined and systems-relevant information. Often, a misperception of a client stems from an emotional reaction that causes normally objective professionals to remember selectively or even invent case history without realizing it.

**Integration with *Getting There from Here*:** Note that *Getting There from Here*, corresponds to section one and part of section two. *Getting There from Here* leads the client through a process that can better prepare them for intervention and for an effective dialogue with helping professionals. If your client would have trouble completing *Getting There from Here* independently, you should take them through it with support and dialogue. This way, you will not only get assessment information, but the client will receive initial counseling with the structure of *Getting There from Here*. This can help the initial assessment and counseling work together well, and be more thorough and relevant.

**The Approach:** By flowing structured information from the client's perspective directly into the intake summary, and then moving to the assessment section in which the clinician integrates all appropriate information into an assessment, the writer makes it

clear where the information is coming from and how the assessment resulted. I have read many reports that went in the wrong direction, missed critical information, or overlooked vital responsibilities or systems issues because it did not embody this kind of thinking.

I developed this approach based on diverse clinical, supervisory and monitoring experience. There isn't room for it here, but I have many opinions about effective assessment and planing, such as how to make it relevant to systems dynamics, and how to avoid pitfalls common to the process of establishing treatment goals.

**No Warranty:** Of course, this document is provided as is, with no warranty. It is up to you in your professional, clinical judgement to determine whether or how to use or modify it.

**Please make suggestions:** I welcome all suggestions. Send any modifications you make.

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I hope you find this helpful. - Bob Yourell

# Intake Assessment and Plan

## I. Client's Initial Perspective of Issues\*

1. Functional limitations, and their causes
2. Subjective Distress Elements and Their Significance
3. Desires and Expectations and Hopes
4. Client's Internal Resources and Activation Issues
5. Client's Perspective on External Resources, Their Value and Accessibility
6. Client's Analysis of Problems, and Self-Assessment (Needs, Capacities, Intentions, Own Responsibility for any Problems)
7. Client's Plan, History of Efforts, History of Help, Legal or Professional involvement. Perspective on Results of Prior Efforts

\*For specifics, see "Getting There from Here" The Yourell Self-Planner

## II. Plan Basis

- **Using Same Categories as Above:** Additional information available and its sources, including clinician's observations. Indicate where there is conflicting information. Include clinician assessment (#6), including diagnosis.
- **Summary and Interpretation** most important to developing the plan. Recommendations for additional information-gathering or assessment (including specialists), modalities, treatment and case management. Indicate how confident you are in the assessment and plan, and explain why, citing specific reservations.

## III. Treatment Plan

**Goals and Objectives:** Overall goals followed by objectives.

- **Baselines:** For each goal. Current baseline, lifetime range, key factors that affect the baseline, particularly those contributing to the highest and lowest levels attained, variability over time and in relevant contexts, goal.
- **Elements and Mitigation:** Confidence of clinician regarding likelihood of improvement. Obstacles and resources pertaining to the goal.
- **Objectives:** to address obstacles and to facilitate achieving the goal.
  - **Plan:** How will each objective be reached. Who is to complete what steps and accomplish what results?
  - **Time:** Estimated time to achieve each objective
- **Time:** When to reassess and how. When the goal is likely to be reached.

## IV. Progress

1. **Progress to this date, if case has begun.** Includes perceptions of clinician, client, other parties.
2. **External Monitoring:** What monitoring is already in place, or recommended. What reports or contacts must clinician provide, when, and to whom.
3. **Results or actions expected in the short-term.**
4. **Any changes to treatment plan** recommended or taking place, and the rationale.

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Clinician: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: / /

Client Name: \_\_\_\_\_ Date: / /