Individualized Action Plan: Psychopharmacology

This form is designed to be used for Individuals who are receiving psychopharmacology services only. This IAP-Psychopharmacology form only is to be completed by the primary provider of psychopharmacology services.

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 (this information can be included in the "Intervention(s)/ Method(s)/ Action(s)" section). For JCAHO include interaction with the criminal or juvenile justice system if applicable. (This information can be included in the "Supports, Resources, Organizations, & Individuals Needed to meet this Goal" section.)

Note: For Chemical Dependency programs, the IAP-Psychopharmacology Plan can only be used in Methadone Medical Maintenance Programs.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record Number, and D.O.B. must be completed on each page)
Organization Name/ Program Name:	Record the name of the organization and program providing the service.
Individual's Name:	Record the first name, last name, and middle initial of the Individual being served.
Record #:	Record your agency's established identification number for the Individual.
D.O.B:	Document date of birth of the Individual served.
Date Plan Initiated:	Record the date the Individual served and provider(s) will begin to work on these goal(s).
Target Completion Date:	Record the date by which the Individual served would like to accomplish the goal or the date by which the Individual served and provider(s) believe the goal can be completed. This indicates the anticipated duration of treatment.
Adjusted Target Date: **As per IAP Review/Revision or Progress Note dated:**	**Documentation of an adjusted target date is based on agency policy in either the IAP Review/Revision form or Progress note** Record the new target date for the completion of the goal. For example, if the team decides at a review that the goal needs to be continued beyond the initial target completion date, the new target date would need to be indicated. Record the date of the review/revision or the progress note when the target completion date was adjusted.

Data Field	Goals, Objectives, and Interventions Instructions
Desired Outcomes in Words of the Individual Served:	Document the goal in the words of the Individual served. This should reflect his or her desired outcome and can be used as a benchmark by the Individual 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 me to stop fighting.**
Goal #: **Linked to Assessed Need #_____ from form dated _____:**	Check the appropriate goal(s) in the list provided to indicate the desired outcomes of the Individual served (family/guardian as appropriate), or check *Other* and specify the goal. Indicate the assigned number associated with the assessed need. Specify the name and date of the form that identified the assessed need.
Objectives:	Check the appropriate objective(s) that will help the Individual served reach his/her identified goal(s), or check *Other* and specify the objective.
Individual's Strengths and Skills That Will be Utilized to Meet This Goal:	Document the strengths and skills that can be used to work towards accomplishing the Individual's goals. **Examples:** • **Individual is medication compliant.** • **Individual is able to self- administer medications.**
Supports, Resources, Organizations, & Persons Needed to Meet This Goal:	Document the supports, resources and collateral persons available to support the Individual served in accomplishing his/her goal. ***Examples*** • **Individual attends individual therapy on a bi-weekly basis at the Holbrook Mental Health Clinic.** • **Individual's family is still very involved and will provide support for medication management.**
Therapeutic Intervention Methods, Provider, Frequency, and Duration:	Check the appropriate Therapeutic Intervention Methods and corresponding Provider(s), Frequency, and Duration of services for each intervention. If a therapeutic intervention is not listed, check *Other* and list.
Data Field	**Referrals, Rationale, and Response Instructions**
Referrals/Additional Evaluations:	Check box(s) that best identifies additional assessment needs of the Individual served or check O*ther* and list the additional assessment needed. Check none required as applicable.
Explained rationale, benefits, risks and treatment alternatives to/for the Individual?	Check *Yes* to indicate that the rationale, benefits, risks and treatment alternatives contained in the Individualized Action Plan: Psychopharmacology were explained to the Individual served (parent/guardian/other as appropriate).

Data Field	Methadone Program Information Instructions
Methadone Programs Only – Attendance Schedule/Daily Dosage	For Methadone Programs only, document the attendance schedule and dosage of methadone.
Data Field	**Transition Discharge Criteria Instructions**
Transition/Discharge Criteria: How Will the Provider/Individual/ Guardian Know That Level of Care Change is Warranted?	• Transition/discharge planning should begin as early as possible in the treatment process and documentation of the planning is required. Include evidence of attainment of a higher level of functioning. • **Include a brief summary that supports when a level of care change is warranted.** Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Reduction in symptoms as evidenced by: client self-report and staff observation that symptoms have decreased • Services are no longer medically necessary as evidenced by: Individual's ability to function with increased independence. • 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
For COA Programs Only: Estimated length of treatment and stay:	For COA (Council on Accreditation) programs only: Record the date of anticipated transition/discharge based on Individual's belief of when the criteria for such transition would be met and/or provider assessment.
If Individual refuses any part of the plan, describe reason and plan for continuation of services.	Indicate reason for refusal. Document recommendations for follow up services if the Individual served has not agreed to the IAP: Psychopharmacology.

Data Field	Signatures/Confirmation Instructions
Individual has participated in the development of this plan. **Other (s) _____ participated in the development of this plan.**	Indicate if Individual served participated in the development of the plan. If the Individual served did not participate, provide reason. Check Yes or No to indicate if other persons participated in the development of the plan. If Yes, list the names.
Print Individual's Signature:	The Individual served should be given the option to sign the IAP-Psychopharmacology. If the Individual served does not sign, list the reasons and an explanation below.
Date:	Date of this signature.
Print Parent/Guardian Signature:	The parent/guardian/other signature is necessary if Individual served is a minor or an adult who has a legal guardian. This space can also be used for any family/significant other as defined by the Individual served if he/she wishes them involved in process. Check if *Not applicable*.
Date:	Date of this signature.
Print NPP Name/Credentials:	**Legibly** record **NPP**'s signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date:	Date of this signature.
Print Psychiatrist/MD/ DO/ Credentials:	**Legibly** record **Psychiatrist/MD/DO's** signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date:	Date of this signature.
If Applicable, Additional Staff Sign Below:	Any additional staff involved in the development of the IAP-Psychopharmacology plan should legibly record their name and credentials and date. Check if *Not applicable*.