Mid-America (HHS Region 7)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Treatment Planning for Assertive Community Treatment Teams September 28, 2022

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MUNROE-MEYER INSTITUTE

SAMHSA

Substance Abuse and Mental Health Services Administration

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This work is supported by grants under Funding Opportunity Announcement (FOA) No. SM-18-015 from the DHHS, SAMHSA.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

STRENGTHS-BASED AND HOPEFUL

INCLUSIVE AND ACCEPTING OF DIVERSE CULTURES, GENDERS, PERSPECTIVES, AND EXPERIENCES

HEALING-CENTERED/ TRAUMA-RESPONSIVE

INVITING TO INDIVIDUALS PARTICIPATING IN THEIR OWN JOURNEYS

PERSON-FIRST AND FREE OF LABELS

NON-JUDGMENTAL AND AVOIDING ASSUMPTIONS

RESPECTFUL, CLEAR AND UNDERSTANDABLE

CONSISTENT WITH OUR ACTIONS, POLICIES, AND PRODUCTS

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Announcements

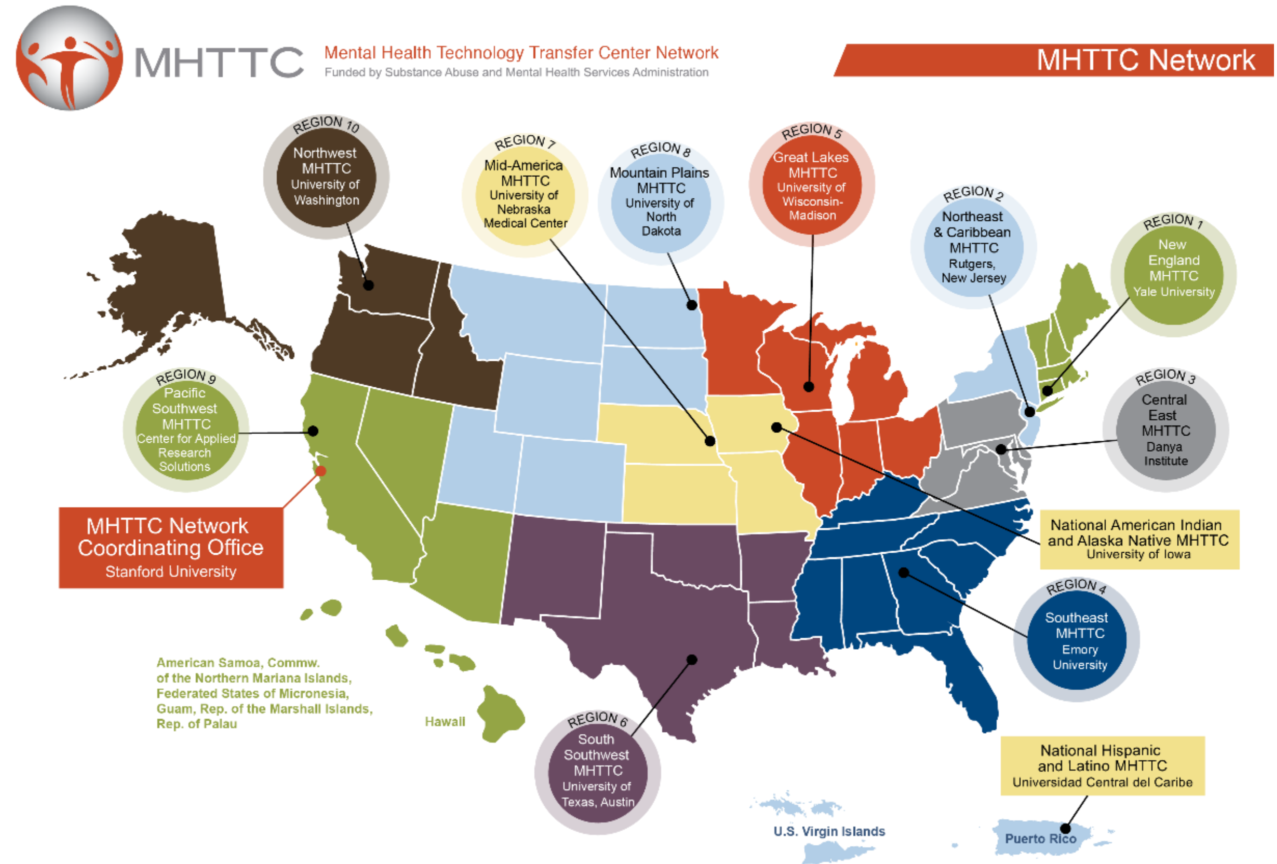
- This webinar is recorded.

https://mhttcnetwork.org/centers/mid-america-mhttc/implementing-assertive-community-treatment-act-kansas

Mid-America Mental Health Technology Transfer Center

Established to increase utilization of evidence-based mental health practices.

- Missouri, Iowa, Nebraska, and Kansas.
- Free training and technical assistance.
- SAMHSA grant awarded to the Behavioral Health Education Center of Nebraska at University of Nebraska Medical Center.
  (5 years, $3.7 million, grant number: H79SM081769)



Objectives

From this presentation, we will gain the following:

Knowledge:

- How to conduct an effective treatment planning meeting
- Develop SMART (specific, measurable, achievable, relevant and time specific) goals
- Understand how to use the information from the assessments to help guide treatment goals

Treatment Planning Foundation

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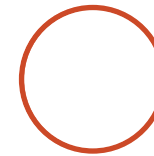
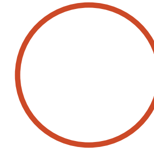
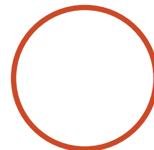
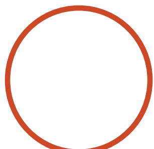
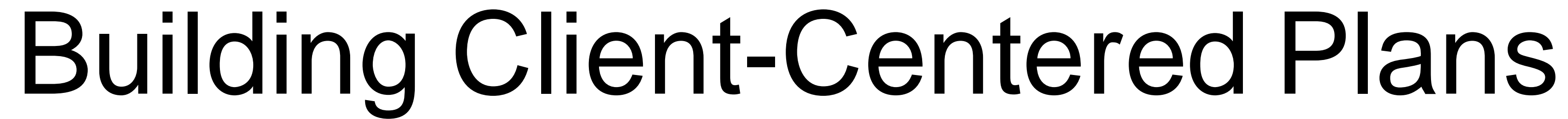

Building a Client-Centered Care Plan


Conducting Assessments Team Input


Identifying Goals & Establishing Priorities


Support Clients in Developing Their Own Action Plan



- Building a Client-Centered Care Plan
- Conducting Assessments
- Identifying Goals & Establishing Priorities
- Support Clients in Developing Their Own Action Plan

Treatment Planning for Case Management

It is the foundation of case management, driving engagement and, ultimately, outcomes.

It is client-centered, focusing on what the CLIENT is ready to do to promote their own health.

Treatment planning is not about telling the client what to do.

Treatment Plan: Essential Characteristics

- Client-focused and client driven
- Outcome-oriented, action-focused
- Fluid and adaptable

Personalized care Plan for: ______________________ Date: ______________

My health concerns are:		Why getting healthy matters:	

Date Set	Patient Goal	Action Steps (who, what, when)	Referrals/Resources	Concerns?	Planned Follow up
Example 3/3/22	*Remember to take medications*	*1. I will get my prescriptions filled on the last Thursday of the month beginning in May*	*Medication Reminder App*		*3/10/19*

Confidence Scale

My Red Flags/Warning Signs:

Symptom	What to do
e.g. Feeling shaky, dizzy, sweaty, hungry	*Check blood sugar; If blood sugar is low, eat a snack*
Possible Barriers?	
How will I address them?	
Referrals Made?	**Pharmacy with home delivery for individuals with disabilities**

We will re-evaluate my progress on ______________________

______________________ Patient Signature/Date

______________________ Care Team Member Signature/Date

Personalized care Plan for: ______________________ Date: ______________________

My health concerns are:		Why getting healthy matters:	

Date Set	Patient Goal	Action Steps (who, what, when)	Referrals/R		p
Example *3/3/22*	*Remember to take medications*	*1. I will get my prescriptions filled on the last Thursday of the month beginning in May*	*Medication Re*		

Help prioritize attainable and realistic goals

Confidence Scale

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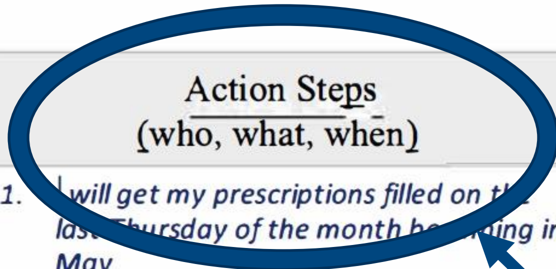
Care Team Member Signature/Date

Personalized care Plan for: Date:

My health concerns are:		Why getting healthy matters:	



Date Set	Patient Goal	Action Steps (who, what, when)	Referrals/Resources	Concerns?	Planned Follow up
Example *3/3/22*	*Remember to take medications*	*1. I will get my prescriptions filled on the last Thursday of the month beginning in May*	*Medication Reminder App*		*3/10/19*

Brainstorm a detailed action plan. *Identify by when and by who for each action*

Confidence Scale

Not confident Somewhat confident

7

Remember:
Always write goals and actions in the client's own words!

th disabilities

Patient Signature/Date

Care Team Member Signature/Date

Personalized care Plan for: Date:

My health concerns are: getting healthy matters:

Consider possible barriers and make a plan for how to respond

Date Set	Patient Goal		Referrals/Resources	Concerns?	Planned Follow up
Example *3/3/22*	*Remember to take medicati*		*Medication Reminder App*		*3/10/19*

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How will I address them?	
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We will re-evaluate my progress on ______________________

Patient Signature/Date

Care Team Member Signature/Date

Personalized care Plan for: Date:

My health conc		Why getting healthy matters:	

Assess the client's confidence in accomplishing the goal/plan

Date Set		Action Steps , what, when)	Referrals/Resources	Concerns?	Planned Follow up
Example *3/3/22*	*Re*	*y prescriptions filled on the ay of the month beginning in*	*Medication Reminder App*		*3/10/19*

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Possible Barriers?	
How will I address them?	
Referrals Made?	Pharmacy with home delivery fo

Document any referrals made and resources present

We will re-evaluate my progress on ______________________

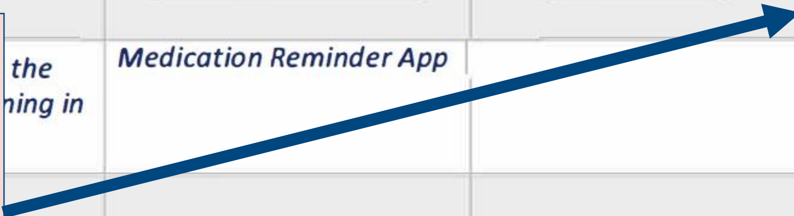
Patient Signature/Date

Care Team Member Signature/Date

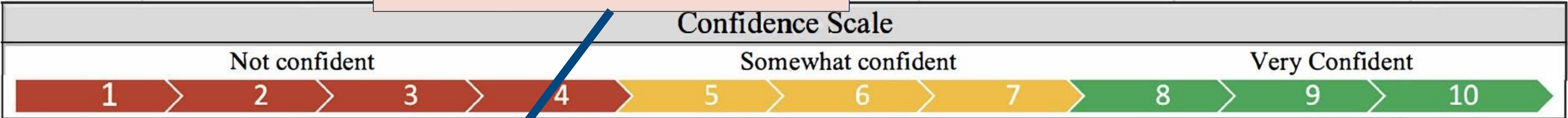
Personalized care Plan for: Date:

My health concerns are:		Why getting healthy matters:	

Date Set	Patient Goal	Action Steps (who, what, when)	Referrals/Resources	Concerns?	Planned Follow up
Example *3/3/22*	*Remember to take medic*	*the* *ning in*	*Medication Reminder App*		*3/10/22*



Identify a timeframe to revisit the plan or any actions with the client



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Possible Barriers?	
How will I address them?	
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We will re-evaluate my progress on ______________________

Patient Signature/Date

Care Team Member Signature/Date

Steps for a client-centered care plan

When you've completed the care plan:

- Provide the client with a copy
- Moving forward, documentation should be reflective of Tx plan objectives, noting progress, barriers and opportunities discovered.
- Celebrate treatment plan wins

“You might think you are going to sit down and do this all at once in some logical order – assess risks and resources, come up with goals and a plan. But that isn’t how it usually goes.

Especially when we first meet with clients, we want to follow their lead about what is most important to talk about. We know that if the client decides that they want to keep working with us – that we will develop this plan together.

Like everything, it’s a process and the plan keeps developing. That’s a good thing, because new goals or priorities come up, or the client realizes that some of their actions are just too unrealistic.”

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- Building a Client-Centered Care Plan
- Family Dynamics & Working With Families
- Conducting Assessments
- Identifying Goals & Establishing Priorities
- Support Clients in Developing Their Own Action Plan

Utilizing Assessments & Information

1 Formal Assessments

2 Information Assessments

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Keep it strengths-based

It is “*asking about, listening for, and acknowledging a client’s strengths, including internal and external resources, and their knowledge, skills, and past accomplishments. Team-based approaches will support a client in building upon and expanding these strengths as they work together*”

Berthold et al. (2016)

Internal Resources

- Good health
- History of successful coping
- Ability to reach out & ask for help
- Creativity
- Healthy self-esteem

External Resources

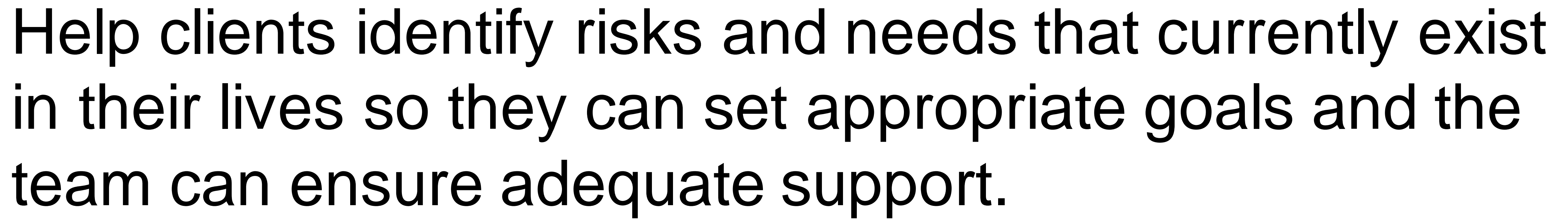
- Supportive relationships with family or friends
- Adequate health insurance
- A safe home & neighborhood
- Access to natural community supports

Team Communication is key

"With some clients, so much is happening in their life, and it is easy for them to get lost in the difficulties and the problems, and I can help them to also see and really appreciate their strengths.

And this makes it easier for them to reflect on the skills that they already have, and to focus on how to use them to move their life forward in the direction they want to go."

Berthold et al. (2016)



The process of identifying & prioritizing means **learning what clients need help most with & what they are ready to take on** in the present moment.

The Treatment Plan

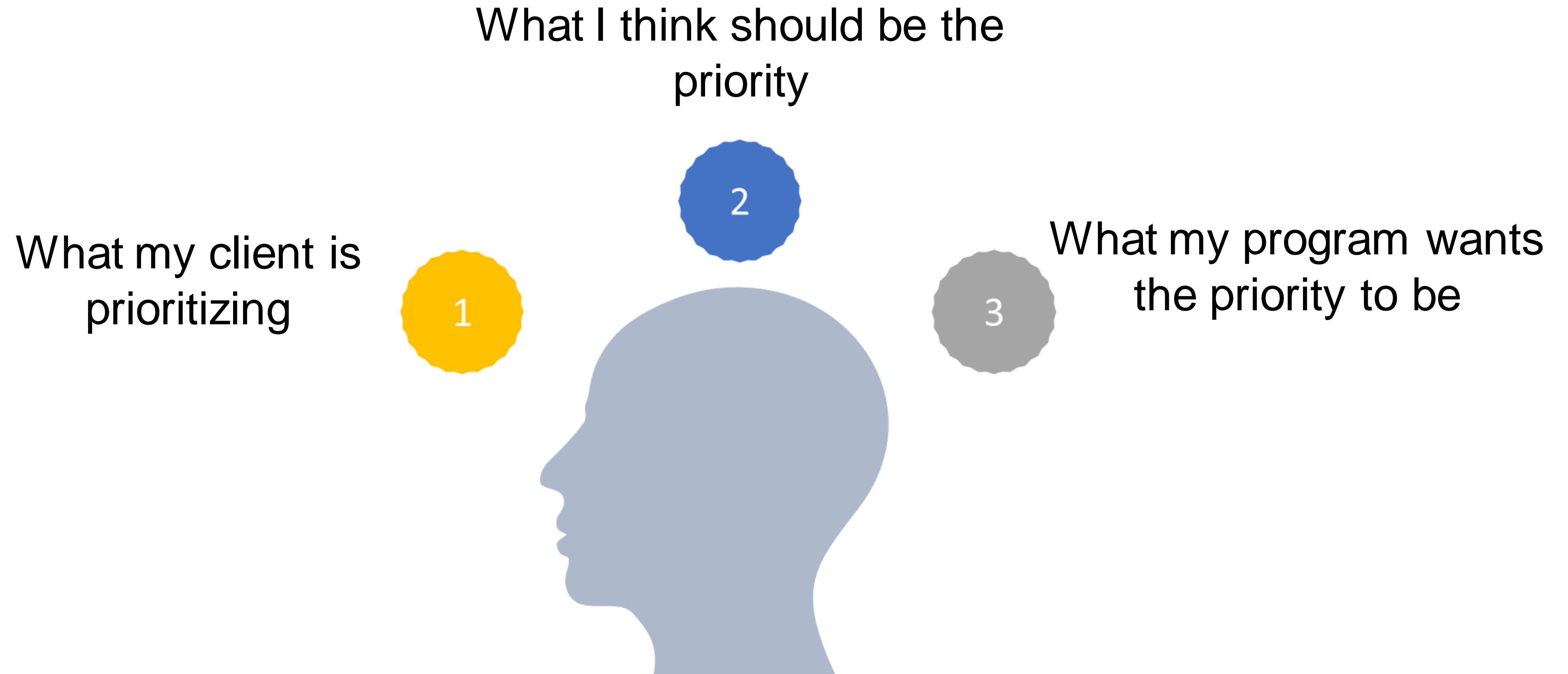
- ✓ Written in clients' own words
- ✓ Includes information meaningful to client
- ✓ Built around client-identified goals
- ✓ Focused on what the client is ready to do

Identifying Goals & Establishing Priorities

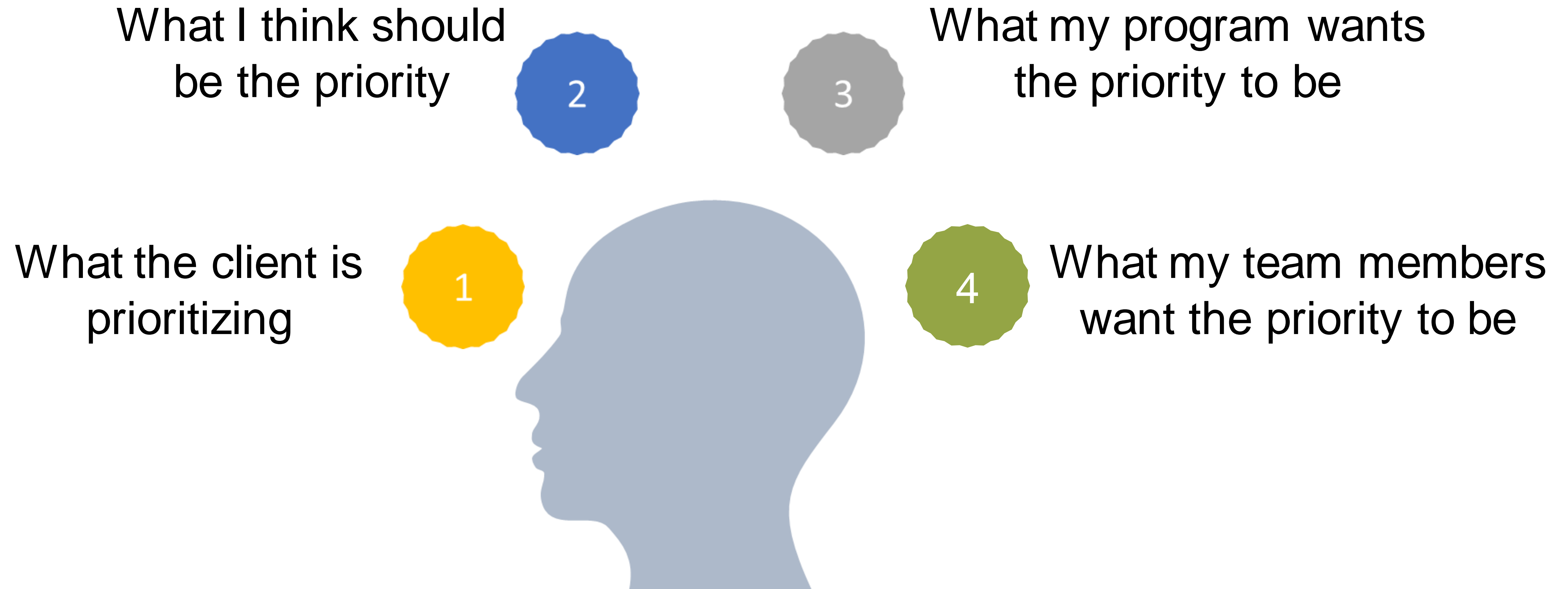
- Goals must come from the client

- The goal(s) a client prioritizes may not align with what you feel should be the priority.

Internal Tension



Internal Tension



The value of client identified goals & priorities

1

Client autonomy & self-determination

2

More likely to be motivated to work towards them

3

Enhanced level of accountability

SMART Goals

Specific – what will you accomplish

Measurable – how will you know it's accomplished

Achievable – is the goal realistic?

Relevant – why is this goal significant to you?

Time-bound – by when will you achieve this?

Identifying & Prioritizing Goals

- As needs change, goals can change
- Talk about why their goals are changing
- Celebrate wins – no matter how small!

Assessing Client Risks & Needs

"What concerns you most about your safety at home?"

"What are some of the challenges you're facing in terms of eating a healthier diet?"

"What puts you most at risk for being hospitalized again?"

Help clients identify risks and needs that currently exist in their lives so they can set appropriate goals and the team can ensure adequate support.

"What resources do you most need in your life?"

"What are you most concerned about?"

"What is the biggest challenge you are facing right now?"

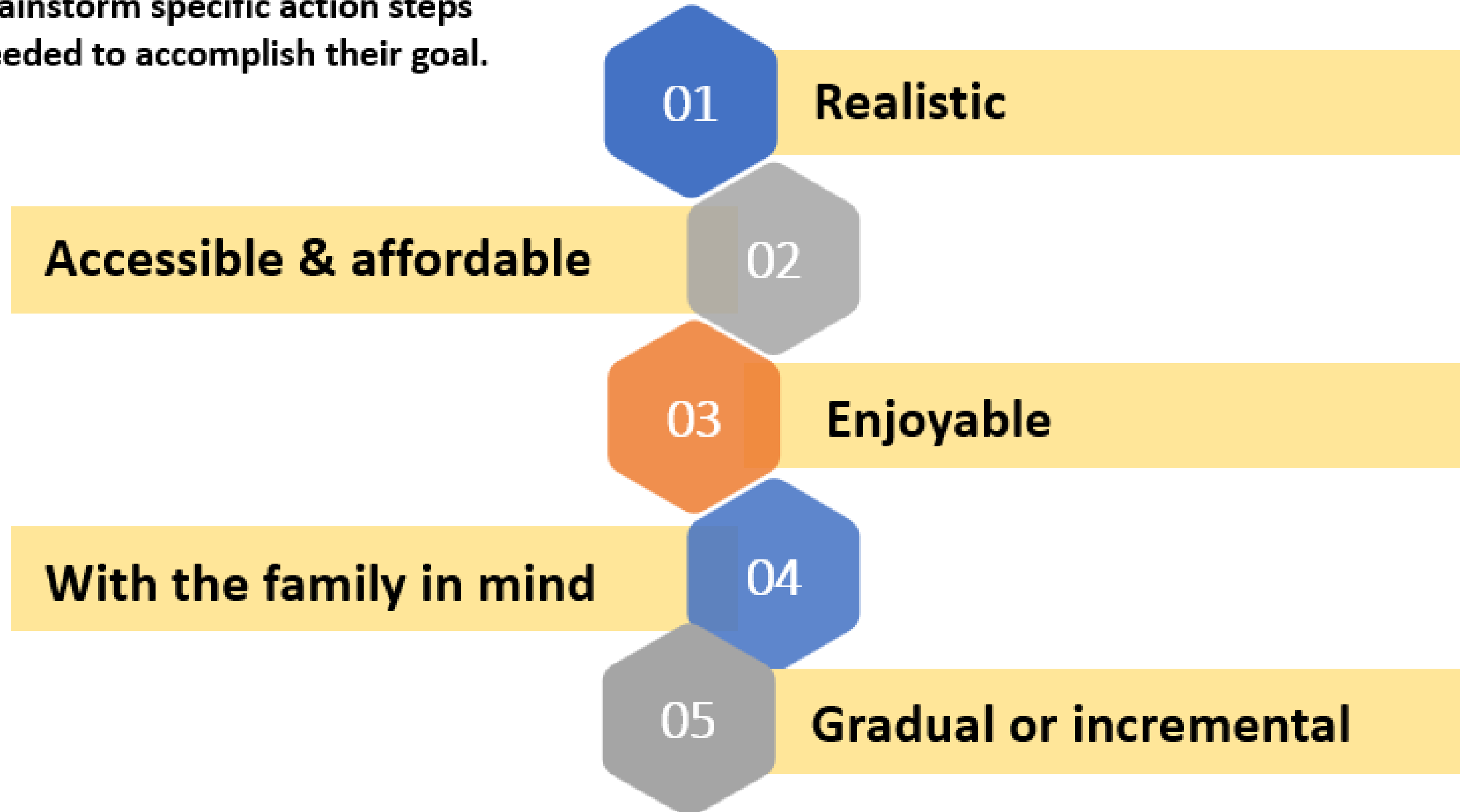
Supporting Clients in Developing Their Plan

Lay out what actions needs to be taken

- By whom
- By when
- Identify any challenges that may exist
- What are the potential resources
- Are there potential referrals needed to support success

Identifying Specific Actions

Brainstorm specific action steps needed to accomplish their goal.



Identifying Actions: When

For each action, identify when (and possibly where) it will take place.

But how long should a client give themselves?

- Too long, and it's less likely to be accomplished
- Too short, and it could set them up for failure

Think in days, weeks, or possibly a month

Identifying Actions: When

For each action, identify when (...) it will take place

... d a client g ... elves?

➢ Too long, and it's less likely ...

➢ Too short, and it could set ...

Think in days, weeks, or possibly a month

What internal & external resources exist?

How difficult is the action?

What can the past tell us?

Identifying Actions: How?

How can we use resources and referrals to support the success of this action step?

External Resources?

- Family & friends, work, counselor, membership in a group, etc.?

Internal Resources?

- Sources of motivation, past successes, specific knowledge or skills, etc.?

Identifying Actions: Barriers

Guide clients in anticipating, planning for barriers.

What barriers or challenges may exist?

Have they experienced them before?

What steps can they take to overcome them?

For health conditions, document red flags or warning signs a condition is worsening and what clients should do if they arise.

Referrals

- Write down what referrals you have made or will make.

Client Confidence

- On a scale from 0 to 10, rate your confidence in being able to successfully implement the action plan.

Managing Client Expectations

- An important step in planning is to help clients establish healthy expectations both for themselves and for your team.

- Keep plans realistic & adaptable to client’s needs

Identifying Goals

The treatment plan is meant to meet more **immediate goals**.

"What are those other realistic goals that can be worked towards in a reasonable timeframe that will ultimately get me to my larger goal?"

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Treatment Planning Scenario

Will is a 42-year-old male diagnosed with schizophrenia and has been living with his parents for the last three years and during that time has been managing his schizophrenia but otherwise marginally engaged in his health or healthcare. He recently went to his primary care provider, Dr. Smith, with symptoms of fatigue, blurry vision, constant hunger, and frequent urination – all symptoms of uncontrolled diabetes.

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Treatment Planning: Will

Dr. Smith, questioned him about his mental health status as well as his uncontrolled diabetes and suggested he address this with his ACT Team. Dr. Smith feels Will needs more 1:1 day-to-day support, for diabetes management.

Dr. Smith suggested his ACT Team develop a plan of care for Will with the primary goal of getting his diabetes under control.

Treatment Planning: Will

You just completed your treatment plan assessments with Will and during that visit you discover that Will recently lost his Medicaid, due to not completing his annual paperwork. He currently has no insurance and recently began drinking alcohol to deal with this stress. His MH status has also led to an increase of symptoms and isolation as he hides his drinking from his family. The situation is taking a significant toll on him emotionally as he fears he may no longer be considered for an apartment.

Treatment Planning: Will

Will is somewhat leery of the treatment planning process and not quite sure if he trusts ACT staff and provider now, due to his fears of being judged by staff and his family of his recent relapse in drinking.

However, Will says "I feel desperate, I don't know where to start but I know I have to start somewhere." He wants to get supplies to monitor his blood sugar which will help him control his diabetes but says what he thinks most about is losing his apartment, and not having Medicaid.

Are you ready to start helping Will develop a treatment plan? If not, what steps might you need to take before you get started?

What key information on this table can you fill in following your treatment planning interaction with Will?

Lifestyle area	Notes from Assessment
Internal & External Resources	
Risk Factors or Challenges	
Potential Goals	
Potential Need for Additional Resources	

What key information did you list?

Lifestyle area	Notes from Assessment & Tx Meeting
Internal & External Resources	• Close family & friends • Identified coping mechanism (e.g., poor eating, drinking) • Bikes (exercise) • Desire to get his diabetes under control
Risk Factors or Challenges	• Poor physical health • Some distrust in healthcare system • Feelings of depression and isolation • Lack of nutritious foods • Loss of Medicaid
Potential Goals	• Get diabetes under control • Apply for Medicaid • Talk with family and/or friends about relapse
Potential Need for Additional Resources	• Medicaid enrollment • Healthy food assistance • Education on diabetes • Support groups or counseling

Treatment Planning

1. How would you go about helping Will identify and prioritize his goals?

2. Write one SMART goal for Will based on the information you gathered during your first interaction.

Treatment Planning

3. Based on that goal, what are 1 or 2 actions Will could take to help achieve that goal? What is a reasonable timeline for that action?

4. What potential actions would you, as a team commit to as it relates to Will's care plan?

Final Thoughts

- Client-driven & written in the client’s own words
- As needs change, goals can change
- Talk about why their goals are changing
- Celebrate wins – no matter how small!
- You are there to support clients in developing their own action plans. They are the pilots.

Open Discussion, Sharing and Questions

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