Enhancing Concurrent Capability Toolkit
Integrated Treatment Planning
Quick Reference Sheet

Creating a Treatment Plan

What is a treatment plan?

Treatment plans:

- Are based on screening and assessment information
- Identify the person's most important long-term and short-term goals for wellness and recovery through collaboration with the family
- Describe **SMART** goals—**S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**ime-limited
- Reflect a verbal agreement between the clinician and the client

A treatment plan is an evolving document. The treatment plan must be reviewed and adjusted as goals are met, new information is acquired, or the person's status changes.

Treatment plans are also called:

- Care plans
- Service plans
- Goal plans
- Recovery plans

Effectively developing an integrated treatment plan means more than just filling out a piece of paper. It requires careful thought and collaboration with the person and their family, as well as other team members, agencies, programs and services.

What is included in a treatment plan?

Treatment plans include:

- Name of the person who the plan is about
- Names of the clinician and any others involved in the person's care
- Date of treatment plan
- Presenting issues
- The person's goals for wellness and recovery
- Specific actions to support recovery (such as employment, recreation, exercise, suitable housing, peer-support worker, skill building)
- Specific therapies and approaches prescribed (such as medication, cognitive behavioural therapy, dialectical behaviour therapy, motivational interviewing)
- Other agencies or programs involved with the person
- Anticipated length treatment and frequency of contact with the person
- Potential challenges
- Consent of the person to share this information, as necessary
- Signature of the person and clinician, indicating they both agree to the plan
- Timelines for review of the plan (monthly, weekly)

Suggested activity

1. Have each team member collect the plans, templates and tools you use for people seeking treatment.
2. Compare each tool against the list above and have them decide which components are the same and which are different.
3. Identify which components could be added to the list or any that could be added to the tools you are already using.

Excerpt from: **Enhancing Concurrent Capability Toolkit: Integrated Treatment Planning**

Concurrent Capable Practice Supports, Practice Supports & Provincial Partnerships
Provincial Addiction & Mental Health

Alberta Health Services

The Components of a Person-Centred Treatment Plan

(adapted from Mueser et al., 2003 and Center for Substance Abuse Treatment, 2006)

Acute safety needs	Determines the need for immediate acute stabilization to establish safety prior to routine assessment
Severity of concurrent disorder	Determines the most appropriate setting for treatment (see the Quadrant Model, as seen in the "Comprehensive Assessment" chapter)
Appropriate care setting	Determines the client's program assignments (see the ASAM Patient Placement Criteria, 2015: http://www. asam.org/ publications/the-asam-criteria/about)
Diagnosis	Determines the recommended treatment intervention
Disability	Determines case management needs and whether an enhanced level of intervention is required
Strengths and skills	Determines the areas of prior success around which to organize future treatment interventions and determines areas of skill-building needed for management of either disorder
Availability and continuity of recovery support	Determines whether continuing relationships need to be established and whether existing relationships are able to provide contingencies to promote learning
Cultural context	Determines culturally appropriate treatment interventions and settings
Problem priorities	Determines specific problems to be solved and opportunities for contingencies to promote treatment participation
State of recovery/Client's readiness to change	Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness to change