Individualized Action Plan: Detoxification

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 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 Detox Plan documents the Individualized Action Plan for persons in detoxification programs and should be completed per program protocol by the person or person(s) responsible for planning and delivering care. The form design is based on the **American Society of Addiction Medicine's** (**ASAM**) Patient Placement Criteria and includes six standardized dimensions. The form is designed to incorporate these specific treatment components into the development of individualized action plan.

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 the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number:	Record your 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 of admission.
Anticipated Discharge Date:	Record anticipated discharge date of the person served.
Date Plan Initiated:	Record date the IAP was initially developed, including month, date, and year. This is the date 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	Linkage and Desired Outcomes Instructions
Linked to Assessed Need(s) # ____ from form dated _____:	List the number of the treatment recommendation/assessed needs from the date of an approved form. Check or indicate the *Other* form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendations # 1 and 2 from form dated 01/08/07: Assessment**
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(s). This statement will be utilized in formulating goals and objectives 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 drinking.** • **I need to find a positive recovery environment.**

Data Field	Treatment Area Goals/Objectives/ Interventions Instructions
Treatment Area:	Check if the treatment area for each dimension is considered Active, Referred, Monitoring, or Not Clinically Appropriate. • Active means this area will be addressed during the treatment episode. • Referred is for problems that will not be addressed during the treatment episode, but are issues the clinician will assist the person with as part of the continuing care process. Example: Making an appointment for outpatient mental health treatment for after the person has left the program. • Monitoring means there is a treatment issue that will not be directly addressed during this treatment episode, but will be monitored while in treatment. Example: The nursing staff is monitoring the person's diabetes during treatment. • Not Clinically Appropriate means the treatment area is not applicable or appropriate at this time and no action will be taken.
Goal Target Date:	Record the anticipated date the person will attain his or her goals.
Adjusted Target Date:	A revised goal target date in the event that changes need to be made with the original anticipated goal target date. The rationale for changes to the goal target date is to be documented in the progress note.
Goal:	Check the appropriate box that lists the goal in each treatment area. Each goal section has space that allows the provider to create an individualized goal for the person.
Objectives:	Check the appropriate box that lists the objectives in each treatment area. The objectives are designed to assist the person with meeting the goals in each treatment area. Each objective section has space that allows the provider to create an individualized goal for the person.
Therapeutic Intervention(s)/Method(s):	Describe the actual therapeutic 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 relapse prevention skills.** • **Help person identify strengths and interests.** • **Use CBT to assist person served in identifying triggers .** • **Connect person served to available community resources.**
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.
Responsible: (Type of Provider)	Indicate the credentials and title of the program staff, not the specific individuals 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:** • **Internal Medicine** • **Nurse** • **Therapist** • **Case manager**

Data Field	Client Review/Goal Agreement Instructions
Person Understands?	The person served indicates whether or not he/she understands the goal and a mark is placed in the appropriate checkbox. If the person served does not understand, an explanation should be written in a progress note for the date of the IAP.
Person Agrees?	If the person served agrees with goal check *Yes*. If the person served does not agree with goal, check *No* and document the content of the discussion and outcome in a progress note on the date of the IAP.
Person's Initials:	Person served should initial to document active participation in goal development.

Data Field	Person's Strengths/Skills/Supports Instructions
Person's Strengths and Skills and How They Will be Used to Meet Goals:	Document the strengths and skills that can be used towards accomplishing the goals. **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 whom 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 Goals:	List supports and resources needed to accomplish goals. Include natural and community supports; 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 Goals:	Record any potential barriers to meeting goals, which the person served identifies or were identified in the development of the Individualized Action Plan. **Examples:** • **Person served does not have drivers license.** • **Person served does not have a stable recovery environment.**

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the anticipated date transition/discharge based on the person's belief of when the criteria for such transition would be met, and/or on the provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Check all that apply and document evidence, which supports or describes any criteria checked.

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 has either accepted a copy or elected not to receive a copy.
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:	**Legibly** record the 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 signature.
Supervisor's Signature/Credentials	**Legibly** record the signature and credentials of the supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Record the date of signature.
Physician Signature/Credentials:	**Legibly** record the physician's signature and credentials if required by agency policy. Please note that certain payers do require a physician's signature. Check if *N/A*.
Date:	Record the date of signature.