ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 05/24

CHAPTER		**CHAPTER**	**SECTION**	**SUBJECT**
Service Delivery		03	002	0040
SECTION	**SUBJECT**			
Records	Goal Writing			
WRITTEN BY	**REVIEWED BY**		**AUTHORIZED BY**	
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☐ Community Agency Contractors
- ☐ Residential Programs
- ☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure that Individual Plans of Service/Supports, goals, objectives, and interventions be written in a consistent format and in a manner that reflects Person-Centered Planning; supports self-determination; is strength based; allows for objective measurement of progress; is understood by individuals, families, and support staff; and promotes focused intervention that assists individuals in putting strategies into practice that will help him/her make progress.

III. DEFINITIONS:

A. Goals: The section of the treatment plan where desired outcomes are documented. Goals are statements of what is personally meaningful to the individual; ideas and plans they would like to achieve; they can be short-term or long-term. Goals should be positively stated and behaviorally focused; they should be prioritized with direction from the individual; some goals may be deferred. The goal statement(s) need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures.

B. Intervention Plan: The section of the treatment plan that describes actions to be taken by individuals, formal supports, and natural supports towards achieving identified objectives. Intervention plans describe progressive action steps and environmental prompts used to help individuals move in the direction of their goals. Intervention plans may guide the flow of communication within the family service team, indicating who is responsible to pass along particular information to other team members. Intervention plans may include actions that the individual/family are expected to take towards goal achievement. They should also provide details regarding where interventions will be implemented, who will implement them, when and how often they will be monitored, how they will be documented (use of charts, etc.), who may need to be trained and how that will be facilitated, and the criteria for discontinuance. Intervention plans may identify particular tools or supports that are to be used (e.g., respite, natural supports, etc.) Intervention plans may need to be very detailed and specific, especially when they are written to help others understand and facilitate specific responses to target behaviors and responses to desired

behaviors. There should be at least one intervention for every objective. Interventions should be selected on the basis of the individual's needs.

C. Objectives: The section of the treatment plan where intermediate steps towards goal achievement are documented. These intermediate steps are positively stated, strength based, behaviorally specific, time limited, and measurable. Objectives are generally targeted at perceived barriers to goal attainment and should be achievable within a reasonably short time frame. Objectives provide a mechanism for recognizing progress towards desired goals. In contrast to long term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the individual has achieved the established objectives.

D. Outcome/Plan for the Future: For the purposes of this administrative procedure, the section of the treatment plan that records the desired outcomes expressed by the individual (and family in the case of minor children), in their own words when possible (hopes, dreams and plan for the future). These outcomes do not have to be attainable in the foreseeable future, nor do they have to be measurable. The items expressed in this area, will help formulate the goal(s) and objectives that the individual will work on.

E. Support Plans: A plan to provide assistance for an individual in a necessary targeted area where progress should not reasonably be expected. Support plans can help individuals maintain a skill level in a particular area or assist an individual with necessary activities of daily living that he/she cannot and will not be able to independently complete. Support Plans need to be strength based and individualized. Support Plans should be based on the individual's hopes, dreams and plan for the future.

IV. STANDARDS:

A. Staff who provide treatment to individuals will receive mandatory training in Person-Centered Planning 101 via myLearningPointe and Person-Centered Planning 301. More training in treatment planning is available within myLearningPointe.

V. PROCEDURES:

Treatment Staff

1. Gathers information via formal assessment and the Person-Centered Planning process.

2. Insures that the hopes, dreams, strengths and needs of the individual drive the treatment planning process and documents treatment planning in a manner consistent with agency policy and administrative procedures.

Supervisor/Designee

3. Reviews treatment plans prior to signing off and via clinical supervision or clinical consultation, and insures that treatment plans are written in a format consistent with agency policy and administrative procedures.

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4. Assigns particular myLearningPointe Training for professional staff who are having difficulty with writing a treatment plan (which can include Person-Centered Planning 101 and 301).

VI. REFERENCES:

A. MDHHS Contract

VII. EXHIBITS:

None Available

VIII. REVISION HISTORY:

Dates issued 0/02, 0/04, 10/06, 10/08, 10/10, 08/12, 09/13, 09/13, 09/14, 03/16, 03/17, 03/19, 03/20, 01/22, 03/21, 03/23.