Individual Treatment Planning

Client Name /ID #: _____

D.O.B: _____

Purpose

To identify client's needs and goals (immediate and long-term) in addressing the harms associated with their problematic substance use or mental health concerns and determine the required actions, interventions and support.

Instructions

- Make the Individual Treatment Plan personal for your client- make sure it is documented in a language that he/she can understand.
- Explain the purpose (in your own terms) and proceedings of Individual Treatment Planning including confidentiality and mandated responsibilities, as well as roles and responsibilities of each party involved to the client before commencing.
- Write legibly – other case workers might need to reference information gathered in the Individual Treatment Plan.
- Ensure that your name, signature and date are recorded on each page of the Individual Treatment Plan.

Conducted by _____

Position/Designation _____

Date _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Case Notes

- Most recent case notes on top
- When preparing your case notes, always complete your case notes as if they are subject to review, FOI or subpoenaed to a court of law.
- Include the date, time and the practitioner's name which should be printed and signed and not on behalf of another practitioner.
- Ensure they are legible, brief and accurate and complete whilst avoiding value judgements and conclusions
- Avoid abbreviations where possible
- Any alterations should be made neatly and preferably signed when amended

Client Name /ID #: _____

D.O.B: _____

Date	*Details of Engagement* (E.g. Record of intervention or action, discussion, observations etc.)

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Date	*Details of Engagement* (E.g. Record of intervention or action, discussion, observations etc.)

Client Name /ID #:

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Referral & Acknowledgement Cover Sheet

To be attached to Client Information; Personal Details Form AND Outcome of Initial Screen or Case Formulation when making a referral to an external service provider.

Client Name /ID #: _____

D.O.B: _____

Details of organisation making referral (your organisation)

Name _____

Position _____ **Organisation** _____

Email _____ **Phone** _____

Fax _____

Details of organisation to receive referral (the external organisation)

Name _____

Position _____ **Organisation** _____

Email _____ **Phone** _____

Fax _____ **Date of referral** _____

Reason for referral/type of referral requested _____

_____

_____

Priority referral? Yes No

If yes, provide detail _____

_____

_____

The following are attached:

- ◯ Client Information; Personal Details Form
- ◯ Outcome of Initial Screen
- ◯ Case Formulation
- ◯ Individual Treatment Plan
- ◯ Other _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Acknowledgement of referral

(Complete if a referral has been received and provide back to referring organisation)

Details of organisation receiving referral

Organisation _____ **Program** _____

Location/Service Region _____

Primary Contact person name _____

Email _____ **Phone** _____

Fax _____

Date referral received _____

Status of referral ○ Accepted ○

Wait-listed ○ Rejected ○

Details of referral outcome _____

_____

_____

_____

Date of proposed assessment _____

Request for further client information

Details of types/specific information required _____

_____

_____

_____

_____
Client Name /ID #:

_____
D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Individual Treatment Plan (ITP)

I _____ (client name) understand and agree to this plan.

Signed _____ Date _____

Client Name /ID #: _____

D.O.B: _____

Treatment Goal or Outcome Based on assessed needs and risks	Strategies	Required Intervention(s), Treatment-type or Services	By who?	By when	Review Date for this goal/ outcome	Modifications to plan

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

STAFF USE ONLY Practitioner Name: _____ Position: _____

Date: _____

Client Name /ID #: _____

D.O.B: _____

Review & Evaluation of Individual Treatment Plan

Treatment Goal/Outcome	Methods of evaluation (E.g. discussion & feedback from client, minutes from case-conference etc.)	Evaluation of effectiveness of strategies and interventions (include supporting evidence)	Identification of service gaps and/or need for development of resources

Relapse Prevention Plan

- It is recommended that you complete Brief Intervention using Remote Alcohol and Other Drugs Workforce Intervention Tools (E.g. Yarning about Relapse)
- Ensure you discuss the fact that relapse isn't considered a failure.
- Emphasis that the most important aspect of relapse is the ability to recognise why it happened.

Client Name /ID #: _____

D.O.B: _____

My Cravings Plan

(Adapted from Copeland et al. 2009)

When I'm having a craving, I feel like _____

When I'm having a craving I act _____

When I'm having a craving I think _____

High risk situations (When am I more likely to want to drink/use?)	**My coping plan** (To help me to manage my cravings, I will...)

(Adapted from Insight Alcohol and Other Drug Training Unit, 2013)

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Our 5-step Plan to 'Getting back on Track' (for just in case)	**Who can help me with this?**
Step 1	
Step 2	
Step 3	
Step 4	
Step 5	

Client Name /ID #:

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Aftercare Plan

STAFF USE ONLY Practitioner Name: _____ Position: _____

Date: _____

To be developed and implemented prior to date of exit from service

Client Name /ID #: _____

D.O.B: _____

Goals to address risk of relapse or harm	Activities or Strategies	Required Intervention(s) or Treatment-type	Name of Service (Specialist or non-specialist)	Available social and support networks	Priority? √

Details of agreed aftercare engagement

(to be negotiated with client including frequency, duration, method and purpose of engagements)

Client Name /ID #:

D.O.B:

Summary of Actions Taken for Referral (either for active or self-referral)

Date	Details	Signed

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Record of Aftercare Actions and Engagements

Date	Details of actions, outcomes etc.	Signed

Client Name /ID #:

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____