# TREATMENT PLAN UNDER MHL SECTION 9.60

*Article 28 Facilities*

| | | | | |
|---|---|---|---|---|
| Subject of the Petition Name: | | | | D/O/B: |
| *Subject Also Known As :* | | | | Tel: |
| Subject Home/Residence Address | | | | |
| | | | | |
| Physician's Name:, M.D.. | Board eligible: | [ ] | Board certified: | [ x ] |
| Assisted Outpatient Treatment Program Physician Appointed by the Acting/Director of Community Services to | | | | |
| Develop Treatment Plan Pursuant to MHL 9.60 (i) (1) | | | | |
| Date of Treatment Plan: | | | | |

Section 9.60 (a) (1) of the Mental Hygiene Law (MHL) allows the following categories of service to be ordered by the court:

[Required Services]

- Intensive Case Management (ICM)/Assertive Community Treatment Team (ACT) to provide care coordination

[Permitted Services]

- Medication
- Periodic blood tests or urinalysis to determine compliance with prescribed medications
- Individual or group therapy
- Day or partial day programming activities
- Educational and vocational training or activities
- Alcohol or substance abuse treatment and counseling, and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance abuse.
- Supervision of living arrangements
- Any other services within a local or unified service plan developed pursuant to article forty-one of the Mental Hygiene Law, prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicate to result in suicide or the need for hospitalization.

*(Note: ICM/ACT services is required to be a part of a court-ordered treatment plan pursuant to MHL section 9.60 (a) (1); other services may be part of a treatment plan but are not mandatory.)*

**PLEASE COMPLETE ENTIRE FORM**

A. In preparing a treatment plan, the subject of the petition must be given an opportunity to participate actively in developing the plan.

Was the subject of the petition given an opportunity to participate in the treatment plan?

| | |
|---|---|
| YES | NO |

In addition, upon the request of the patient, an individual significant to the patient (e.g. a relative or close friend) may participate in developing the plan.

Did the subject of the petition request that any other person participate in developing the treatment plan?

| | |
|---|---|
| YES | NO |

If yes, were such person(s) given the opportunity to participate?

| | |
|---|---|
| YES | NO |

Please list the name(s) of any individual(s) who participated in the development of this treatment plan:

| | |
|---|---|
| 1. | 2. |
| 3. | 4. |

B. Will medication be included as a category of service on this treatment plan?

| YES | NO |
|---|---|

If the answer is yes, the **MEDICATION WORKSHEET** must be completed.

C. Will alcohol or substance abuse counseling, treatment, or testing is included as a category of service?

| YES | NO |
|---|---|

If the answer is yes, the **ALCOHOL AND SUBSTANCE ABUSE WORKSHEET** must be completed.

D. For all categories of service, other than medication, please list below the category of service. Add additional sheets of paper, if necessary.

| **Category of Service(s)** | **List of Provider(s):** |
|---|---|
| [ ] Intensive Case Manager<br>[ ] Supportive Case Manager<br>[ ] ACT Team<br>Frequency: [ ] weekly<br>[ ] 6 times per month<br>[ ] Contingency see below* | Organization Name<br>Contact Person:<br>Tel:<br>Address: |
| 1a. ICM/ACT Supervisor's Info**:** | Name<br>Tel: |
| ** *Contingency*: | *[ ] ICM Service Pending*<br>*[ ] ACT Service Pending* |

| | |
|---|---|
| 1. Medication Management<br>Frequency: [ ] bi-weekly [ ] monthly | Organization Name<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 2. [ ] Partial Hospital Program (PHP)<br>Frequency: 5 day(s) per week *(6 week program)*<br>[ ] Contingency (see below) **<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |
| ** *Contingency*: | *To be determined by Partial Hospital Program, upon completion (6weeks).*<br>• *Continuing Day Treatment*<br>• *Individual/Group Therapy*<br>• *MICA Day Treatment* |

| | |
|---|---|
| 3. select all that apply:<br>[ ] MICA Continuing Day *(Substance Abuse Counseling)*<br>[ ] Continuing Day Treatment<br>[ ] Continuing Day Treatment *(Substance Abuse Counseling)*<br>[ ] Individual/Group Therapy<br>[ ] Individual/Group Therapy *(Substance Abuse Counseling)*<br>Frequency:_____day(s) per week<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 4. select all that apply *(MICA use only)*:<br>[ ] Toxicology<br>[ ] Breathalyzer<br>Frequency: at least once per month<br>[ ] N/A | Organization Name:<br>Contact Person: a<br>Tel:<br>Address: |

| | |
|---|---|
| 5. [ ] Medication Monitoring for<br>_____<br>Frequency: at provider's discretion<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address |

| | |
|---|---|
| 6. [ ] Vocational Rehabilitation *(Workshop/IPRT)*<br>[ ] Drop-in-Center<br>Frequency: _____ day(s) per week<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 7. [ ] Psychosocial Rehabilitation<br>*(Clubhouse)*<br>Frequency:_____ day(s) per week<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 8. [ ] Psychiatric Rehabilitation *(IPRT)*<br>*Substance Abuse Counseling*<br>Frequency:_____ day(s) per week<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 9. [ ] ECT<br>Frequency:_____ day(s) per week<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address: |

| | |
|---|---|
| 10. select all that apply:<br>[ ] Supervised Residence<br>[ ] Supportive Housing<br>[ ] Other: _____<br>[ ] Contingency*** see below<br>[ ] N/A | Organization Name:<br>Contact Person:<br>Tel:<br>Address |
| *** Contingency, select one* | *[ ] Subject is pending acceptance to a Supervised Residence.*<br>*[ ]Subject is pending acceptance to a MICA Residence.*<br>*[ ] Subject is pending transferred to New Residence/Housing.*<br>*[ ] Subject is pending transferred to Family Residence.*<br>*[ ]Subject will be transitioning to his/her home.* |

Please indicated if client is currently:

| |
|---|
| Working [ ] Fulltime [ ] Part-time [ ] n/a |
| Enrolled in School [ ] Fulltime [ ] Part-time [ ] n/a |

## MEDICATION WORKSHEET

1. List all types of classes of medications recommended to provide maximum benefit to the subject of the petition (e.g. Antipsychotics, antidepressants, Mood Stabilizers, Anxiolytics, Antiparkinsonians). Please mark all that apply.

| | |
|---|---|
| | Antipsychotics |
| | Antiparkinsonians |
| | Mood Stabilizers |
| | Antidepressants |
| | Anxiolytics |

2. List each medication recommended to provide maximum benefit to the subject of the petition, the dosage, frequently, and route you anticipate prescribing, and whether self-administration or administration by authorized personnel is recommended for each medication. Whenever possible, indicate contingencies/alternatives.

| MEDICATION | CLASS | RANGES | | | ADMINISTRATION | |
|---|---|---|---|---|---|---|
| a) | | | up to | | Self [ ] | Personnel [ ] |
| Current Dosage: | | | | | | |
| Alternative: [ ] * | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| b) | | | up to | | Self [ ] | Personnel [ ] |
| Current Dosage: I | | | | | | |
| Alternative: [ ] * | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| c) | | | up to | | Self [ ] | Personnel [ ] |
| Current Dosage:y | | | | | | |
| Alternative: [ ] * | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| d) | | | up to | | Self [ ] | Personnel [ ] |
| Current Dosage: | | | | | | |
| Alternative: [ ] * | | | | | | |

## ALCOHOL/SUBSTANCE ABUSE WORKSHEET

1. List the subject's alcohol abuse and or substance abuse diagnosis (es):

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|---|
| |
| |

2. What treatments and/or counseling to address alcohol and/or substance abuse are recommended for this subject?

| TYPE OF SERVICE | FREQUENCY/DURATION |
|---|---|
| 1. | |
| 2. | |
| 3. | |

3. If alcohol testing (blood level and/or breathalyzer) is recommended:

| |
|---|
| a) Does this subject have a history of alcohol abuse that is clinically related to his/her mental illness? _____If yes, state facts that support this conclusion: |
| |

| |
|---|
| b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or others? _____ If yes, state facts that support this conclusion: |
| |

4. If testing for illegal substance (blood or urinalysis) is recommended:

| |
|---|
| a) Does this subject have a history of substance abuse that is clinically related to his/her mental illness? ___ If yes, state facts that support this conclusion: |
| |

| |
|---|
| b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or others? _____ If yes, state facts that support this conclusion: |
| |

***[Note: Treatment/Medication as identified herein may be modified if deemed clinically appropriate by Service Provider and with the approval of the AOT Team for said County.]***

_____ _____

Physician's Signature Date

**PLEASE NOTE:** *The following clinical information is now required by New City Department of Health and Mental Hygiene to be incorporated as part of an initial/re-petition investigation for entry into AOT Program. Therefore, there may exist additional clinical risk assessment data pertinent to this client in other sources of information.*

| 1. **History of Suicidal Ideation** *(e.g., serious threats of suicide or self-harm, intention, planning, or other ideations).* |
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| |

| 2. **History of Endangering Self** *(e.g., suicide attempts, gestures, other physical abuse towards self, failure to care for self).* |
|---|
| |

| 3. **History of Homicidal Ideation** *(e.g., serious threats of harm towards others, intention, planning, or other aggressive/homicidal ideations).* |
|---|
| |

| 4. **History of Endangering Others** (*e.g., homicidal and assaultive behavior, other physical abuse, sexual abuse, fire-setting).* |
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| |

Note: If necessary, please add additional pages for comments.