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. Stages of Change - Transtheoretical Model of Change (Prochaska and DiClemente)

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; not actively interested in change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of possible "problem" & possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a "problem" or needs to change; wants to change, but this desire exists simultaneously with being satisfied with the status quo; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong discord and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

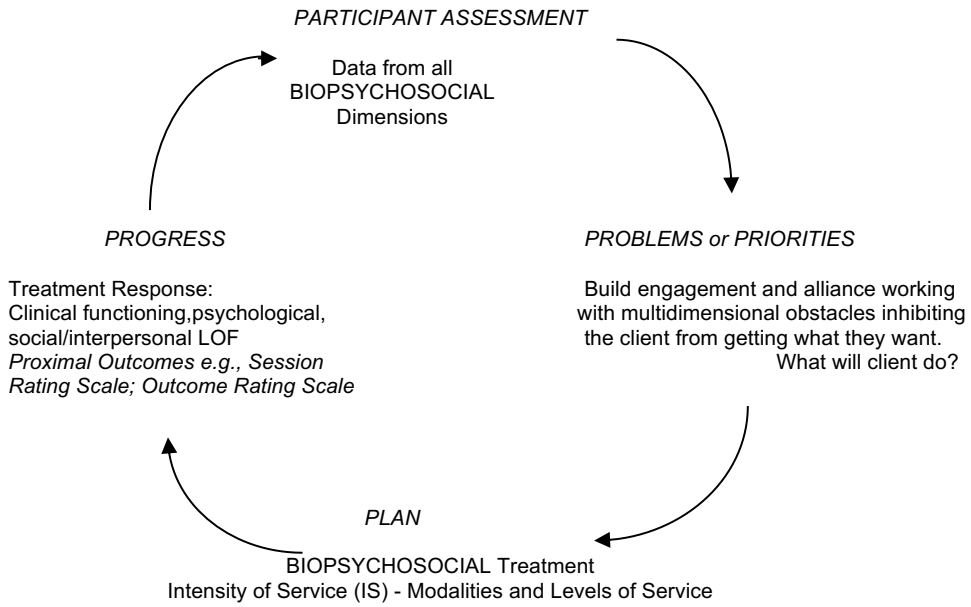
Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

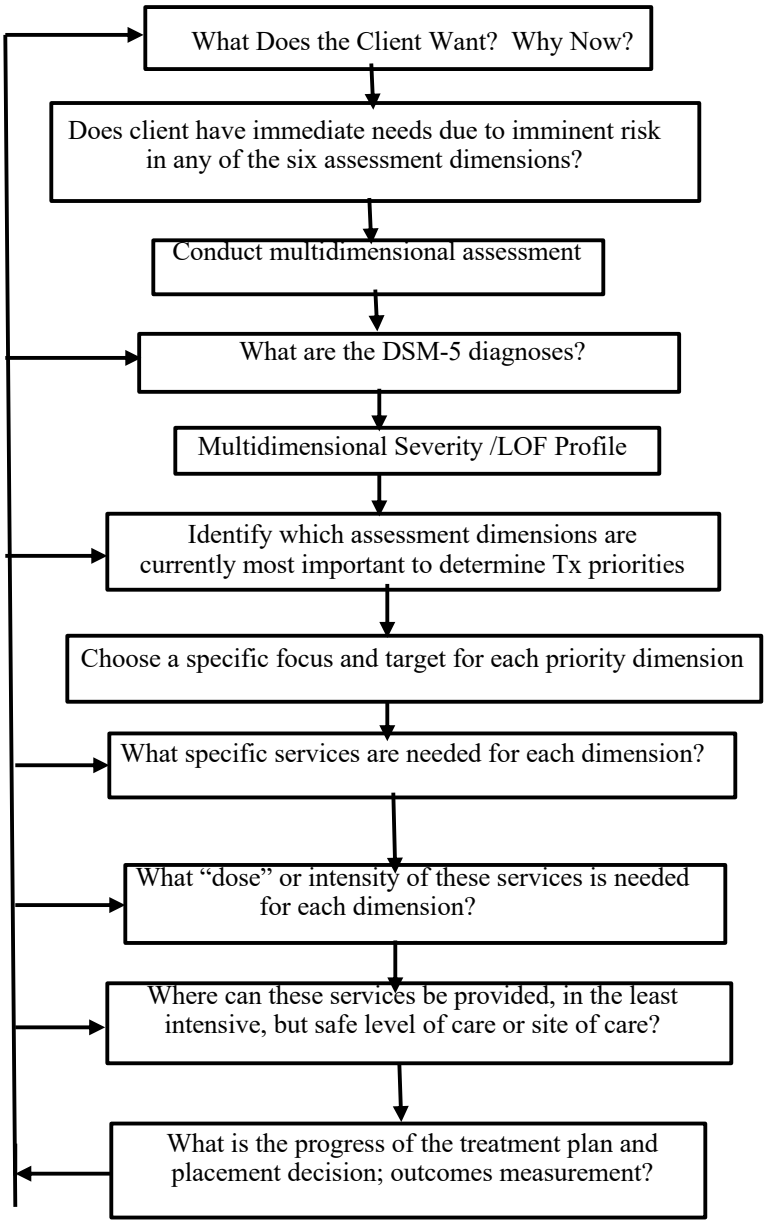
Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

C. **Developing the Treatment Contract** *(The ASAM Criteria* 2013, page 58)

	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?

D. **Measurement-Based Practice (Feedback Informed Treatment)**





(The ASAM Criteria 2013*,* p 124)

E. **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?*

LITERATURE REFERENCES

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