Kennebec BEHAVIORAL HEALTH
Mental Health and Substance Abuse Specialists
Improving lives with effective, innovative care

Policy Number: 4032
Subject: Treatment Plan, ISP or Service Plan

Policy:
KBH personnel develops a Treatment or Service Plan for all child and adult clients receiving services. The Treatment or Service Plan is person-centered, diagnostic, and developed with the participation of clients and/or their guardians. For child and adolescent clients, the plan is family-centered, youth-guided, and developmentally appropriate.

Purpose:
The purposes of the Treatment or Service Plan are to clarify a plan for addressing client needs, to guide the client's treatment or service, to respect and incorporate the client's own strengths, personal goals, abilities, values, priorities, and preferences, and to provide a basis for measuring progress.

Procedure:
An initial Treatment or Service Plan reflects the client's service needs assessed through an initial comprehensive assessment and early in treatment/service. The initial plan is completed within 30 days of the client starting in the service, with the following exceptions: for substance use disorder treatment, the initial plan is completed within the first 4 sessions; for adult residential treatment (PNMI), the initial plan is completed within 72 hours of admission. Plans are periodically reviewed at a minimum frequency of every 90 days, except for programs in which an approved DHHS Mental Health Licensing waiver allows for less frequent review.

The Treatment and Service Plans must reflect ongoing assessment of the clients' needs, strengths, abilities, priorities, and preferences, and the client's progress on goals. Treatment planning is driven by the client and/or guardian (except in extenuating circumstances when the client and/or guardian cannot participate), and the plan is updated, based on progress and changes in the client's current needs and goals. Participation is demonstrated by the signature of the client and/or guardian, and treatment provider. Staff should attempt to obtain a wet or electronic signature of the client and/or guardian. If, however, this is not possible verbal consent will be accepted in place of a wet or electronic signature. Documentation of this verbal consent needs to be documented in the client record. A copy of the plan is offered to the client and/or guardian.

Coordination:
With the goal of engaging an interdisciplinary team to support the client, KBH personnel invites participation and coordinates with the client's primary care provider, the client's other treatment and service providers, and other parties that the client identifies as care providers, including those that practice culturally traditional native or spiritual care. These parties help to assess the client's medical, psychosocial, emotional, therapeutic, spiritual, cultural, and recovery support needs, and may consult on the Treatment or Service Plan. When adult clients choose to involve family or natural supports, KBH personnel invite those supportive people to support the client's treatment or service goals. Coordination and communication with these parties is done in compliance with HIPAA and other privacy and confidentiality laws, and with Designated Collaborating Organization or other service contracts.

Content: Treatment Plan
The Treatment Plan includes the following key elements, collected by the assigned KBH personnel and informed by the client and/or guardian: A statement of each identified need; long term goals in the client and/or guardian's own statements; short term goals reflecting changes on which the client and/or guardian are focused at the time of the plan; action steps which reflect concrete and specific actions to which the client, guardian, assigned KBH personnel, and others have agreed to take in order to achieve goals. The Treatment Plan also includes a description of the client's strengths, abilities, and preferences that will support progress in treatment.

Each time a treatment or service plan is periodically reviewed with the client/guardian, the assigned KBH personnel includes a description of progress on each goal and action step, changes to the client's overall status, barriers to progress, and shared decision-making. Goals and action steps are ended as they are achieved, completed or closed, and new goals and actions are added to reflect the client's current and prioritized needs and goals. To satisfy regulatory and grantor requirements, additional information may be included in the treatment or service plan, including results of required assessments, updated eligibility criteria, client strengths, needs, abilities and preferences, and rationale for continuing treatment or service. Finally, in each treatment or service plan, information about planning for discharge and/or transition to other recommended services is included, and updated to reflect movement towards discharge or transition.

Related to the client and/or guardian's participation in planning, each of the following exceptions are clearly documented in the client's record as they apply: if the client or guardian does not participate in treatment or service planning; if a client or guardian signature is missing or late; if a copy of the plan is not provided to the client or guardian; or if the client or guardian declines a copy.

Resource Data Summary:
The Resource Data Summary (RDS) is a standardized assessment tool that collects data for Maine's Department of Health and Human Services (DHHS) related to unmet needs of clients. Completion of the RDS is required for all clients receiving Community Supports Services, as defined by Maine's DHHS and Maine's Division of Regulatory and Licensing Services, each time a treatment or service plan is reviewed. Not only does the tool help to identify unmet needs which may inform the treatment or service plan, but also informs Maine DHHS regional support of Community Supports Services.

Policy Revision History:
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