4. Person-Centered Treatment Matching & Treatment Planning

People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental health and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services (SAMHSA/HRSA). Additionally, it is found that in order to provide effective integrated care, it can best be accomplished in the context of a person-centered, stage-wise plan of care, in consideration of an individual's readiness for change and one's person-centered goals and dreams.

Skill	Knowledge	Resources/ Sources of Information
4.1 Able to formulate a Narrative (Integrative) Summary based on history and assessment data.	● Understand the role and importance for the development of a Narrative (Integrative) Summary in the context of Person-Centered Recovery Planning. ● Understand the key elements to be included in the Narrative Summary. ● Understand the need for inclusion of a cultural formulation within the Narrative Summary. ● Understand how to include transition and discharge planning within the Narrative Summary.	**Writing a Person-Centered Integrated Summary** https://www.ct.gov/dmhas/lib/dmhas/publications/CSP-integratedsummaries.pdf **Considering the Individualized Recovery Plan: The Role of the Interpretive Summary in Formulating an Understanding of the Person** https://www.omh.ny.gov/omhweb/pros/person_centered_workbook/chapter3.pdf
4.2 Able to utilize the results of an integrated assessment in collaboration with the client to develop an integrated treatment plan that captures and addresses the interaction between mental health and substance abuse.	Understand that a person-centered treatment plan: ● Addresses both the substance related and mental disorder concurrently with a level of intensity based on the client's assessment information and consistent with the acuity, severity, and disability associated with each disorder. ● Contains specific detail as indicated by clear, objective, measurable outcomes with targeted behaviors and goals aimed at reducing the adverse consequences of both disorders and their interaction.	**Treatment Planning for Person-Centered Care" (Adams, N. & Grieder, D., 2014 Diane Grieder, MEd video:** https://mdbehavioralhealth.com/EIP/course/intro/10461 **"Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning 1st Edition"** **(Tandora, J., Miller, R., Slade, M., Davidson, L., 2014)** **An Introduction to Person-Centered Treatment Planning** https://www.mentalhealthcommission.ca/sites/default/files/2016-11/An%20Introduction%20to%20Person-Centered%20Planning_oct_216_eng.pdf **Creating a Plan that Honors the Person AND Satisfies the CSP/RP Chart** http://www.ct.gov/dmhas/lib/dmhas/publications/CSP-PCPdocumentationTraining.pdf

	● Identifies the client's strengths, and supports the use of them in reaching desired outcomes. ● Identifies the client's natural supports, and supports the use of them in reaching desired outcomes. ● Suggests intervention strategies compatible with each stage of change and stage of treatment for each disorder. ● Uses both substance use and mental disorder symptom reduction as well as abstinence based substance abuse models matched to the client's stage of change. Clearly articulates the treatment plan in writing and has it available in the client's record for review at case consultation, supervision, or updates by all involved in the clinical treatment team.	
4.3 Able to work collaboratively with others to ensure treatment plan goals are implemented.	● Understand that effective teamwork positively impacts client safety and treatment progress. ● Knowledge of the roles, functions, and responsibilities of individuals in and outside of an organization that impact the client's care. (Family members, insurance providers, treatment providers etc.) ● Knowledge of the skills that promote a culture of collaboration and effective team work (clinically and organizationally).	**Effective Teamwork - World Health Organization** http://www.who.int/patientsafety/education/curriculum/who_mc_topic-4.pdf **Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health** http://www.safetynetmedicalhome.org/sites/default/files/Common-Barriers-Strategies-Support-Health-Care-Teams.pdf **Collaboration and Teamwork** https://www.integration.samhsa.gov/workforce/collaboration-and-teamwork
4.4. Able to generate collaborative documentation that reflect advances and barriers to treatment goals.	● Understand that what is captured in the assessment is addressed or followed up in treatment. ● Understand that documentation can be a clinical tool used to assist and support	**Collaborative Documentation with Children and Families - Getting the Tools to Work for You** https://www.thenationalcouncil.org/wp-content/uploads/2012/11/NC-C-and-A-CD-Training-3-21-12.pdf

	staff in maintaining person centered treatment. ● Understand the importance of revisiting the treatment plan on an ongoing basis as means to track engagement, alignment, and progress.	**Documenting Services Delivered in Behavioral Health Programs: Writing progress notes** http://niatx.net/pdf/mentalhealth/round6/Writing_Progress_notes.pdf **Collaborative Documentation: A Clinical Tool** https://www.integration.samhsa.gov/mai-coc-grantees-online-community/Breakout4_Collaborative_Documentation.pdf
4.5 Able to generate a discharge/ transition plan that is individualized, collaborative, comprehensive, clearly understood and defined.	● Understand that discharge/transition planning is a process that begins upon admission to a program. ● Understand key elements of effective discharge/ transition planning include: ○ Involvement of the individual, family, natural supports, members of the clinical team, and community partners. ○ Identification of services (treatment, case management, housing, recovery supports, etc.) needed post-discharge ○ Relapse prevention interventions and contingency planning ○ Clearly defined roles and responsibilities. ○ Mechanism to monitor progress.	**Transitions of Care: The need for a more effective approach to continuing patient care** https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf **Best Practice Manual for Discharge Planning: Mental Health and Substance Abuse Facilities - Chapter 1 pages 8-20** http://www.dcf.state.fl.us/publicnotices/20150519resource2.pdf **Executing High-Quality Care Transitions: A Call to Do It Right** https://caretransitions.org/wp-content/uploads/2015/06/46_Executing-High-Quality-Care-Transitions-A-Call-to-Do-It-Right.pdf **Care Transition Measure** https://caretransitions.org/wp-content/uploads/2015/08/CTM-15.pdf
4.6 Able to promote relapse prevention and self-efficacy.	• Understand that recovery is an ongoing long-term process. • Knowledgeable of relapse prevention strategies and techniques. • Understand the importance of support networks in achieving success early on in treatment and post treatment. • Knowledge of recovery supports for substance use and mental health.	**Living with Co-Occurring Addiction and Mental Health Worksheets** http://www.bhevolution.org/public/livingwith.page **Action Planning for Prevention and Recovery** http://www.npaihb.org/wp-content/uploads/2018/12/action-planning-for-recovery.pdf **Care Transition Toolkit: Download The Tools** https://www.resourcesforintegratedcare.com/care-transition-toolkit/download **Next Step Towards a Better Life SAMSHA** https://store.samhsa.gov/system/files/sma14-4474.pdf **Social Support**

		https://www.heretohelp.bc.ca/sites/default/files/wellness-module-3-social-support.pdf **Co-Occurring Disorders Treatment Workbook: Module 8 - Relapse Prevention** http://scholarcommons.usf.edu/cgi/viewcontent.cgi?article=1593&context=mhlp_facpub