

## ASAC TREATMENT PLANNING

The Evaluation/Assessment of the client/patient, which shall be an analysis and synthesis of all data gathered to date, and shall address the client/patient's strengths, problems, and areas of clinical concern. Sufficient information shall be collected so that the assessment process allows for the development of a complete assessment of the client/patient's status and a comprehensive plan of treatment can be developed. The amount of data gathered is dependent on each client/patient's past and present situations.

A comprehensive treatment plan is to be developed as soon after the client/patient's admission as is clinically feasible, but no more than thirty days after the admission date in an outpatient or halfway house program and seven days after admission to a residential or intensive outpatient program.

Before the comprehensive treatment plan is developed, the counselor shall thoroughly evaluate and analyze the data. The development of the treatment plan will be a joint process involving the client/patient and counselor. The client/patient and counselor must sign and date the treatment plan.

Each treatment plan shall be developed in partnership with client/patient, be culturally and environmentally specific so as to meet the needs of the client/patient, written in a manner readily understandable to the client/patient, with assistance if necessary, and will contain the following:

1. A clear and concise statement of the client/patient's current strengths and needs;
2. A clear and concise statement of the goals the client/patient will be attempting to achieve;
3. The type and frequency of the activities in which the client/patient will be participating;
4. The criteria to be met for successful completion of treatment;
5. The primary and support services to be provided;
6. The staff person(s) responsible for treatment.

The following guidelines are to be followed by staff when developing treatment plan goals:

1. Are steps toward achieving desired results?
2. Are specific, realistic, and within the client/patient's reach and specified in observable, objective behavioral terms.
3. Short-term goals are defined as forty-five days or less for residential client/patients and ninety days or less for outpatient client/patients.
4. Long-term goals are defined as forty-six days or more for residential client/patients and ninety-one days or more for outpatient client/patients.

It is the primary counselor's responsibility to inform each client/patient that they will provide a copy of their treatment plan upon specific request. The primary counselor and the client/patient shall review the treatment plan as often as necessary and in accordance with the time frame specified within the continued service review. The Treatment Plan/Review will be completed in the I-Smart file, a copy printed out for signatures/date (See I-Smart Treatment Plan and Treatment Review Outlines).

The review shall consist of a reassessment of the client/patient's current status in accordance with the continued service review criteria, accomplishments and needs, and a redefining of treatment goals when appropriate. The date of the review, any changes, as well as the individuals involved in the review shall also be recorded in the review process.

The Supervisor will review a sample of each counselor's treatment plans, treatment reviews, transfers and discharges within the their component.

The Deputy Director will also monitor on a random basis, the reviews performed by the Supervisors.