"Ideas for Treatment Improvement"

ADDICTION Messenger

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SERIES 22

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Treatment Planning - Part 1

Creating a Living Document

"Just because something doesn't do what you planned it to do doesn't mean it's useless."
~ Thomas A. Edison (1847 - 1931) ~

Counselors, supervisors and administrators in addiction treatment agencies can utilize treatment planning to guide treatment activities, monitor client progress and assess treatment outcomes. Treatment planning is often viewed as "paperwork" rather than clinically valuable and useful information. The goal of this Addiction Messenger series on "Treatment Planning" is to provide you information and strategies that can transform "paperwork" into a critically valuable activity in the treatment process.

The *"Addiction Counseling Competencies: the Knowledge, Skills and Attitudes of Professional Practice"* (Technical Assistance Publication 21) published by Center for Substance Abuse Treatment (1998) defines treatment planning as:

> "A collaborative process through which the counselor and client develop desired treatment outcomes and identify the strategies for achieving them. At a minimum the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns and legal needs."

The *"Principles of Effective Treatment - A Research-Based Guide"* published by the National Institute on Drug Abuse (2000), refers to treatment planning in Principle No. 4 as:

> "An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery."

The Joint Commission of Accreditation of Healthcare Organiztions' (1992) *"Patient Records in Addiction Treatment - Documenting the Quality of Care"* notes that:

> "Treatment plans are living, continuously evolving documents intended to guide treatment interventions and track the patient's progress"

Most treatment agencies describe themselves as using individualized treatment plans based on the client's specific needs. David Mee-Lee, M.D., in his monthly newsletter, TIPS and TOPICS (Vol. 1, No. 4), poses the question "Do we really believe in individualized treatment?" He suggests you do an experiment in your agency. Go to the chart rack in your agency and pick 4 or 5 charts, at random, to review. Do the problem statements start

sounding alike?

"Legal issues"
"Lacks knowledge of addiction"
"Lacks knowledge of disease concept"

Do the treatment assignments start sounding alike?

"Individual therapy"
"Group therapy"
"Attend AA meetings"

How about the progress notes? Are you reading:

"Attended group and gave feedback to others"
"Gaining insight into disease concept"
"Continue current objectives"

If you're finding strong similarities in each of the charts you might be wondering, "Do all of these clients have the same problems?", "Do they each have the same severity of illness?", or "Do they need the exact same strategies?" Dr. Mee-Lee's question, "Do we really believe in individualized treatment?" leaves much to be considered and stimulates thoughts on what makes a client's treatment plan a vibrant and living part of their recovery.

Making a Treatment Plan a Living Document

TIPS and TOPICS, the same issue cited above, provides some suggestions. These thoughts and suggestions can help you "walk the talk" regarding individualized treatment plans.

1. As you start your next group counseling sesssion ask the group, "What do you want to get from this meeting to help you advance your treatment plan?" Notice the clients' response. Are you getting generic answers like "To improve my self esteem" or "To keep PO off my back"? Do these types of responses make you wonder if the person is "doing time" instead of doing treatment? What if that client gave the response, "I want to get some feedback from the group members on the decisional balance sheet I've been working on"? It would be a definite sign that you're providing client-centered services and that your client is working on issues reflected in the treatment plan.

2. Before you document any problem statement or treatment issue in the treatment plan, try asking yourself, "What made me say that?". Try to answer that question by making it specific to something the client said or that your assessment indicated. Write that down as the problem statement or focus of treatment instead of a generic problem. An example would be instead of writing that the client, "Lacks a supportive environment", you might want to write as a problem statement in the treatment plan that the "Client lives with a drug dealer". This problem statement will stem from your response to "What made me say that?"

3. Here's something to try that will help you gage if a treatment plan is a living, evolving, person-centered and participatory instrument that is a significant part of a clients recovery. Gather the progress notes from a client's chart, read them in order from the oldest to t he most recent. Without looking at the problems statements, can you tell what the problems and treatment issues are? Can you understand what knowledge or skill deficits are being addressed in the treatment plan and services provided?

If the progress notes seem disjointed, and only note if the client attended a group or not...

If anecdotes regarding what was discussed are disconnected...

If there are generic statements about continuing treatment objectives that could apply to almost any other client's chart...

Maybe that treatment plan has become a stagnant and dying record instead of a vibrant part of that client's recovery process.

TIPS and TOPICS (Vol. 2, No. 2), provides suggestions on making treatment contracts, treatment planning and documentation a client-centered, participatory, strength-based and collaborative process.

Treatment Contracts

The treatment contract is an agreement between the client and counselor to work together towards the client's goals. What is that client's most important goal when you meet them? Working toward that goal is the contract. A clearly defined contract is what drives the assessment and service planning process and gives shape and focus to the treatment plan.

Treatment Plans

It's crucial that your client understand the link between their treatment contract and their treatment plan. It's unlikely that collaborative participation will occur if the client doesn't see the link. The problem statement that's documented in the treatment plan needs to make sense to the client. If the problem statements are specific and concrete they will help the client identify any potential obstacles in reaching their treatment goal.

Example: If a treatment contract is to help the client keep their marriage, then a problem statement like "poor insight" or "doesn't understand disease concept" may not elicit a "buy-in" from the client. But if the problem statement noted

that the client "feels marriage is threatened but not because of drinking" it can be used to discover whether continuing to drink will increase or decrease the threat to their marriage.

Dr. Mee-Lee suggests five key questions to use in developing the treatment contract:

1. What is the collaboratively agreed upon treatment contract?
2. Why now and what is the level of readiness of the client?
3. How does the client think they'll achieve their goal?
4. Where are they willing to receive treatment? Explore their ideas about types of programs and levels of care.
5. When are they willling to receive treatment? What are their ideas about when to start and how long their treatment should last?

Exploring What, Why, Where and When

One method of developing a participatory treatment plan involves exploring:

- what the client has been told they need,
- what they want,
- what they need to change, and
- what the client thinks the you want to hear.

The chart below was adapted from TIPS and TOPICS Vol. 2, No. 2. Using this chart can assist you in exploring What, Why, Where and When with your client.

Subscribe to Dr. Mee-Lee's
TIPS and TOPICS at:
www.DMLMD.com

	Client	Clinical Assessment	Treatment Plan
What?	What does the client want?	What does the client need?	What is the treatment contract?
Why?	Why now? What's the level of readiness to change?	What reasons for recommending treatment are revealed in the assessment data?	Is it linked to what the client wants? Or needs?
How?	How will s/he get there? How will treatment help? How quickly?	How will you work with client to facilitate his/her acceptance of the plan?	Does the plan reflect the client's buy-in or commitment to the plan?
Where?	Where do I go?	What 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?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the process? What are the expectations of the referral?

Next Issue:

"SMART Treatment Planning"

Sources:

Center for Substance Abuse Treatment (1998) **Addiction Counseling Competencies: the Knowledge, Skills and Attitudes of Professional Practice.** Technical Assistance Publication 21. DHHS Publication No. (SMA) 98-3171. Rockville, Maryland: CSAT

National Institute on Drug Abuse (2000) **Principles of Effective Treatment - A Research-Based Guide**. NIH Publication No. 00-4180

Joint Commission of Accreditation of Healthcare Organiztions (1992) **"Patient Records in Addiction Treatment - Documenting the Quality of Care".** p.29

David Mee-Lee, M.D., Training and Consulting, **TIP and TOPICS, Vol.1, No. 4**. and **Vol. 2, No. 2**. Retrieved from the World Wide Web at **http://dmlmd.com/2003.07.ezine.pf.html** on April 13, 2006.

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PRE - TEST Series 22

1.
Treatment planning includes which of the following?
a. Identifies important client treatment goals.
b. Describes measurable, time-sensitive action steps toward acheiving goals.
c. Does not reflect a verbal agreement between counselor and client.
d. a and b

2.
The treatment plan is developed by the client's counselor.

True or False

3.
Which of the following potential problem areas does the ASI identify?
a. Medical status and drug/alcohol use.
b. Employment and support
c. Family/social and legal status
d. all of the above.

4.
Name two ways in which the ASI can guide the treatment plan.
1.
2.

5.
S.M.A.R.T. treatment planning objectives are realistic because the client is able to attain them in the time period and achievable given their environment, support systems and level of functioning.

True or False

6.
The seven problem domains in the ASI help support the importance of viewing clients and their problems from a biopsychosocial perspective.

True or False

7.
A clearly defined Treatment Contract is what drives the the assessment and service planning process but doesn't gives shape and focus to the treatment plan.

True or False

8. S.M.A.R.T stands for (fill in the blanks):
S means ________________________
M means _______________________
A means ________________________
R means ________________________
T means ________________________

9.
To arrange for a ASI S.M.A.R.T. training contact:

____

10.
The ASI is not:
a. a personality test.
b. a medical test.
c. an instrument that leads to DSM-IV-TR diagnosis.
d. all of the above.

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