THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Individualized Service Plan (ISP)

PURPOSE: To develop and implement an appropriate method to develop client treatment plans.

POLICY: The development of the Individualized Service Plan will be a collaborative process between the client and service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services.

PROCEDURE:

1. The Individualized Service Plan will be developed with the active participation of the person serviced and
- Is prepared using the information from the primary assessment and interpretive summary
- Is based on the current mental health/AOD needs and desires of the persons served, the family (when appropriate), natural support systems, and other needed services
- Involves the family of the person served, when applicable or permitted
- Identifies any needs beyond the scope of the program
- Specifies the services to be provided by the program
- Specifies referrals for additional services
- Is communicated to the person served in a manner that is understandable
- Is reviewed periodically with the person served for continuing relevance and is modified as needed.

2. The Individualized Service Plan shall document, at minimum, the following:
- A description of the specific mental health and/or AOD needs of the client
- Goals or Anticipated treatment outcomes based upon the mental health and/or AOD needs identified above. Such outcomes shall be mutually agreed upon by the provider and the client. If these outcomes are not mutually agreed upon, the reason(s) needs to be fully documented in the client record
    - These should be expressed in the words of the person served
    - Reflective of the informed choice of the person served or parent/guardian
    - Appropriate to the person's age
    - Based upon the person's:
        - Strengths
        - Needs
        - Abilities
        - Preferences
- Specific service or treatment objectives that are:
    - Reflective of the expectations of the person served and the treatment team
    - Reflective of the person's age
    - Reflective of the person's development
    - Reflective of the person's culture and ethnicity
    - Responsive to the person's disabilities/disorders or concern
    - Understandable to the person served
    - Measurable
    - Achievable
    - Time specific
    - Appropriate to the treatment setting
- Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health/ AOD need and treatment outcome
- Frequency of specific treatment interventions
- Mandated and/or court-ordered treatment

- Evidence that the plan has been developed with the active participation of the client. As appropriate, involvement of family members, parents, legal guardians/custodians or significant others shall also be documented
- As relevant, the inability or refusal of the client to participate in service planning and the reason(s) given
- The signature(s) of the agency staff member(s) responsible for developing the Individualized Service Plan, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable.

3. The Individualized Service Plan must be completed with five sessions or 45 days whichever is shorter.
4. The Individualized Service Plan shall be reviewed at the client's request, when clinically indicated, and/or when a recommended service is terminated, denied, or no longer available to the client.
5. A new Individualized Service Plan shall be written at minimum every twelve months. Beyond the initial five sessions or 45 days (whichever occurs first) time frame allowed for the initial ISP development, there shall be no services rendered in the absence of an ISP.
6. A review of an existing Individualized Service Plan shall occur at regular intervals to evaluate the client's progress. If no progress has been made, the clinician and client should consider if treatment is still warranted or if the Individualized Service Plan should be changed. Evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians/custodians or significant others should be noted. As relevant, the inability or refusal of the client to participate and the reason(s) given should be noted, as well as the date on which the review was completed and the documented evidence of clinical supervision, as applicable.
7. At the completion of an ISP (when the target date has been reached or termination of services is occurring), the clinician shall update whether the client has met or not met each of the goals/objectives as well as the appropriate dates for each and the date of discontinuance of the ISP.

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-27-05; CARF Section 3, Criterion C, 1-3

REVIEWED: February 2018