IEMT Treatment Plans

For clients facing complex mental health, emotional and psychological challenges

A treatment plan is a set of written instructions and records pertaining to the treatment and management of a mental health condition and/or crisis. A treatment plan should include the client's key personal information, the diagnosis and/or presenting problem, an outline of the treatment under consideration, expected and intended outcomes, and the measurement of these outcomes during, and at the conclusion of, treatment.

A treatment plan should include:

- A definition, qualification, and quantification of the presenting problem
- A description of the treatment proposed by the coach/therapist
- A timeline for treatment, including frequency and duration of sessions
- Identification of the major treatment goals in the SMART format

Whilst for many clients a treatment plan is not necessary there are many scenarios and presenting problems for which a treatment plan will offer an opportunity for the client to collaborate in their treatment and to provide a structured framework for treatment. Many clients with complex issues and who may be new to therapy/treatment may find this reassuring, professional and motivating.

Where the appropriate permissions exist the treatment plans may be shared with mental health professionals and community support teams in order to increase multi-disciplinary communication, cooperation, and collaboration.

IEMT Practitioners should consider a treatment plan in the following scenarios:

- Clients experiencing serious mental illness or distress
- Clients experiencing multiple issues affecting them emotionally, physically, socially, and psychologically
- Clients with serious physical health issues
- Clients engaged in the criminal justice system
- Clients under compulsory treatment orders
- Clients engaged with multiple care/support/treatment agencies
- Clients referred by employers
- Working with teenagers and/or their families
- The vulnerable elderly
- Clients with developmental disabilities and/or intellectual challenges
- Clients experiencing sexual orientation or gender identity issues
- Clients who are being bullied and/or abused and/or exploited
- Clients with little socio-economic resource, minimal opportunities, and poor prospects

Each treatment plan is unique to each individual though many similarities and recurring themes will undoubtedly arise over time.

Contents of a Treatment Plan

All treatment plans are specific to each client. They are the collaborative result of the discussions and agreements that exist between the coach/therapist and the client.

Differences in the care plans between different clients are most likely to manifest in any or all of the following components:

- Demographics and personal history
- Assessment/diagnosis – whilst many people may share the same diagnosis, the experience of the client will be unique as will the context in which the presenting problem/illness/distress occurs
- The presenting problem – i.e. the problems or symptoms that initially brought the client to treatment
- Existing resources – the pre-existing resources that the client brings to treatment. These will be either intrinsic (i.e. clients own strengths and characteristics) and extrinsic (i.e. family support, financial aid, social support)
- Treatment contract – the agreement between the therapist and client that summarises the intentions of treatment
- Responsibilities – a section on who is responsible for which components of treatment, including the coach/therapist and other agencies across the multi-disciplinary and community support agencies
- Treatment outcomes – what are the intended and expected outcomes of treatment
- Specific interventions – the techniques, exercises, and interventions deployed by the coach/therapist
- Session frequency, duration, and number
- Progress/outcomes – the ability, rate, range, and degree of therapeutic progress will vary enormously between clients

Behavioural Observations

Note behavioral observations of the client's presentation of self. The coach/practitioner should assess the client's overall mental state which involves observing their physical appearance and interactions with others.

The coach/practitioner should also assess the client's overall mood (i.e.*sad, angry, indifferent*) and overall affect (*range, scope, and articulation of emotional expression*). These observations assist the coach/practitioner in making an effective diagnosis and developing an appropriate treatment plan.

Examples of observations that constitute the mental status exam include:

- Orientation to time, date, and place
- Self-grooming and hygiene (also observe fingernails, breath, odour, the freshness of clothing, etc)
- Eye contact - avoidant, little, none, or normal
- Mood - angry, withdrawn, irritable, tearful, anxious, depressed, etc
- Affect - appropriate/inappropriate, labile, stoical, blunted, flat
- Thought content disturbances - i.e. delusions, hallucinations, obsessions, intrusions, suicidal thoughts

- Behavioral disturbances such as aggression, poor impulse control, unreasonable demands
- Motor activity - agitation, calm, restless, rigid
- Speech (volume, speed, coherence)
- Interactional style (i) - i.e. nervous giggling, bombastic, cooperative, erratic
- Interactional style (ii) - active participant, passive, failure to initiate, conversationally domineering, etc
- Intellectual functioning (impaired, unimpaired)
- Memory - short term, long term
- Perceptual disturbances - i.e. hallucinations, the agency of communication and meaning
- Attention span - ability to focus and concentrate

Targets, Goals and Outcomes

To evaluate the effectiveness of the treatment plan, the coach/practitioner needs to track the client's progress and measure the efficacy of treatment and interventions. In some instances, it may be beneficial to ask the client to keep track of their inner experiences and behaviours in a log, chart, or diary so that progress can be monitored.

People in treatment are more likely to complete objectives when the goals are personally important to them, thus all goals should add value or meaning to the client's situation.

"*People are not lazy. They simply have impotent goals—that is, goals that do not inspire them.*" — **Tony Robbins**

SMART Goals

All outcomes, aims and treatment goals should be measurable using the SMART criteria:

- **Specific** – target a specific area for improvement. (*what*)
- **Measurable** – quantify or at least suggest an indicator of progress. (*how much*)
- **Assignable** – specify who will do it. (*who*)
- **Realistic** – state what results can realistically be achieved, given available resources. (*why*)
- **Time-related** – specify when the result(s) can be achieved. (*when*)

The term S.M.A.R.T. Goals and S.M.A.R.T. Objectives are often used. Although the acronym SMART generally stays the same, *objectives* and *goals* can differ. Goals are the distinct purpose that is to be anticipated from the assignment or project, while objectives, on the other hand, are the determined steps that will direct the full completion of the project goals. (**SAMHSA Native Connections.** "*Setting Goals and Developing Specific, Measurable, Achievable, Relevant, and Time-bound Objectives" (PDF). Substance Abuse and Mental Health Services Administration*.")

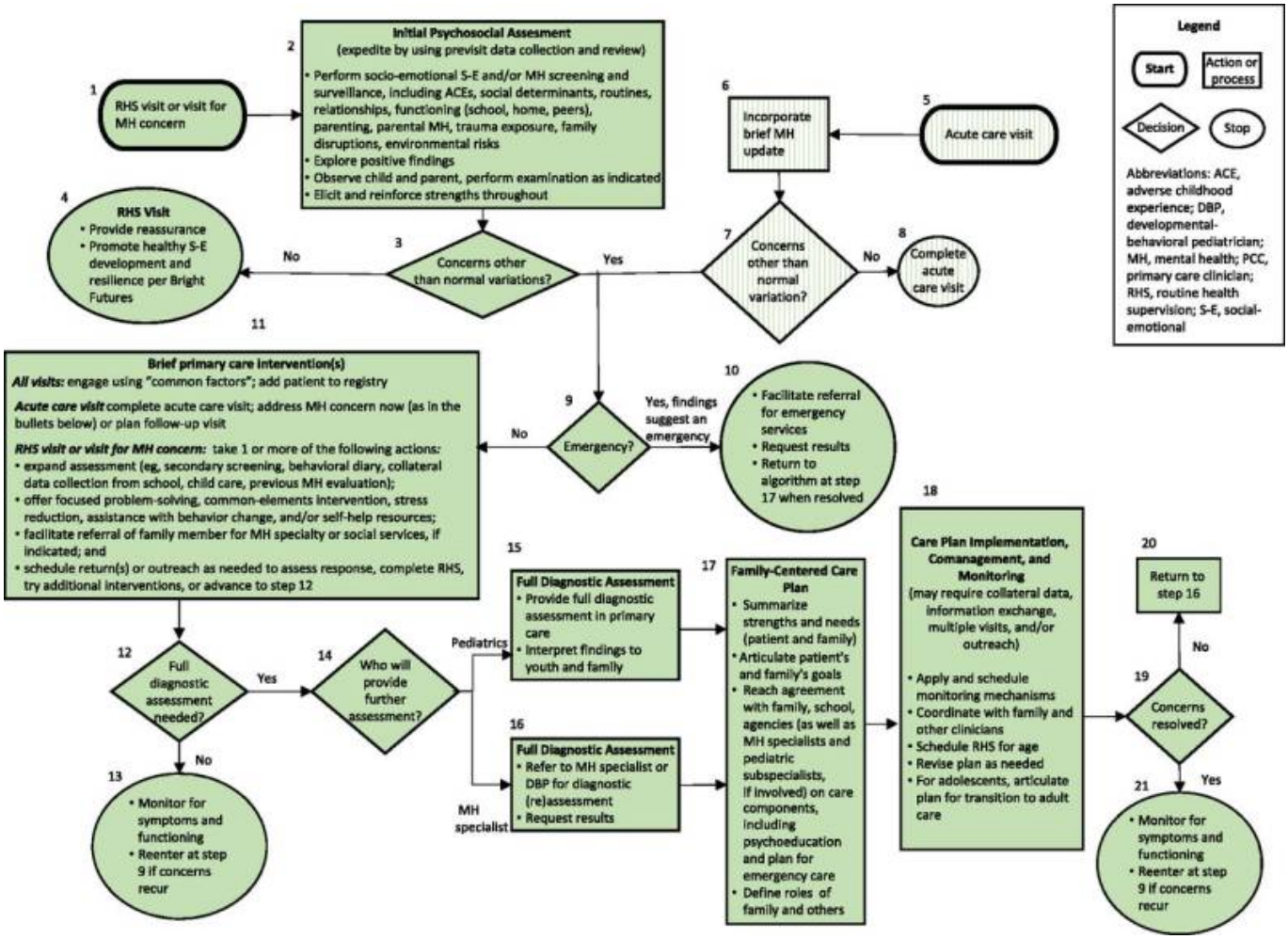
Two additional criteria create the SMARTER system:

- **Evaluate** - The sixth step in goal setting using the S.M.AR.T.E.R. method is to ensure that all progress towards each goal is evaluated.

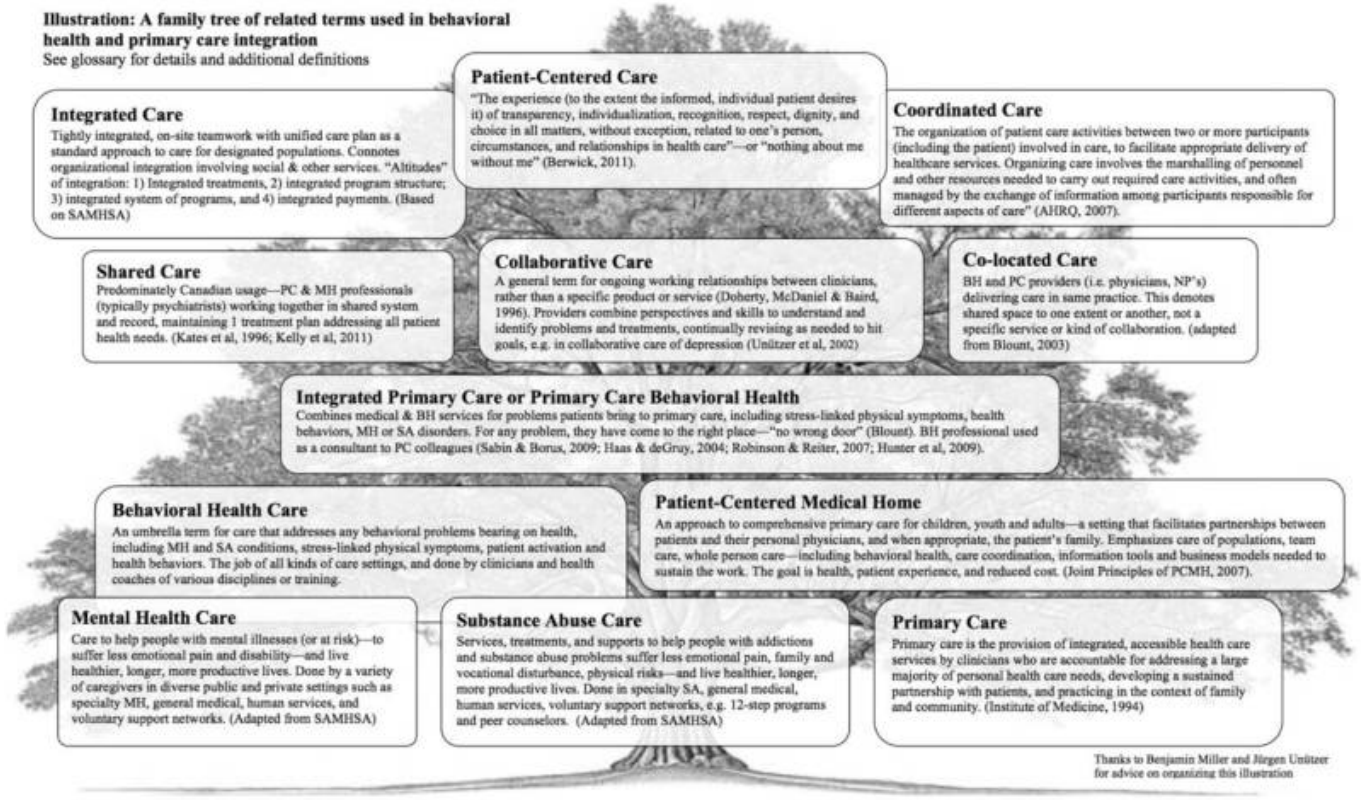
- **Readjust** - The seventh step is to adjust treatment according to the evaluation.

SAMPLEs - not for inclusion

Schizophrenia				
Signs & Symptoms	**Causes**	**Rule Outs**	**Labs/Tests/Exams**	**Interventions**
• At least for 1 month, 2 or more from the following: ◆ Delusions ◆ Hallucinations ◆ Disorganized speech ◆ Disorganized behavior ◆ Negative symptoms (alogia, affective flattening, avolition) • Functional disturbances at school, work, self care, personal relations • Disturbance continues for 6 mo	• Dopamine hypothesis (excess) • Brain abnormalities (3rd ventricle sometimes larger) • Frontal lobe – decreased glucose use/smaller frontal lobe • Genetic – familial; monozygotic twin (47% risk vs 12% dizygotic) • Virus • No specific cause	• Schizophreniform disorder • Schizoaffective • Mood disorder with psychotic symptoms • Medical disorder/substance abuse with psychotic episode • Delusional disorder • Note: With schizophrenia, the condition persists for at least 6 mo and is chronic and deteriorating	• Psychiatric evaluation and mental status exam • No test can diagnose schizophrenia • Positive and Negative Syndrome Scale (PANSS) • Abnormal Involuntary Movement Scale (AIMS) • Need to rule out other possible medical/substance use disorders: LFTs, toxicology screens, CBC, TFT, CT scan, etc.	• Antipsychotic – usually atypicals for new onset: risperidone, olanzapine, aripiprazole, etc. • Acute psychotic episode may need high potency (haloperidol) • Hospitalization until positive symptoms under control • Patient/family education • NAMI for patient/family education, as patient advocate

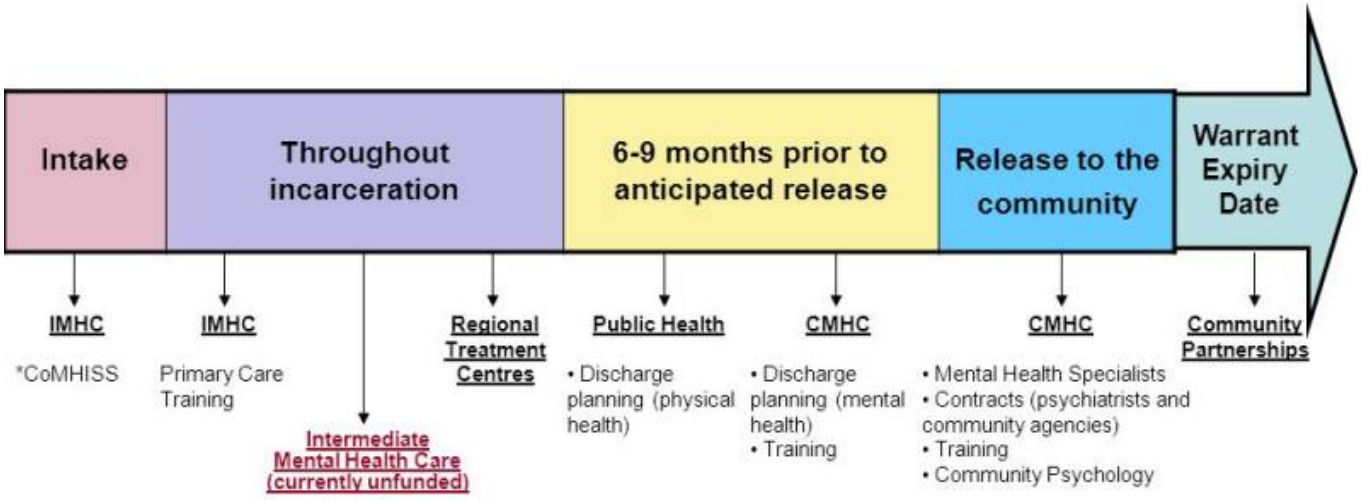

Legend
Start
Action or process
Decision
Stop
Abbreviations: ACE, adverse childhood experience; DBP, developmental-behavioral pediatrician; MH, mental health; PCC, primary care clinician; RHS, routine health supervision; S-E, social-emotional
1
RHS visit or visit for MH concern
2
Initial Psychosocial Assesment
(expedite by using previsit data collection and review)
• Perform socio-emotional S-E and/or MH screening and surveillance, including ACEs, social determinants, routines, relationships, functioning (school, home, peers), parenting, parental MH, trauma exposure, family disruptions, environmental risks
• Explore positive findings
• Observe child and parent, perform examination as indicated
• Elicit and reinforce strengths throughout
3
Concerns other than normal variations?
No
Yes
4
RHS Visit
• Provide reassurance
• Promote healthy S-E development and resilience per Bright Futures
5
Acute care visit
6
Incorporate brief MH update
7
Concerns other than normal variation?
No
8
Complete acute care visit
9
Emergency?
No
Yes, findings suggest an emergency
10
• Facilitate referral for emergency services
• Request results
• Return to algorithm at step 17 when resolved
11
Brief primary care intervention(s)
All visits: engage using "common factors"; add patient to registry
Acute care visit complete acute care visit; address MH concern now (as in the bullets below) or plan follow-up visit
RHS visit or visit for MH concern: take 1 or more of the following actions:
• expand assessment (eg, secondary screening, behavioral diary, collateral data collection from school, child care, previous MH evaluation);
• offer focused problem-solving, common-elements intervention, stress reduction, assistance with behavior change, and/or self-help resources;
• facilitate referral of family member for MH specialty or social services, if indicated; and
• schedule return(s) or outreach as needed to assess response, complete RHS, try additional interventions, or advance to step 12
12
Full diagnostic assessment needed?
Yes
No
13
• Monitor for symptoms and functioning
• Reenter at step 9 if concerns recur
14
Who will provide further assessment?
Pediatrics
MH specialist
15
Full Diagnostic Assessment
• Provide full diagnostic assessment in primary care
• Interpret findings to youth and family
16
Full Diagnostic Assessment
• Refer to MH specialist or DBP for diagnostic (re)assessment
• Request results
17
Family-Centered Care Plan
• Summarize strengths and needs (patient and family)
• Articulate patient's and family's goals
• Reach agreement with family, school, agencies (as well as MH specialists and pediatric subspecialists, if involved) on care components, including psychoeducation and plan for emergency care
• Define roles of family and others
18
Care Plan Implementation, Comanagement, and Monitoring
(may require collateral data, information exchange, multiple visits, and/or outreach)
• Apply and schedule monitoring mechanisms
• Coordinate with family and other clinicians
• Schedule RHS for age
• Revise plan as needed
• For adolescents, articulate plan for transition to adult care
19
Concerns resolved?
No
Yes
20
Return to step 16
21
• Monitor for symptoms and functioning
• Reenter at step 9 if concerns recur


PLANNING CYCLE
Build a Community Coalition
Asses Community Health and Community Resources
Identify Health Problems/ Set Priorities
Conduct Problem Analyses/ Select Interventions
Develop Objectives and Performance Measures
Write and Implement a Program Action Plan
Develop an Evaluation/ Performance Monitoring Plan



Continuum of Care:

Mental Health Initiatives, Public Health and Regional Treatment Centres



CoMHISS: Computerized Mental Health Intake Screening System
IMHC: Institutional Mental Health Care
CMHC: Community Mental Health Care

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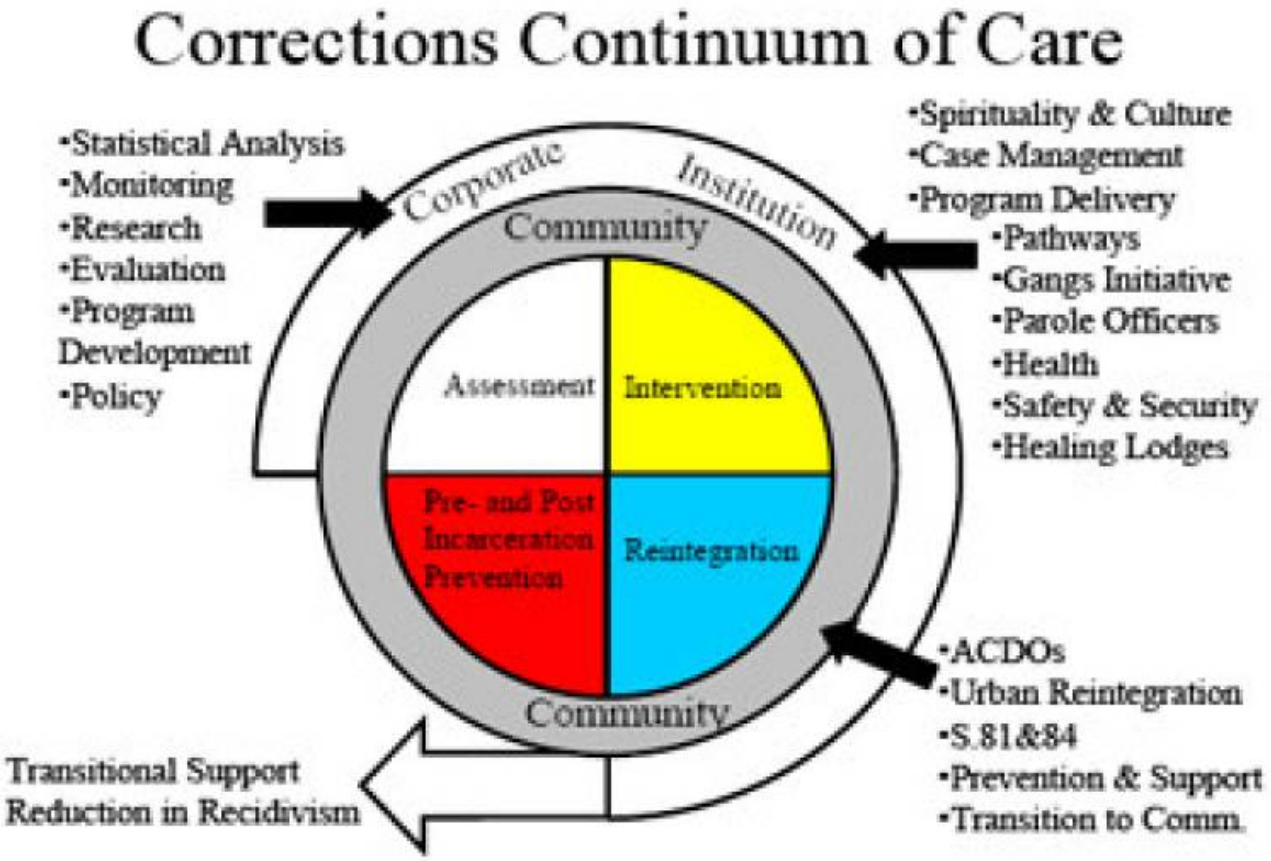
Corrections Continuum of Care
•Statistical Analysis
•Monitoring
•Research
•Evaluation
•Program Development
•Policy
Corporate
Institution
Community
Assessment
Intervention
Pre- and Post Incarceration Prevention
Reintegration
Community
•Spirituality & Culture
•Case Management
•Program Delivery
•Pathways
•Gangs Initiative
•Parole Officers
•Health
•Safety & Security
•Healing Lodges
•ACDOs
•Urban Reintegration
•S.81&84
•Prevention & Support
•Transition to Comm.
Transitional Support
Reduction in Recidivism

Figure. Suggested Approach to Diagnosis and Management of SUDs and Co-Occurring Disorders in the Emergency Department

ASAM-PPC, American Society of Addiction Medicine Patient Placement Criteria.

Continuum of Care:

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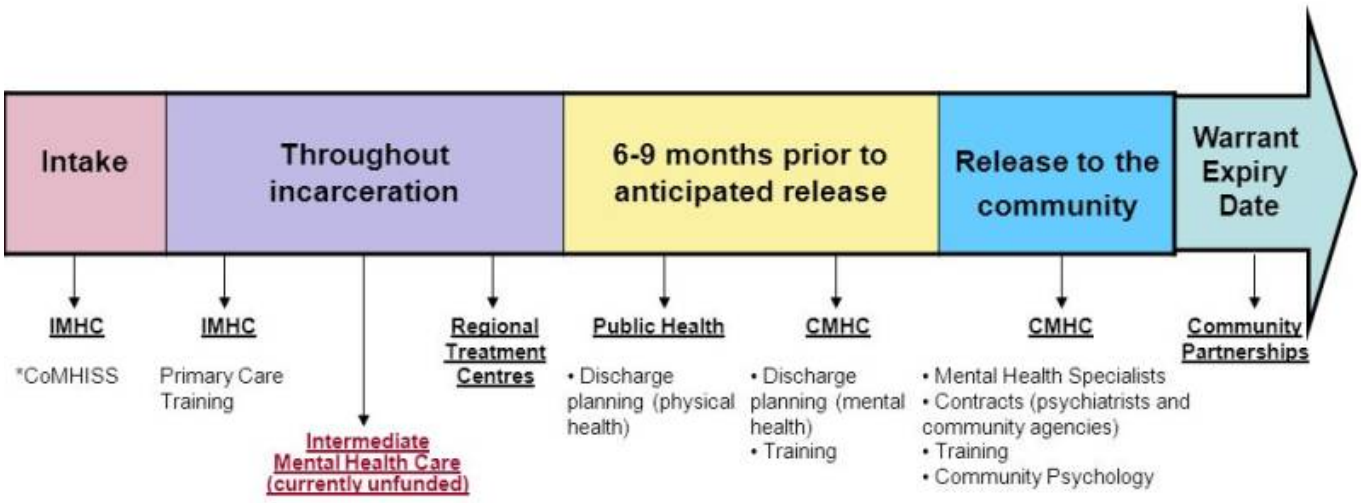

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Stepped Care Model