Integrated treatment planning

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Introduction

How was this toolkit chapter created?

The content for this chapter was developed following a literature review and discussions within Alberta Health Services to establish what resources were available and what needed to be included for Addiction and Mental Health (AMH) related to integrated treatment planning. A number of relevant websites were reviewed related to specific addiction and mental health associations and organizations. Content was validated by a variety of stakeholders, who were part of a provincial reference group and AMH clinical network. Representation on these committees was inclusive of the various zones and provincial sectors representing Addiction and Mental Health.

We would like to acknowledge the work of the participants who helped create this resource and are grateful for their valuable contributions.

We are committed to matching toolkit content to the needs of the people who will be using it. We welcome any feedback, questions or suggestions for additions or revisions to the content. We wish to learn from the experiences at the front line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@ahs.ca

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Learning objectives

This chapter will focus on the practical applications of integrated treatment planning practices for managers and front-line staff that can be applied to all scenarios. You will learn how to develop an integrated treatment plan and consider how to improve integrated treatment planning in your practice.

As with other chapters in this toolkit, we have tried to keep the main part of the chapter brief. If topics are of further interest to you, there is detailed information available in the appendices. Throughout the chapter, you'll find suggested activities and resources to assist in developing an integrated treatment plan.

The following topics are covered in this chapter:

- What is integrated treatment planning (ITP)
- Integrated treatment planning as part of clinical decision-making
- Goals of integrated treatment planning
- Elements of an integrated treatment plan
- The steps in developing an integrated treatment plan
- Using motivation-based treatment techniques and setting SMART goals
- The bigger picture of integrated treatment planning

Terms and definitions

For the purposes of this chapter, the following terms and definitions will be used:

Family: Persons who are related in any way (biologically, legally or emotionally), including immediate relatives, extended family, partners, advocates, cultural supports, guardians and other individuals identified as being in the individual's support system.

Individual or person: The person, patient or client in question who has a concurrent disorder and who is working with clinicians, family and/or others on recovery, treatment or care. These two terms will be used interchangeably.

Integrated treatment planning

What is integrated treatment planning?

Treatment planning is a collaborative approach with the person experiencing an addiction issue, mental health concern, or both, and their family. It incorporates health-care services, community supports, self-help groups and cultural supports (e.g., elders, cultural support workers) to support recovery outcomes.

An integrated treatment plan should be developed with the person and their family, and in consultation or collaboration with other addiction and/or mental health services. If additional concurrent concerns become apparent during the assessment or treatment planning phases, there should be ongoing consultation and collaboration with all services and clinicians to provide the most appropriate care. Other areas of support that ensure basic life needs are being met should also be part of the coordinated care and treatment plan, such as housing and employment, and cultural and traditional practices.

Broadly defined, integrated treatment is "any mechanism by which treatment interventions for [concurrent disorders] are combined within the context of a primary treatment relationship or service setting" (SAMHSA, 2003). One clinician or treatment team takes overall responsibility for blending treatment and support interventions into one coherent package (Drake et al., 2004).

Historical context for integrated treatment for concurrent disorders

Historically, treatment for substance abuse disorders has been done in isolation from other health-care systems. This forces patients and families to have to choose which system to seek treatment in (Miller et al., 2011).

The concept of integrated treatment was developed to respond to the difficulties clients had when navigating between substance abuse and mental health systems (Drake and Mueser, 2000).

Parallel treatment systems are an issue for people with concurrent disorders. Whether patients are working with hospitals, corrections facilities or community health services, all clinicians and treatment

teams should work together in a coordinated, integrated manner to remove this treatment barrier (CCSA, 2009).

Key messages

Integrated treatment planning is a way of making sure that treatment is seamless, coordinated and comprehensive.

It is inclusive of the person seeking treatment, the person's family members and the clinician and/or treatment team.

Integrated treatment planning works best when the person has a trusting relationship with one case manager (e.g., a health-care professional or therapist) and supports fostering a culturally safe environment. Working with a team of professionals and programs may be required to treat the individual, but one clinician should be responsible for coordinating and overseeing the treatment or recovery plan.

The degree of collaboration may differ for each person depending on their diagnosis, recovery goals and treatment strategies.

Goals of integrated treatment planning

At the service level, the goals for integrated treatment planning are to improve access, quality of care and health outcomes. Overall benefits of integrated treatment planning include

- meeting the person's needs in a timely manner
- reducing the need for the person seeking services to navigate complex health systems
- providing a measure for tracking progress and successes
- providing a forum for engagement with the person and their family
- an opportunity for health professionals to offer information and education
- communicating actions, intentions and goals
- ensuring treatment effectively targets the individual's needs and is strengths-based, building on skills and using available resources
- providing multidisciplinary staff with a common understanding and language about the assessment and treatment planning process

- providing health professionals with the sense that their work is effective and meaningful

Alberta Health Services's **Patient First Strategy** can be applied to working with individuals with concurrent disorders. This strategy strengthens AHS's culture and practices to fully embrace patient- and family-centred care (PFCC).

> This model of care sees [individuals] and families as integral members of the health-care team, and encourages their active participation in all aspects of care, including as partners in planning, implementation and evaluation of existing and future care and services (Alberta Health Services, 2015)

More information about the Patient First Strategy can be found here: http://www.albertahealthservices.ca/assets/info/pf/first/if-pf-1-pf-strategy.pdf.

Other evidence-informed practice for treating concurrent disorders that have been studied and promoted as a best practice include the following:

- **Integrated dual disorder treatment (IDDT) model**

  The IDDT evidence-based practice involves cross-trained practitioners providing integrated, comprehensive services to individuals with concurrent disorders simultaneously in the same venue, with the goal of recovery from both illnesses.

- **Integrated placement and support (IPS) model**

  The IPS model supports employment for individuals with mental illness who want to work in competitive settings.

More detailed information on both of these models, as well as the history of integrated treatment planning, can be found in Appendix 1.

Clinical decision making: Integrated treatment planning

As discussed in the "Standard approach to screening" and "Comprehensive assessment" chapters, screening, assessment and treatment planning can overlap, but they also have unique qualities and follow a progressive timeline. The sequencing of the three activities makes sense, as each process builds on the others (see below). Between each process is a decision point where the clinician, in collaboration with the individual and their family, decides what to do next. For integrated treatment planning, the decision points and the overall process should appear seamless even when multiple clinicians or program areas are involved.

Clinical decision-making process

SCREENING

Identifies the possibility of a problem

Usually done very early, i.e. at initial contact

Outcome is often immediate action (assessment, referral to services)[1]

Universal (all who enter treatment)

Usually brief[2]

Can be self-administered

DECISION POINT ✔

ASSESSMENT

Gathers detailed information about the nature and extent of the problem(s) and strengths

Usually done after the need for assessment has been determined

Outcome is detailed information that forms the base for the treatment plan

More selective and targeted

Usually lengthier[2]

Usually done in person

DECISION POINT ✔

TREATMENT PLANNING

Develop treatment goals, choose interventions or programs to attain the goals.

Monitor progress and adjust treatment plan as needed.

DECISION POINT ✔

1 While assessment may identify immediate needs, it is usually more concerned with longer-term treatment planning and service co-ordination.

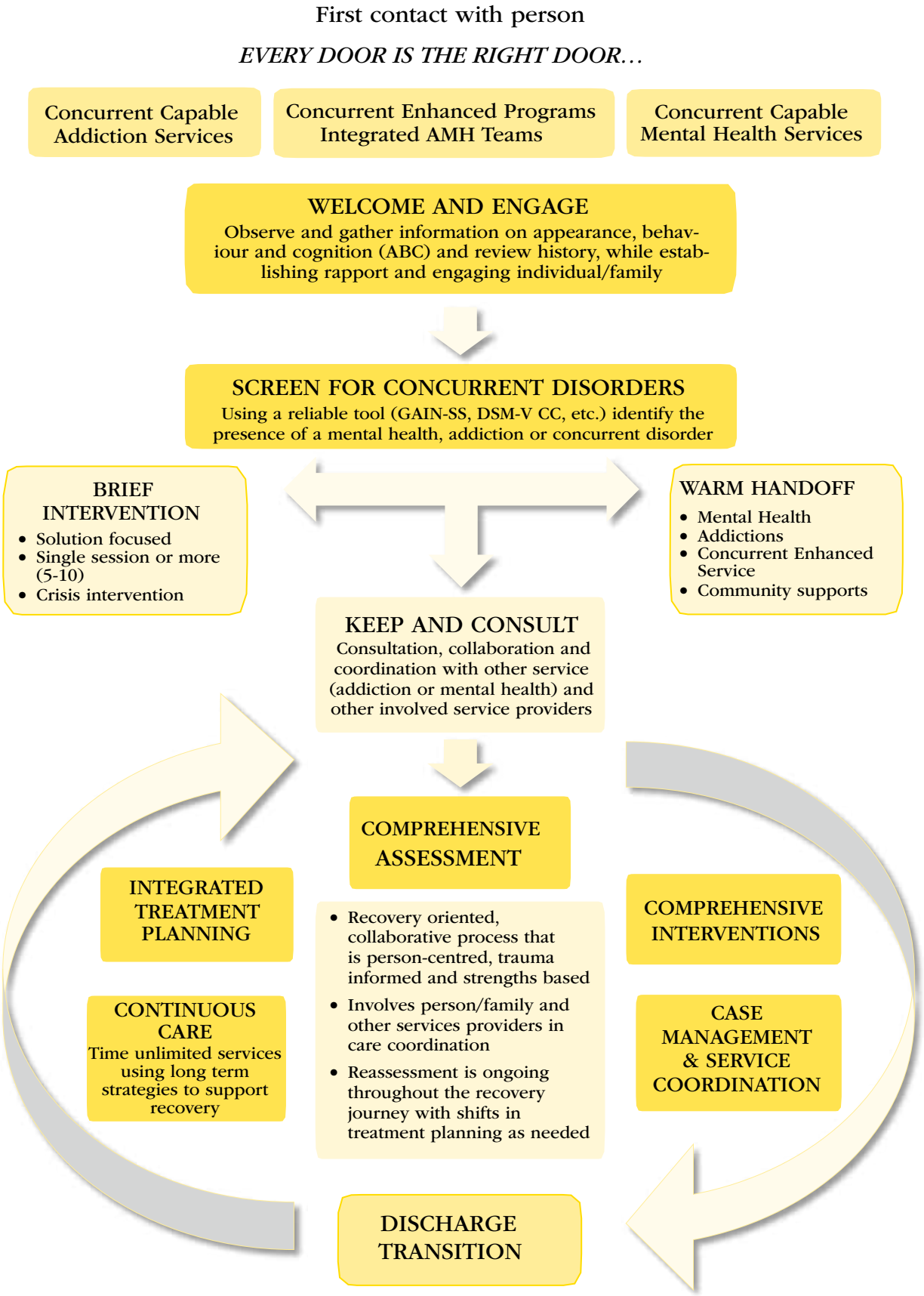
2 Some assessment tools may actually be briefer than some screening tools if the assessment tool focuses only on specific disorders, and the screening tool is multidimensional in its coverage.

Standard approach to concurrent capable practice

The Standard Approach to Concurrent Capable Practice Algorithm outlines a process for delivering concurrent capable care. Developing an integrated treatment plan should be person-centred, trauma-informed and recovery-oriented. It is important to recognize that even though the process has certain steps, it is also cyclical in nature and is a process of ongoing re-assessment and continuous care that changes as goals are met and priorities shift.

Integrated treatment planning requires that clinicians understand when the process requires you to keep and consult with the person seeking treatment, and when to provide a warm handoff to another clinician or program. This decision will be discussed throughout the chapter.

A standard approach to concurrent capable practice



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You're already treatment planning

Integrated treatment planning is done with the person and their family, as well as in consultation or collaboration with other service providers. You must be mindful that you are working with the individual to establish successful recovery outcomes as they identify them. As these goals and needs get identified through a collaborative process, you have already begun thinking about how you can best support them in their recovery journey. You may also begin deciding whether the individual requires additional services that are provided in consultation or collaboration with other services, agencies or programs.

For example, a person recently referred to your program by her family physician for alcohol use discloses that she believes her family is coming into her apartment at night and moving her belongings around to confuse her. She is angry and refuses to see them. You administer the GAIN-SS screening tool and identify the possibility of a mental health disorder.

There are several different outcomes for this person:

First Scenario, ("Keep and Consult"): A risk assessment identifies no immediate safety risk, so the person is admitted to your service for counseling. Based on the GAIN-SS scores and the identification of a mental health disorder, you consult with your mental health colleague and perhaps invite them to attend the next visit to conduct a collaborative assessment with the person and their family. The "consult" part of this scenario means you collaborate and work together to identify the person's wishes, goals and desires for treatment and support them in developing their recovery journey. Sometimes you may be able to consult and collaborate with your colleague by telephone, identifying treatment options and next steps; however, it is important to remember that this involves more than one phone call and should be ongoing as long as the mental-health issues are present.

Second Scenario, ("Warm Handoff"): During your conversation, the person reveals she has a diagnosis of schizoaffective disorder and has not been taking her medications because she doesn't like the way they make her feel. She has not been sleeping, and her appetite and energy

level are low. She says that alcohol helps her fall asleep at night and that she drinks 2–3 times per week. She has had two mental health hospitalizations in the last 18 months. Recognizing that this individual requires more support than your service can provide, you call the mental health office to facilitate a referral. If your zone uses a central intake system, you make the referral and advise that you will stay involved with the client until she is able to assume service. You might even accompany her to their first visit to ensure they connect with the service before discharging her from your caseload.

A warm handoff is more than sending a referral. Here are some tips to make it more successful:

- Meet face to face with the referral agency and the person and their family
- Invite the person to meet at the new office next time
- Develop a collaborative relationship with internal and external community partners
- Call the referral agency and discuss the referral prior to sending the referral package
- Continue to support the person until their initial visit with the referral agency

What is a treatment plan?

A treatment plan is a document that

- is created based on screening and assessment information
- identifies the person's most important long- and short-term goals for wellness and recovery through collaboration with the family
- describes SMART goals—specific, measurable, attainable, realistic and time-limited
- reflects a verbal agreement between the clinician and the client

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

Treatment plans are also called

- care plans
- service plans
- goal plans
- recovery plans

The treatment plan

Treatment plans typically include the following components:

- Name of the person who the plan is about
- Name of the clinician, and the names of any others involved in the person's care
- Date of treatment plan
- Presenting issues
- The person's goals for wellness and recovery
- Actions to support recovery (e.g., employment, recreation/exercise, suitable housing, peer-support worker, skill building)
- Specific therapies and approaches as prescribed (e.g., medication, cognitive behavioural therapy, dialectical behavioural therapy, motivational interviewing)
- Other involved agencies/programs
- Anticipated length treatment and frequency of contact with the person
- Potential challenges
- Consent of the individual to share this information, as necessary

- Signature of the individual and clinician, agreeing to the plan
- Timelines for review of the plan (e.g., monthly, weekly)

Ensuring that an integrated treatment plan is effectively developed 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.

For sample treatment plans, see Appendix 2.

suggested activity

Have each team member collect the treatment plan templates and tools that they use with individuals seeking treatment.

Compare each tool against the list above and have them decide what components are the same and which are different.

Identify any components that could be added to the list or any that could be added to the tools you are already using.

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

Elements of integrated treatment planning

Persons with concurrent disorders come from many diverse groups. There are no universal methods of treatment, because each person, diagnosis, motivation for recovery, and socio-economic and environmental situation is unique (Novotna, 2014).

To help understand the unique nature of integrated treatment planning for persons with concurrent disorders, consider the following key elements:

- Trauma-informed approaches to care
- Recovery focused
- Informed consent
- Evidence-informed practice
- Social determinants of health
- Motivation-based treatment
- Cultural competency and safety

This model of care sees patients and families as integral members of the health-care team, and encourages their active participation in all aspects of care, including as partners in planning, implementation and evaluation of existing and future care and services.

The Patient First Strategy will enable us to advance health care in Alberta by empowering and enabling Albertans to be at the centre of their health care team, improving their own health and wellness.

> "Recovery oriented practice acknowledges the unique nature of each person's journey of wellness and everyone's right to find their own way to living a life of value and purpose in the community of their choice." (Mental Health Commission of Canada, Recovery Guidelines, 2015)

Elements of Integrated Treatment Planning

Element	Description	Tips and resources
Person-centred	A person-centred plan takes into consideration the client's values, cultural preferences, concerns and expectations in order to achieve their identified goals. Shared decision making between the person and clinician works best.	• Use welcoming and engaging strategies to build a relationship with the person that makes them feel safe, comfortable and respected. • The individual, as well as their family, as necessary, should be involved in their treatment planning and identifying goals for recovery.
Trauma-informed approaches to care	Trauma-informed care recognizes that it is common for individuals who use mental health and addiction services to have experienced trauma that may greatly influence their ability or willingness to engage with service providers or programs for help. Trauma-informed care does not require that the person disclose a trauma, but it does mean that service and care providers must use practices based on trauma awareness; safety and trustworthiness; opportunities for choice, collaboration and connection; and strengths-based and skill building (Canadian Centre on Substance Abuse , 2014).	• Build a trusting relationship with the individual by being respectful, honest, clear and responsive. • Listen to the individual's story, acknowledge their emotions and validate their experiences. What is Trauma Informed Care? TIC E-Learning Module A1, MyLearningLink, Alberta Health Services http://mylearninglink.albertahealthservices.ca/elearning/bins/index.asp Canadian Centre on Substance Abuse, Trauma-Informed Care Toolkit www.ccsa.ca//Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf `Registered Nurses' Association of Ontario. Engaging Clients Who Use Substances http://rnao.ca/bpg/guidelines/engaging-clients-who-use-substances

Element	Description	Tips and resources
Recovery-focused	A recovery-focused perspective means that providers and clinicians acknowledge that recovery is a person-driven process that means different things to different people. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2011) defines recovery from mental disorders and substance use disorders as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery might also mean • hope • support • personal responsibility • dignity • education • self-advocacy	• Have the individual identify what recovery means to them. • Recognize that recovery is a journey and is unique to each person. • Quote the person when writing out their goals. • Collaborate and have the individual sign the goals they have set. • Have the person choose the interventions they feel will work for them. Mental Health Commission of Canada, Guidelines for Recovery-Oriented Practice http://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Recovery_Guidelines_2016_ENG.PDF
Informed consent	For individuals with concurrent disorders, their health information and/or treatment plans are often shared with supporting services, clinicians or agencies. Obtaining informed consent means • the clinician and person having a shared discussion identifying what information may or may not be shared with others • allowing the person to ask questions and make a decision about the sharing of information • documentation of the discussion and the decision that was made about sharing information and treatment	• Have the individual sign a consent form outlining that they understand that their treatment plan or other information may be shared with other programs. • Include any specific instructions on sharing information in the treatment plan.

Element	Description	Tips and resources
Evidence-informed practice	Clinically relevant research and best practice treatment approaches should be used to help inform the treatment options that are the most effective, safe and relevant. Clinical expertise may also be required to help guide the development of an integrated treatment plan, bringing clinical skills and past experience to identify and treat each person's unique state and diagnosis.	• Tailor interventions to the motivational level or stage the person is at. • Stay up to date on best practice guidelines and interventions for specific concurrent disorder diagnoses.
Social determinants of health	Clinicians and frontline staff need to understand the social determinants of health[1] and health inequities[2] and how they may affect a client's treatment. Ongoing support in basic life areas, such as income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; gender; and culture helps clients • maintain treatment successes • ensure their basic life needs are being met • prevent relapses	• Ask the individual about possible barriers that might exist for them to access treatment i.e. transportation, availability of food, child care • Consider that addressing basic life needs prior to specific treatment interventions may enable the client to better respond to treatment. • Addressing issues that may otherwise impede successful recovery might include helping the person to secure stable housing, limiting access to money for substance use or helping a client achieve a goal to 'get their driver's license back' in order to overcome transportation issues that might prohibit them from attending treatment services.
Motivation-based treatment	To treat concurrent disorders most effectively, interventions should be related to the person's motivation for change. A person's motivation may change at different stages of treatment for concurrent disorders. An awareness of stage-matched interventions helps guide the person in their treatment options.	• Tailor interventions to the individual's motivational level and stage of change.

[1] The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities (WHO, 2014).

[2] Health inequities are the differences in the health of individuals that result largely from the social determinants of health. They are socially produced (and therefore modifiable), systemic in their distribution across the population and unfair (RNAO, 2015).

Element	Description	Tips and resources
Cultural competency and safety	Cultural competency shows a level of demonstrated professional practice required to provide effective clinical care to patients from a particular ethnic or racial group. It includes behaviours, attitudes, knowledge, skills and policies that can come together on a continuum to reflect the ability of a system, agency, program or individual to provide care to patients with diverse values, beliefs and behaviours. Cultural safety is about power relationships in the health-care setting. It means setting up systems that enable the less powerful to monitor the attitudes and service of the more powerful, to comment freely and without repercussions and ultimately to create useful and positive change that benefits the health-care system and the people we serve (AHS, Aboriginal Health Team, 2015).	• You will never be completely aware of another culture—so be safe with their culture so that they can be safe with yours. • In the health-care environment, service providers are considered to be the more powerful person in the provider-patient relationship. Recognizing this dynamic is an important element of cultural safety, especially for Aboriginal people, who may perceive the hospital or clinic as an intimidating setting. For more information about cultural competency and safety, see Appendix 3.

Cultural Safety and Cultural Competence

> | *suggested activity* | <

Read the following case study and discuss.

A 38-year-old Aboriginal woman with a history of crystal meth use is admitted to addiction services. Within a few days she demands to see her "Elder" and wants to attend a sweat lodge ceremony to be "cleansed." You have connections to the Aboriginal community and can arrange a sweat lodge ceremony in the future. How would you work with this individual? With your team? With the individual's family or community members? What factors need to be considered to ensure cultural safety and competence?

Understanding stages of change and stages of treatment

Recognizing what stage a particular person is at can help you decide which interventions are most likely to be successful at a particular point in their treatment and recovery.

Two models can help with this:

- The Stages of Change Model, which describes the process of behavioural change
- The Stages of Treatment Model, which describes the phases of treatment

The Health of the Nation Outcome Scales (HoNOS) is another instrument that can be used to help clinicians rate a problem's severity. The 12- to 15-item scale was designed for people with mental illness, regardless of diagnosis, and has also been used with those with addictions. It is intended to be easily incorporated into routine clinical work, and to be used to track change over time in key areas of client health and functioning.

Using the above models and scales can help understand where a person is at in both their motivation to change and their treatment, and can assist with integrated treatment planning.

See Appendix 4 for a chart outlining the Stages of Change and Stages of Treatment Models.

See Appendix 5 for the HoNOS Adult tool from Addictions and Mental Health, Alberta Health Services.

The steps to integrated treatment planning

Treatment planning involves combining and integrating information obtained from the first steps of screening and comprehensive assessment into a coherent set of actions with the person, their family members and their treatment team.

The treatment planning process typically occurs at an interdisciplinary case conference, which take place regularly within addiction and mental health teams. These conferences use a collaborative and person-centred approach with a focus on individual strengths and recovery-oriented care.

Participants at case conferences can include

- physicians
- psychiatrists
- allied health professionals
- addiction counsellors
- nursing staff
- support staff
- peer support workers
- person seeking services
- family members/support system
- mental health clinicians/therapists
- community service providers

Example: Weekly case conference at a co-located addiction and mental health outpatient clinic

1. The clinician who completed the intake tasks (screening and assessment) with the person presents a description of them to the interdisciplinary team (in person or virtually) for a case conference. This presentation includes the person's hopes, goals and reasons for accessing services, as well as a list of prioritized and identified needs through screening and assessment.
2. The team discusses best approaches and therapies to help the person achieve their recovery goals.
3. The individual is invited into the case conference to hear the team's

recommendations and to contribute their thoughts and actions that support recovery.

4. After the case conference, a final treatment plan is written by a clinician and co-signed by the person, who receives a copy.
5. At each conference afterward, the treatment plan is reviewed by the team and the individual.

For a sample case conference presentation format template, see Appendix 6.

The clinician's role in treatment planning is

- to identify and prioritize the problem from information gathered from screening and assessment, and present it at the case conference
- to coach the person to identify their short- and long-term goals, strengths and perceptions of the severity of each issue or need
- to support and empathize with the person when they encounter challenges and barriers to achieving their goals
- to celebrate with the person as they take small steps in their treatment plans
- to provide treatment options and interventions that will assist them in meeting their recovery goals
- to review the treatment plan regularly at case conferences to monitor progress and modify, as needed (in collaboration with the person and their family)

In addition, it is your responsibility to ensure that treatment and interventions are delivered to the person in a way that is coordinated and collaborative. Treatment options depend on the services available and the appropriate treatment required.

Mueser et al (2003) suggests that addressing the areas in which the disorders interact has the most promise for improving the outcomes of both disorders.

Key messages

Integrated treatment plans may involve interventions that directly or indirectly address the concurrent disorders.

Treatment needs to be delivered in a way that is coordinated and collaborative. This can often be managed through effective case management, which will be discussed in an upcoming chapter.

Treatment approaches will vary in content, length and degree of ongoing support, depending on the person's needs and motivation level.

A person may exhibit symptoms that may be perceived as cultural, and that may require further exploration.

"Effective [concurrent disorder] programs combine mental health and substance abuse and addictions interventions that are tailored for the complex needs of clients" (Substance Abuse and Mental Health Services Administration, 2009).

The implementation of a treatment plan should be regularly reviewed, revised and updated as necessary, with the individual celebrating small steps toward their goals.

For more detailed steps in planning, see the treatment planning checklist developed by the Addiction Technology Transfer Centre Network: http://www.nattc.org/aboutUs/blendingInitiative/matrs/CHECKLISTMATRS.pdf

> *"Focusing on inherent and diverse strengths and abilities of each person, rather than deficits or limitations, motivates people to feel good about themselves and builds confidence and resilience while helping people take action towards achieving their goals" (Mental Health Commission of Canada, 2015)*

Setting SMART goals

How do we develop goals and objectives that meet a person's motivation for recovery? One way is by developing SMART goals as part of an integrated treatment plan (Addiction Messenger, 2006 and Meyer, 2003).

Smart Goals

Smart goals are:	Description	Answers questions
S – Specific	• Make objectives and interventions that are specific and goal-focused to allow you and the individual to note progress. • Target specific behaviours that can help the person reduce symptoms and improve functioning.	What? Why? Who? Where? Which?
M – Measurable	• Measuring progress helps you, the individual and other staff members stay on track, reach target dates and experience the achievement of continued effort that is required to reach the ultimate goal. • Allows you and the individual to document change. • Provides a means of holding you, the individual and other staff members accountable.	How much? How many? How will we know the goal is accomplished?
A - Attainable	• Goals, objectives and interventions are achievable during treatment. • Focus on "improved functioning" rather than the "end" of the individual's problem. • Identify those goals that can be attained given the level of care provided, the individual's motivation and services and support available. • Revise objectives and interventions as needed when the individual moves from one level of care to another.	How can the goal be accomplished? How realistic is the goal?
R – Relevant	• Objectives are realistic and practical. • Goals and objectives are achievable, given the individual's environment, support system, diagnosis and level of functioning. • There is a good understanding of the steps the person can take on their own behalf to achieve their goals.	Does this seem worthwhile? Is this the right time? Are the right people involved to support the goal?
T – Time-limited	• Sets a target date on the goals and objectives. • Ensures review and evaluation of progress towards the goals, objectives and interventions and allows for modifications to be made in a timely manner.	At what point will the goals be achieved (e.g., today, six months from now)?

Writing SMART goals

Working with a partner, or on your own, read the case study provided and write two or three SMART goals as if you were working in collaboration with the person involved.

Remember, SMART goals are:
S – Specific
M – Measurable
A – Attainable
R – Relevant
T – Time-limited

Case study:

Jody is a married, 40-year-old woman who was recently admitted to your program. Jody says she would like help reducing her alcohol intake and to have a better relationship with her children and husband. Jody is currently prescribed Cymbalta (30 mg daily) by her family physician for anxiety, which she has been taking for the last year. She smokes one half of a pack of cigarettes daily and takes medication for hypertension.

Jody reported feeling fearful, nervous, irritable and stressed, with problems sleeping.

Jody disclosed drinking a bottle of wine daily since going on long-term disability one year ago.

She has been admitted to detox on two prior occasions; the last time was one year ago. Jody acknowledged that she did not complete treatment, nor did she follow through with recommendations that included counselling through Adult Addiction Services.

Jody disclosed having thoughts of suicide a year ago before she was last admitted to detox, when she thought about taking an overdose of the Cymbalta she had just started in combination with alcohol.

Jody has never attempted suicide and reports no history of self-harm behaviour. Her husband is threatening to leave her and take the children.

SMART goal #1

_____

_____

SMART goal #2

_____

_____

SMART goal #3

_____

_____

Reflecting on your current treatment planning process

Reflecting on your current treatment planning process, how do you treatment plan now?

List the steps you usually take after screening and assessment with the person below (e.g., case conferences, written treatment plan).

1. _____
2. _____
3. _____
4. _____

Reflecting on the integrated treatment planning components (see below), how could you modify your process to be more concurrent capable?

1. _____
2. _____
3. _____
4. _____

> | exercise | <

Components of integrated treatment planning:

- ✓ Person-centred
- ✓ Recovery focused
- ✓ Trauma informed
- ✓ Informed consent
- ✓ Social determinants of health
- ✓ Evidence informed
- ✓ Motivation-based treatment

Challenges to integrated treatment planning

Spend a few moments, either alone or with a colleague, thinking about challenges you have faced in your work related to integrated treatment planning.

For each challenge, identify strategies that might help reduce or eliminate it.

Challenge	Strategy

Successful integrated treatment planning

Historically, persons with concurrent disorders were treated in parallel treatment systems for substance use and mental health. Remnants of these systems remain today and can sometimes pose barriers to treatment if systems are not integrated or services do not interact.

Key messages

Ensuring the following can help make for successful integrated treatment planning:

Clinicians and clinical services recognize the need for collaborative treatment approaches and help coordinating this for the individual in a seamless manner.

Trained professionals have a common understanding of concurrent disorders and understand the role of other professionals in the field with whom they might collaborate.

Working with the individual to set recovery-focused goals, even if they are unwilling to address the concurrent disorder (they may be willing to focus on one component to start).

Ensuring the individual is at the centre of the decision-making for developing the plan.

Working with the individual to identify and develop a plan with SMART goals.

The vulnerable population of individuals with concurrent disorders often requires addressing socio-economic issues (e.g., poverty, homelessness, unemployment) to ensure successful outcomes.

Including peer support workers and/or family members in treatment planning.

Sustaining the individual's participation in the ongoing treatment.

Continuity of treatment across various services.

Working with the individual to evaluate the treatment plan and change intervention options or address other needs that might lead to poor treatment adherence.

It's not just the plan—it's you!

A key component of creating an integrated treatment plan is realizing that it is not just the plan itself. Rather, it is also the engagement and collaboration amongst and between clinicians, clinical teams, individuals and their families.

In an effort to create successful and seamless integrated treatment planning, remember the following key components:

- Accessible consultation, education and teaching opportunities for frontline staff to manage a wide variety of concurrent disorders.
- Improved collaboration and access between services to ensure that the person is receiving the best care.
- Developing partnerships with other clinicians and clinical programs, community organizations and other agencies or programs that may enhance support and treatment (e.g., family advocacy groups, police, shelters, food banks, social service, criminal justice system).
- Supporting the person in navigating these systems and advising them of available options. To do this, you yourself need to establish relationships with other people, areas and services to ensure you can provide the best options to the individual.
- Knowing when to keep and consult, and when to provide a warm handoff to more appropriate services to ensure continuity of care.

Collaboration Opportunities

Take a few moments to identify programs, services, agencies or people that it would be beneficial to collaborate with for integrated treatment planning.

First, list the networks, programs, services, agencies or people with which you already connect.

_____

_____

_____

Now list the networks, programs, services, agencies or people with which you know exist but with which you have not yet connected.

_____

_____

_____

How could you connect with these areas?

_____

_____

_____

Commit to re-connecting with one or two community partnersselections you already have an established relationship with, and reach out to one or two that you have yet to build a relationship with, but that you feel would help you better accomplish integrated treatment planning.

Conclusion

We hope you have found this chapter to be helpful. If you have any questions, comments or stories to share, please contact concurrent.disorders@ahs.ca.

Want more information on integrated treatment for concurrent disorders?

Check out the Substance Abuse and Mental Health Services Administration's Integrated *Treatment for Co-Occurring Disorders*, which has compiled a list of evidence-based resources on topics such as the historical context of integrated treatment for concurrent disorders, implementation and administrative issues, financing and cost-effectiveness, engagement, system-level integration and evidence on specific treatment approaches, and more: http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367.

APPENDIX 1

Examples of integrated treatment models

The Integrated Dual Disorder Treatment (IDDT) model

Integrated Dual Disorder Treatment (IDDT) evidence-informed practice was developed by Robert E. (Bob) Drake MD, PhD; Kim T. Mueser, PhD; and their colleagues, and is studied by researchers at the Dartmouth Psychiatric Research Center of Dartmouth Medical School in Lebanon, New Hampshire.

Mueser, Noordsy, Drake and Fox (2003) suggest that effective treatment for concurrent disorders is based on shared decision-making and consists of the following components:

- **Integration of services** – the same clinician or program provides treatment for concurrent disorders to the individual (or seamlessly coordinates all treatment for the individual)
- **Comprehensiveness** – acknowledges that reducing or eliminating substance abuse is a major goal of integrated treatment, but that achieving this usually involves more than changing behaviours directly linked to the use, and may involve addressing social and economic factors in the individual's life i.e. employment, social skills training.
- **Assertiveness** – clinicians must actively engage with the individual in the process of treatment even if the individual is unmotivated. This may requires assertive outreach i.e. meeting at the individual's home, developing trust
- **Reduction of negative consequences** – this refers to reducing the negative consequences of substance abuse that may impair insight into treatment or lack of motivation to seek treatment.
- **Long-term perspective (time-unlimited)** – recognizing that adopting healthier lifestyles and changing habits that support recovery can take months or even years.
- **Motivation-based treatment** – interventions should be adapted to the individual's motivation for change for most effective treatment.

- **Multiple psychotherapeutic modalities** – using an array of different treatment approaches typically optimizes individual outcomes.

The IDDT evidence-based practice involves cross-trained practitioners providing integrated comprehensive services directed toward individuals with concurrent disorders simultaneously in the same venue, with the goal of recovery from both illnesses.

More information can be found in Mueser, K.T., Noordsy, D.L., Drake, R.E., Fox, L. (2003). *Integrated treatment for dual disorders a guide to effective practice*. New York, NY: The Guilford Press.

The Integrated Placement and Support model

Resources providing more detailed information on this model include the following:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4079136/

https://waamh.org.au/development-and-training/individual-placement--support-ips.aspx

APPENDIX 2

Sample plan templates

SAMPLE: Treatment Plan Template

My name is:	My support people are:	
My hopes/goals are…	My strengths are…	My needs are…

DATE	PATIENT'S GOALS	ACTION *To be taken and by whom*	TARGET OUTCOMES	TARGET DATE	CLINICIAN *Name/Discipline*
	Goal:				
	Stage of change:				
	Goal:				
	Stage of change:				
	Goal:				
	Stage of change:				

Patient signed ☐ Copy given to patient ☐ Copy sent to community upon discharge

PATIENT PROGRESS	
Achieved targets and successes	Staff signature/Date

SAMPLE: Recovery Plan Template

PROGRAM		Date: 2013	
PERSON: Client		**Team Members**	
Strength based discussion: Describe recent or relevant periods of success:		Person's goals for a happy Life	
GOALS AND OBJECTIVES:	WHAT DO WE DO? (Stage matched interventions)	RESPONSIBLE PERSONS (Who does what?)	Milestones of progress and opportunities for rounds of applause
1. Issue: Stage: Goal Objectives			
2. Issue: Stage: Goal Objectives			
3. Issue: Stage: Goal Objectives			
4. Issue: Stage: Goal Objectives			
SIGNED BY: Client ( ) Family ( ) Program Manager ( ) Staff ( ) Staff ( ) MD ( ) Other ( )			

APPENDIX 3

Cultural safety and cultural competency resources

AHS Aboriginal Sensitivity E Learning Course on AHS My Learning Link

Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators

http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf

Indigenous Cultural Competency Training Program

http://www.culturalcompetency.ca/training/indigenous

Colour Coded Health Care, The Impact of Race and Racism on Canadians Health

http://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf

Cross TL, Barzon BJ, Dennis KW, and Isaacs MR. (1989). Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

APPENDIX 4

Understanding stages of change and stages of treatment

The following chart outlines both models along with clinical intervention examples for each stage (Provincial Concurrent Capable Learning Series (PCCLS), Alberta Health Services):

Alberta Health Services

Provincial Concurrent Capable Learning Series: Treatment Planning

Stages of treatment with the Stages of Change & Clinical Intervention examples for each stage

Stages of Treatment	*Stages of Change*	*Definitions*	*Goal*	*Clinical Intervention*
Engagement	Pre-Contemplation	Client does not have regular contact with concurrent capable clinician	To establish a working relationship with Client	• Outreach • Practical assistance (e.g., food, clothing, housing, benefits, transportation, medical care) • Crisis intervention • Support and assistance to social networks • Stabilization of psychiatric symptoms – medication management • Help in avoiding legal penalties • Help in arranging visitation with family • Family meetings • Close monitoring
Persuasion	• Contemplation • Preparation	Client has regular contact with clinicians, but does not want to work on reducing substance abuse	To develop the client's awareness that substance use is a problem, and increase motivation to change	• Individual and family education • Motivational interviewing • Peer groups (e.g., persuasion groups) • Social skills training to address non-substance-related situations • Structured activity (e.g., supported employment, volunteering, hobbies, church, social organizations, consumer committees, or task forces • Sampling constructive social and recreational activities • Psychological preparation for lifestyle changes necessary to achieve remission • Safe housing (i.e., tolerant of some substance abuse) • Use of medication to treat psychiatric illness that may have a secondary effect on craving/addiction (e.g., SSRI's, atypical antipsychotics)
Active Treatment	Action	Client is motivated to reduce substance use, as indicated by reduction for at least one month but less than six months	To help the client further reduce substance use and, if possible, obtain abstinence	• Family and individual problem solving • Peer groups (e.g., active treatment groups) • Social skills training to address substance related situations • Self-help groups (e.g., Alcoholics Anonymous) • Individual cognitive-behavioural counseling • Substituting activities (e.g., work, sports)

APPENDIX 5

HONOS – Addiction and Mental Health, AHS

Alberta Health Services

Site: _____

HRN: Site: DOB: yyyy/mon/dd

Last Name: First and Additional Names:

PHN: Gender: Age in Years:
Admitting Physician: Encounter #:

Address: Street, City, Province, Postal Code

Telephone Number:
Date of Admission: yyyy/mon/dd Family Physician:

Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA)

Date completed:	yyyy	mon	dd
Unit/Service Name:			

This HoNOSCA completed at:

☐ Admission or assessment only ☐ Midpoint or case review ☐ Discharge – specify type:
☐ Planned or mutually agreed discharge
☐ Transfer to another service
☐ Unplanned discharge

Check here if this HoNOSCA is an inter-rater reliability check ☐

Check here if client is deceased ☐

Instructions: The HoNOSCA is to be completed only by staff who have received HoNOSCA training. Complete your clinical assessment; then rate this client's severity in each of the problem areas listed below. For each HoNOSCA item, base your rating on the most severe occurrence or manifestation of the problem in the preceding 2 weeks. (Please refer to the data collection procedures for exceptions to the 2-week reference period.)

This is the basic **rating scale**.
Always refer to the full HoNOSCA Glossary when making the ratings.

0	1	2	3	4	9
No problem	Minor problem – requiring no action	Mild problem but definitely present	Moderate problem	Severe problem	Unknown. This is to be used only as a last resort when no information can be obtained

HoNOSCA items: *Enter the severity rating in the box to the right of each item. Item 9 also requires a letter choice.*

Section A:			**Rating**
Behaviour	1	Problems with disruptive, antisocial or aggressive behaviour	
	2	Problems with over-activity, attention or concentration	
	3	Non-accidental self-injury	
	4	Problems with alcohol, substance/solvent use	
Impairment	5	Problems with scholastic or language skills	
	6	Problems related to physical illness or disability	
Symptoms	7	Problems associated with hallucinations, delusions, or abnormal perceptions	
	8	Problems with non-organic somatic symptoms	
	9	Problems with emotional & related symptoms From the list below, **choose and rate the single most severe clinical problem** that was not rated in any item above. **A.** Depression **B.** Fears or phobias **C.** Anxiety and panic **D.** Obsessive-compulsive **E.** Worries **F.** Eating – over/under **G.** Sleep – hypersomnia/insomnia **H.** Sexual **I.** Other – such as elation – expansive mood – problems not specified elsewhere. Please specify: _____ Enter letter of chosen problem: Enter rating:	
Social	10	Problems with peer relationships	
	11	Problems with self-care and independence	
	12	Problems with family life and relationships	
	13	Poor school attendance	
Section B: *Problems for the child, parent or care-giver relating to lack of information or access to services.*			
Information	14	Problems with knowledge or understanding about the nature of the child's/adolescent's difficulties	
	15	Problems with lack of information about services or management of the child's/adolescent's difficulties	

Name (please print) *(first name)* *(last name)* **Signature/Designation**

Reproduced with kind permission from Health of the the Nation Outcomes Scales (HoNOS) © Royal College of Psychiatrists 1996

104019 © Alberta Health Services, (2011/02)

Distribution: White - Health Record Yellow - Data Entry

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APPENDIX 6

Sample case conference presentation format

(Used with permission: K. Minkoff, personal communication, November 27, 2015)

ZIA PARTNERS

CCISC Hopeful, Strength-based (Recovery-oriented) Integrated Presenting Format

The [age]-year-old [man/woman/boy/girl] I am presenting is an amazing/cool/special person because:

I like or feel connected to the person I am presenting because:

His or her vision for a happy, meaningful, proud, successful life is:

Over the past several weeks/months, in the face of multiple challenges:

List all the challenges (e.g., continuing mental health issues, substance issues, cognitive/learning issues, health issues, past and current trauma, relationship challenges, housing issues, criminal justice issues, etc.)

1.

2.

3.

This person has amazingly made progress toward his/her goal of happiness by doing the following things:

List the positive things that he/she has been doing in general, and specifically to make progress for each challenge. STAY WITH A STRENGTH-BASED FOCUS (e.g., "He/she has amazingly made 75% of appointments or taken meds 60% of the time."), rather than "He/she does not keep appointments and is med non-compliant."

Also note the STAGE OF CHANGE he/she is in for each issue, reflecting progress in a way that is "stage-matched." (e.g., "He/she has just started to trust us enough to talk about substance issues in spite of bad experiences with talking about these issues with caregivers in the past, and is moving into the contemplation stage.")

1.

2.

3.

Based on the above, I would like some help from the team identifying smart next-steps of progress (skills, etc.) that the person and I/the team can work on in partnership together, for each of the challenges that he/she is facing, in order to help him/her make progress toward the vision of a happy life.

369-B Third Street#223 | San Rafael, CA 94901 | t: 415.342.5961 | info@ziapartners.com | www.ziapartners.com

© 2012 by ZiaPartners, Inc.

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