Individualized Action Plan

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards must demonstrate active participation of the person served and/or his or her parent/guardian. The title "Individualized Action Plan" has been identified for use to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

The form has been designed using components, which can be combined to capture the total number of goals and objectives identified. The components include a goal section with corresponding objectives, as well as a page that provides space for additional necessary information such as other agencies/community supports and resources supporting the IAP and a medication list (mandatory for outpatient substance use counseling only). In addition, a section is provided at the end of the plan to specify the Transition/Level of Care/Discharge Plan. While this may be new to some users, it is in fact a mandatory element of the treatment planning process.

Two versions of the IAP form are available: a condensed version and an expanded version. Both contain identical information but are formatted differently to suit the needs of various persons who may be completing the form. The condensed version is organized with one goal and two corresponding objective spaces all on one page. The user can use as many of this page as necessary to capture the total number of identified goals. The expanded version, which provides larger spaces, breaks the goals and objectives into two separate pages that are used in conjunction for each identified goal. Again, as many pages as necessary should be used to capture the total number of identified goals and objectives. (The "objective sheet", which provides space for three objectives can also be used as necessary with either version if more space is needed for additional objectives). The final page for both versions is the same. Once all goals and objectives are completed and the final page added, the total number of pages should be counted and page "x" of "y" should be indicated in the header of each page.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
***Person's Name:**	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
***Record Number:**	Record agency's established identification number for the person.
***D.O.B:**	Document date of birth of the person served.
Organization Name	Record the organization for whom you are delivering the service.
Date of Admission:	Record date the person served was admitted.
Date Plan Initiated:	Record date that the IAP was initially developed, including month, date, and year. This is the date that the person served signs the plan.
Plan Completed by:	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.

Data Field	Goals/Desired Results/Target Date Instructions
Goal #:	To identify goals, number sequentially. **Example: Goal # 1** (**Note:** individual programs may have differing requirements as to what components must be included in an Individualized Action Plan/Treatment Plan. Providers should follow contractual and regulatory standards as applicable, i.e. for the CBAT and ICBAT programs, the individual goal sheets can be used for medical, educational, family, etc. goals)
Linked to Assessed Need # ____ from form dated _____:	List the number of the treatment recommendation/assessed need from the date of an approved form. Check off or indicate the other form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendation # 1 from form dated 01/08/07: Comprehensive Assessment**
Start Date:	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date:	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed.

Desired Outcomes for this Assessed Need in Person's Words:	Document in the words of the person served his or her desired outcomes for the assessed need. This statement will be utilized in formulating the goal statement described below and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. **Examples:** • **I want to stop losing my cool all the time!** • **I want to go back to school** • **I want my mom and I to stop fighting** • **I want to stop drinking**
State Goal below in Collaboration with the Person Served:	Reframe the desired outcome stated above by describing the goal from a clinical perspective in collaboration with the person served. Goals should be stated in attainable, behavioral/measurable terms. For some programs or courses of treatment, specific goals may be required (i.e. Tobacco Cessation, Medication Management, mandated treatment, etc.). **Example:** **Reduce the number and intensity of anger episodes at home.**

Data Field	Person's Strengths/Skills/Supports Instructions
Person's strengths and skills and how they will be used to meet this goal:	Document the strengths and skills the person served has that can be used to work towards and accomplish this goal. **Examples:** • **Person served can read at the high school level.** • **Person's family is still very involved and will provide support for medication management, transportation, and opportunities for socialization.** • **Person has group of close friends from residence with which he can socialize.** • **Person served currently works in a fast food restaurant and can follow fairly complex instructions.** • **Person served is healthy and is not on any medications for medical conditions.**
Supports and Resources needed to meet this goal:	List supports and resources that will be needed to accomplish the goal. Include natural and community supports as well as cultural and linguistic needs of the person and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. **Examples:** • **AA meetings, Church, community support meetings** • **An interpreter, written materials in another language** • **Meeting space in an area accessible by wheel chair** • **Peer support worker**
Potential Barriers to meeting this goal:	Record any potential barriers to meeting the goal, which the person served identifies or that were identified while developing the IAP. **Examples:** • **Person served does not have drivers license** • **Person served does not have a stable recovery environment**

Data Field	Client Review/Goal Agreement Instructions
Person's Initials:	Person served should initial each goal and objective sheet to document active participation in development of the plan.

Data Field	Objectives Instructions
GOAL # ___	Identify the number of the goal to which the objective applies. **NOTE:** In the condensed version, two objective spaces are automatically attached to each identified goal and this space is not provided. This data field must be completed when the objective sheet is utilized to tie it to its corresponding goal.

OBJECTIVE # ___	Number each objective sequentially and link to the appropriate goal **Examples:** • **Goal #1/Objective #1** • **Goal #1/Objective #2**
(OBJECTIVE):	Describe in measurable terms an objective that will assist the person served in reaching the identified goal. NOTE: In the condensed version there are two spaces provided per goal page. If additional objectives are needed for a specific goal insert an additional objectives sheet. **Examples:** • **Average number of anger episodes will decrease from 10 to 5 per week.** • **Identify and attend an after-school recreational program.** • **Demonstrate competency in using public transportation to get to MD appointments.**
Start Date:	The date the work on this objective will start.
Target Completion Date:	Record the date by which the person served would like to accomplish the objective or the date by which the person served and provider(s) believe the objective can be completed.
Person Served Will:	Indicate the specific actions the person served will take to support achievement of the stated objective. **Examples:** • **Person will ask mother to assist in monitoring number of angry outbursts per week.** • **Person served will talk with guidance counselor about available after-school programs.** • **Person served will attend weekly group on using public transportation.** • **Person served will determine if he is eligible for VA benefits by calling local VA.** • **Person will ask guardian for permission to explore self-management of an allowance.** • **Person served will get a psychiatric assessment to determine if he has ADD.**
Parent/Guardian/ Community/Other Will	Indicate the actions/support the parent/guardian/community/ others will provide to assist the person served in accomplishing the objective. If family or other involvement is not clinically indicated, check box. **Examples:** • **Mother will record number of angry outbursts of the person served per week on calendar.** • **Father will contact local YMCA for a catalog of available programs.** • **Guardian will accompany person on trip to the store via public bus.** • **Daughter will work with father to find VA telephone numbers.** • **Clubhouse Director will provide guardian with educational materials about money management.** • **Father will sign necessary permission forms for stepmother to be able to bring person served to medication appointments.**

Data Field	Interventions and Service Description Instructions
Intervention(s)/Method(s):	Describe the actual therapeutic or rehabilitative interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "Individual Therapy" alone. The statement should be descriptive of the actual methods).* **Examples**: • **Teach/build anger management skills.** • **Help person identify strengths and interests.** • **Use CBT to assist person served in identifying negative/automatic thought**

	patterns regarding use of public transportation. • **Connect person served to available community resources.** • **Work with person and guardian to identify how they will know person served is ready to manage his own money.** • **Complete referral for medication evaluation.**
Service Description/ Modality:	Indicate the types of services the person will receive. Because this is a comprehensive plan this may not necessarily be a behavioral health service. **Examples:** • **Family Therapy** • **Individual therapy** • **Couples therapy** • **Group therapy** • **Psychopharmacology** • **Case management**
Frequency:	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines. **Examples:** • **Daily** • **.5 hours Weekly** • **Bimonthly** • **4 hours per week**
Responsible: (Type of Provider)	Indicate the credential or title of the program staff, not the specific individuals, that are responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Psychiatrist** • **Nurse** • **Therapist** • **Community Support Staff** • **Case Manager**

Data Field	Identifying Information/Agencies Instructions
Other Agencies/Community Supports and Resources Supporting IAP:	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported". **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Medication Information
Medications as Reported by Person Served on Date of IAP:	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication. Check if "None Reported".

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, checkboxes have been provided. Check all that apply and document evidence, which supports or describes any criteria checked. Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Other: placement in a longer-term treatment program • Reduction in symptoms as evidenced by: client self-report that withdrawal discomfort has decreased • Services are no longer medically necessary as evidenced by: scores on the CIWA or COWS assessment • Other: completion of program and appointment with outpatient substance abuse counselor • Attainment of higher level of functioning as evidenced by: ability to manage his or her own medications • Attainment of higher level of functioning as evidenced by: person is no longer at a risk to self or others and is able to agree upon and follow a contract for safety

Data Field	Signatures/Confirmation Instructions
Person's Signature:	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date:	Date of person's signature.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Client's Initials to confirm:	Person should initial to document that he or she has been offered a copy of the IAP, and either accepted a copy or elected not to receive a copy of the Treatment Plan.
Parent/Guardian Signature:	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if "N/A".
Date:	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legible** signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor's Signature/Credentials	**Legible** signature and credentials of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Physician Signature/Credentials:	**Legible** physician's signature and credentials if required by agency policy. Please note certain payers do require physician's signature. Check if "N/A".
Date:	Date of this signature.