How to Develop Treatment Plans that Make Sense to Clients: Improving Documentation and Clinical Use of the Treatment Plan and Progress Notes

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A. **Principles of Focused, Targeted Treatment Planning** - Why Individualize Treatment?

(i) Consider the following:

- What is a treatment plan, and why use one?
  a. NOT just a written plan on paper
  b. Most important with the most complex clients
  c. Should represent a shared vision
- Teamwork
  a. The client is the most important team member
  b. The client is the person who should know the treatment plan the best
  c. Includes productive work with each other, especially across agencies
- Engagement
  a. Do we view the world through the client's eyes?
  b. What does the client want most that drives the treatment plan?
  c. How can we help the client to be utilizing his/her strengths?
  d. How do WE feel if the focus is only on the negative—desires, hopes and goals are critical

(ii) Common Treatment Planning Issues for Improvement

1. Problem Statements – Too general and non-specific
Examples: "Psychiatric"; "Substance Abuse"; "Legal"

2. Goals – Not understood by clients
Examples: By six months, "develop awareness of cognitive deficits" and utilization of cognitive rehabilitation resources"; "Client will reduce the frequency of distorted, negative thoughts, use reframing skills"

3. Interventions – Generic and not individualized
Examples: Substance abuse education weekly – work on healthy living behaviors; Pros and cons of complying with prescribed treatment activities and medications; Contemplator Discovery Group; Dual Recovery Anonymous; MISA Consultation

4. Progress Notes – General; often focused on attendance and compliance rather than documenting client's clinical progress

Examples: "More willing to follow rules and compliant with treatment activities"; "Compliant participation in group"; "Attended and participated in all scheduled groups"; "Plan: Continue to monitor"

- Long progress notes
- No notes related to problems e.g., Substance Abuse
- Difficult to see what the progress note relates to in the Treatment Plan

B. **Engaging the Participant in Collaborative Care**

1. Three aspects of the therapeutic alliance ((Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press. p. 39):

(a)

(b)

(c)

2. Developing the Treatment Contract and Focus of Treatment

	Client	Clinical Assessment	Treatment Plan
What?	What does client want?	What does client need?	What is the Tx contract?
Why?	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
How?	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
Where?	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
When?	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorders, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he was not using anything. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl said he is holding for a friend.

C. **Guidelines for Defining and Writing Problems**

* counterproductive attitudes - 3 I's: irrelevant; irritating; insurance-driven
* productive attitudes - 3 C's: concentrate treatment; communicate; cont.-of-care
* problem identification - "2x4":

A – Appropriate to diagnosis (gambling, addiction and/or mental health);
A - Achievable: time, place, person
B - Brief; B - Behavioral
C - Care: level of care e.g. acute-care oriented, time, place, person;
C - Caring: expressed in accepting, non judgmental words
D - Different: for each patient; what different strategy; time, place, person;
D - Dimension: which of the multidimensional assessment areas does this problem address e.g. Dimension 1

* *What Made Me Say That?*

D. **Skill-Building in Developing and Communicating the Treatment Plan**

1. Making Treatment Plans a "Living" Document

(a) Principles

1. Problems identified should arise from a biopsychosocial assessment and level-of-functioning (LOF) or severity-of-illness (SI) profile.

2. Problems should be short-term in an acute-care treatment plan; may be longer-term in a program with a longer length of stay (LOS).

3. Treatment planning is a continuous, ongoing process of assessment, problem identification and matched treatment strategies. Thus problems, whether in acute care or longer LOS program, should be specific and treatable within the current level of care (LOC); not fixed for the whole LOS; and should be updated and/or resolved and replaced with new problems identified from ongoing assessment.

4. A problem identified at any time may be listed on the Master Problems Index and coded to indicate whether treatment is to be addressed in the current LOC or later in the recovery or treatment process.

(b) Steps to Writing Problems

1. Review the multidimensional Level of Functioning/ Severity Profile and identify which dimensions are of most concern.

2. Look especially at each high and medium severity dimension and ask yourself what concerns you most within that assessment dimension.

3. Review the specific information related to the dimension in the biopsychosocial assessment for help in defining a problem for each dimension of concern.

4. In general, write only one problem for each dimension of concern to keep the treatment plan focused, specific, fluid and achievable. If there is an additional acute problem needing treatment, then a second problem for that dimension may be necessary.

5. Define the problem using the "2x4" guidelines.

6. Check the problem you have decided to document for specificity and individualization by asking yourself, "What made me say that?". If you can answer with a more specific behavior or observation, then that should be the problem, not the more abstract problem originally chosen.

(c) Clinical Problem or Need:

- A situation or issue in need of improvement; and
- Related to the clinical assessment of the client.

(d) Short Term Goal:

1. An expected result or condition which takes a short time to achieve.
2. Related to the identified clinical problem
3. Stated in measurable terms

4. Use action verb to illustrate direction of change - from the perspective of "what the client will be able to do after attending treatment sessions" and not from the perspective of what you as the counselor will do during treatment e.g. "Client will receive education about the effects of drinking on the family"
Begin each Goal with a verb that denotes an observable action, such as: "Define, Describe, List, Explain, Discuss, and Apply" e.g., "Bill will be able to describe how each family member has been affected by his drinking" Avoid words that indicate emotions, feelings or other things that occur in the head, such as "know, learn, appreciate, understand, recognize", etc.

Example: "Bill will appreciate the negative effects and consequences of his drinking on the family"

5. One goal per problem statement
6. Provides a guideline for the direction of care.

(e) Plan of Treatment:

1. Describes the service(s) or action to meet the stated goal
2. Specifies frequency of treatment procedures
3. Has a time for achievement
4. Identifies if client and/or staff member(s) responsible for action or strategy in the treatment plan e.g., Sally is to try the "I have strong willpower, no AA meetings" treatment strategy; and counselor to arrange family meetings or contact to get reports back on how Sally's drinking and family relationships are progressing or not.

(f) Sample Strategies for Treatment Plans

- List three reasons the court sent you to treatment.
- Write down the most recent incidents involving alcohol and other drugs.
- Identify what happens if you don't comply with probation requirements and report to group.
- List the positive and negative aspects of substance use.
- Attend at least one AA meeting and see if you can identify with anyone's story.
- Verbalize in group, what things need to change in your life or not.
- Discuss the positive and negative consequences of continued substance use.
- Explore early childhood history of violence through individual therapy once per week. Focus on what kind of role models the client had.
- For the next incident of rage and anger, fill in the date, trigger, physiological signs and behavior taken; and then discuss how he or she could deescalate the rage.
- Share in group what has been working to prevent relapse and get other suggestions.

Roger, a 53 y/o male client presents for a substance use treatment screening at the request of his probation officer. Information obtained from probation indicates the client has been prescribed Opioid medications for chronic pain due to injuries he sustained after a motorcycle accident 3 years ago. The client was recently involved in a DUI and found to be in possession of narcotics that were not prescribed to him. The client shares with you that he would be interested in talking to someone about the death of his mother 4 months ago and tearfully states his life has "fallen apart again" and that "everything has gotten worse."

The client goes on to express anger at his probation officer and primary care doctor for wanting him to find "different ways to manage the pain." The client states that if people felt as bad as he did "they would need the pills too." Client's self-report indicates that he drinks alcohol 3 times per week, 3-5 beers each time, and feels that the police may have "set him up." The client alleges that it was "not possible" that his blood alcohol was over the legal limit and that "the pills for pain don't impact my driving." The client reports that he takes 8-12 Oxycodone tablets per day and used to "borrow" pills from his mother when he was "feeling really bad." The client states that he knows his probation officer is requiring him to attend treatment, but he does not really want to.

Questions:

1. What two goals for treatment are most important to Roger?

2. To assess severity in each of the 6 ASAM Criteria assessment dimensions, what clinical information for each dimension do you need, if missing in this vignette? Indicate which dimension has missing information and specify what more information you want.

LITERATURE REFERENCES

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