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The Treatment Plan

The treatment plan is the road map that a patient will follow on his or her journey through treatment. The best plans will follow the patient for the next 5 years where the relapse rates drop to around zero (Vaillant, 2003). No two road maps will be the same; everyone's journey is different. Treatment planning begins as soon as the initial assessments are completed. The patient might have immediate needs that must be addressed. Treatment planning is a never-ending stream of therapeutic plans and interventions. It is always moving and changing. I have cowritten a thorough treatment planning book and computer program that should make treatment planning easy: *The Addiction Treatment Planner* (Perkinson & Jongsma, 2006a, 2006b). The planner comes in two forms, as a book and as computer software. The book and software help you write your treatment plan with point-and-click simplicity and have been approved by all accrediting bodies.

How to Build a Treatment Plan

The treatment plan is built around the problems that the patient brings into treatment. Within the treatment plan is a problem list that details each problem. The problem list comes at the end of the diagnostic summary. It tells the staff what the patient will do in treatment. It must take into account all of the physical, emotional, and behavioral problems relevant to the patient's care, as well as the patient's strengths and weaknesses. It must also address each of the six dimensions of ASAM that you are following.

The treatment plan details the therapeutic interventions, what is going to be done, when it is going to be done, and by whom. It must consider each of the patient's needs and come up with clear ways of dealing with each problem. The treatment plan flows into discharge planning, which begins from the initial assessment.

The Diagnostic Summary

After the interdisciplinary team members assess the patient, they meet and develop a summary of their findings. This is the diagnostic summary. This is where members of the clinical team—the physicians, nurses, counselors, psychologists, psychiatrists, recreational therapists, occupational therapists, physical therapists, dietitians, family therapists, teachers, pastors, pharmacists,

and anyone else who is going to be actively involved with the patient's care—meet and develop a summary of the patient's current state and needs. The team members discuss each of the patient's problems and how to best treat it. From this meeting, the diagnostic summary is developed. This details what the problems are, where they came from, and what is going to be done about them. It is much better to do this as a team. As you watch your team function, you will see how valuable it is to have many disciplines involved.

The Problem List

The treatment team will continue to develop the problem list as the patient moves through treatment. New problems will come up and be added or modified as conditions change. The problem list and treatment plan must be fluid. The list changes throughout treatment as different problems come up and others are resolved.

How to Develop a Problem List

A treatment plan must be measurable. It must have a set of problems and solutions that the staff can measure. The problems must be specific, not vague. A problem is a brief clinical statement of a condition of the patient that needs treatment. The problem statement should be no longer than one sentence and should describe only one problem.

All problem statements are abstract concepts. You cannot actually see, hear, touch, taste, or smell the problem. For example, low self-esteem is a clinical phrase that describes a variety of behaviors exhibited by the patient. You can see the behaviors and conclude from them that the patient has low self-esteem, but you cannot actually see low self-esteem.

Problems are evidenced by signs (what you see) and symptoms (what the patient reports). A problem on the treatment plan should be followed by specific physical, emotional, or behavioral evidence that the problem actually exists. List the problem, add "as evidenced by" or "as indicated by," and then describe the concrete evidence you see that tells you that the problem exists.

Examples of a problem list:

Problem 1: Inability to maintain sobriety outside of a structured facility

As evidenced by: Blood alcohol level of .23

As evidenced by: The patient's family report of daily drinking

As evidenced by: Alcohol withdrawal symptoms

As evidenced by: Third DWI

As evidenced by: History of third treatment for addiction

Problem 2: Depression

As evidenced by: Hamilton Depression Rating Scale score of 29

As evidenced by: Psychological evaluation

As evidenced by: Patient's two suicide attempts in the past 3 months

As evidenced by: Depressed affect

Problem 3: Acute alcohol withdrawal

As evidenced by: Coarse hand tremors

As evidenced by: Blood pressure 160/100, pulse 104

As evidenced by: Restless pacing; self-report of strong craving

As evidenced by: Profuse sweating; mild visual disturbances

Goals and Objectives

Once you have generated a problem list, you need to ask yourself what the patient needs to do to restore him- or herself to normal functioning. A person who has a drinking problem needs to stop drinking and must learn the skills necessary to maintain a sober lifestyle. A person who is depressed needs to reestablish normal mood. A person who is dishonest needs to get honest with himself or herself and others. Writing goals, objectives, and interventions in a treatment plan is made much easier for counselors by using *The Addiction Treatment Planner* or *The Addiction Treatment Planner With Disk* (Perkinson & Jongsma, 2006a, 2006b). These plans conform to the highest standards set by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1988).

How to Develop Goals

A goal is a brief clinical statement of the condition you expect to change in the patient or in the patient's family. You must state what you intend to accomplish in general terms, and then specify the condition of the patient that will result from treatment. All goals label a set of behaviors that you want to elicit in the patient.

Goals should be more than the elimination of pathology. They should be directed toward the patient learning new and more functional methods of coping. Focus on more than just stopping the old dysfunctional behavior. Concentrate on replacing it with something more effective.

Examples of Developing Goals

Instead of: The patient will stop drinking.

Use: The patient will develop a program of recovery congruent with a sober lifestyle. (The patient is learning something different.)

Use: The patient will learn to cope with stress in an adaptive manner.

Instead of: The patient will stop negative self-talk. (The patient does not learn something different or use something differently; the patient just avoids something that he or she already knows.)

Use: The patient will develop and use positive self-talk. (Now the patient learns something different that is incompatible with the old behavior.)

Use: The patient will develop a positive self-image. (The patient learns something new and more adaptive.)

The patient or the patient's family must be the subject of each goal. No staff member or staff intervention should be mentioned. Identify one goal and condition at a time, and make each goal one sentence.

Examples of Goals

1. The patient will learn the skills necessary to maintain a sober lifestyle.
2. The patient will learn to express negative feelings to his or her spouse.
3. The patient will develop a positive commitment to sobriety.

4. The patient will develop a healthy diet and begin to gain weight.
5. The patient will learn how to tolerate uncomfortable feelings without using chemicals.
6. The patient will learn to share positive feelings with others.
7. The patient will develop the ability to ask for what he or she wants.
8. The patient will develop the ability to use anger appropriately.
9. The patient will sleep comfortably on a regular basis.
10. The patient will learn healthy communication skills.

How to Develop Objectives

An objective is a specific skill that the patient must acquire to achieve a goal. The objective is what you really set out to accomplish in treatment. It is a concrete behavior that you can see, hear, smell, taste, or feel. An objective must be stated so clearly that almost anyone would know when he or she saw it. Goals usually are abstract statements that you cannot actually see happen. You cannot see someone learn or see his or her self-esteem. However, you can see an individual express 10 positive things about himself or herself. One way of seeing whether you have a goal or an objective is to use the “see Johnny” test developed by Arnold Goldman: “If you can see Johnny do it, then it’s an objective; if you can’t, then it’s a goal.” (Goldman [1989] gives lessons on treatment planning in *Accreditation and Certification: For Providers of Psychiatric, Alcoholism, and Drug Abuse Services*, available from Practical Communications, P.O. Box 742, Bala Cynwyd, PA 19004. Richard Weedman also has done a lot of work in this area. He wrote *Client Records in Addiction Treatment: Documenting the Quality of Care* [JCAHO, 1992]. A copy can be obtained from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. These materials should be read if you have problems with treatment planning.)

Remember, if you can see it, then it usually is an objective. If you cannot see it, then it usually is a goal.

Can you see the patient read about Step One in the *Alcoholics Anonymous* book (2001)? Yes. (Objective)

Can you see the patient understand the illness of addiction? No. (Goal)

Can you see the patient gain insight? No. (Goal)

Can you see the patient improve his or her self-esteem? No. (Goal)

Can you see the patient complete the Step One exercise? Yes. (Objective)

Can you see the patient keep a daily record of his or her dysfunctional thinking? Yes. (Objective)

Can you see the patient share his or her feelings in group? Yes. (Objective)

All goals and objectives are aimed at change. Individuals must change how they feel, what they think, and/or what they do. The best way of developing

goals is to answer these questions: How can you know for sure that the patient has achieved the goal? What must the patient say or do to convince you that the treatment goal has been completed?

State the goal aloud, add on the words “as evidenced by” or “as indicated by,” and then complete the sentence describing the specific objectives that will tell you that the goal has been reached. Each goal will need at least one objective. Each goal and objective will need a number or a letter that identifies it. Each objective will need a completion date. This is the date by which you expect the objective will be completed. If the patient passes this date without completing the objective, then the treatment plan might have to be modified.

Examples of Goals and Objectives

Goal A: The patient will develop a program of recovery congruent with a sober lifestyle, as evidenced by:

1. The patient will share in the Individual Assignments group three times when he or she tried to stop drinking but was unable to stay sober.
2. The patient will make a list of the essential skills necessary for recovery.

Goal B: The patient will learn to use assertiveness skills, as indicated by:

1. The patient will discuss the assertive formula and will role-play three situations where he or she acts assertively.
2. The patient will keep an assertiveness log and will share the log with the counselor daily.
3. The patient will practice assertiveness skills in interpersonal group.

Objectives must be measurable. You must be able to count them. Thoughts, feelings, and actions all can be counted by you or the patient. The patient can count his or her thoughts by keeping a daily record of his or her thinking. The patient can count feelings by keeping a feelings log. You can keep a record of every time a patient acts angry around the unit.

To achieve the goal of maintaining a sober lifestyle, an alcoholic might need to develop one or more of the following skills:

1. Verbalize that he or she has a problem, or verbalize an understanding of the problem.
2. Develop and practice new behaviors that are incompatible with the problem. Read the *Alcoholics Anonymous* book (2001).
3. Practice the Twelve Steps of AA.
4. Go to meetings.
5. Learn how to cope with uncomfortable feelings.
6. Develop a relapse prevention plan.

Patients who are depressed may need to develop one or more of the following skills:

1. Learn how to say positive things to themselves.
2. Develop recreational programs to add fun to their lives.
3. Grieve and learn how to accept the deaths of loved ones.
4. Get accurate in their thinking.
5. Improve the dysfunctional interpersonal relationships with their spouses.
6. Take antidepressant medication.

How to Develop Interventions

Interventions are what you do to help the patient complete the objective. Interventions also are measurable and objective. There should be at least one intervention for every objective. If the patient does not complete the objective, then new interventions should be added to the plan.

Interventions should be selected by looking at what the patient needs. They may include every treatment available from any member of the multidisciplinary team. They may include any therapy from any staff member such as group therapy, individual therapy, behavior therapy, cognitive therapy, occupational therapy, recreation therapy, or family therapy. The person responsible for the intervention needs to be listed below the intervention so that the staff knows who it is.

Examples of Interventions

Intervention: Assign the patient to write a list of five negative consequences of his or her drug use.

*Responsible professional: _____

Intervention: In a conjoint session, have the patient share the connection between drinking and marijuana use.

*Responsible professional: _____

Intervention: In group, encourage the patient to share his or her anxious feelings.

Intervention: Have the patient develop a personal recovery plan that includes all of the activities that he or she plans to attend.

*Responsible professional: _____

How to Evaluate the Effectiveness of Treatment

In treatment, it is vital to keep score of how you are doing. It is the only way in which you will know whether treatment is working. Feelings, thoughts, and behaviors need to be counted. The staff can count them, or the patient can count them. Thoughts and feelings, being internal states, must be recorded by the patient. Behaviors can be recorded by the patient or by the staff. Patients and the staff will record feelings, thoughts, and behaviors and keep a log of these data. The log of the staff is called the patient record or the chart.

How to Select Goals, Objectives, and Interventions

Goals, objectives, and interventions are infinite. It takes clinical skill to decide exactly what the patient needs to do to establish a stable recovery. Every treatment plan is individualized. Everyone is different, and every treatment plan is different. For the same goal, you may have widely different objectives. You need to ask yourself three questions:

1. What is this patient doing that is maladaptive?
2. What does the patient need to do differently?
3. How can I help the patient behave in a new way?

These questions, if asked carefully, will uncover your goals. Once you have your goals, ask yourself this question: What does the patient need to do to achieve these goals? The answer to this will constitute your objectives. Then ask yourself what you can do to help the patient. Each patient will need to do the following three things:

1. Identify that he or she has a problem.
2. Understand exactly what that problem is and how it affects the patient.
3. Apply healthy skills that will reduce or eliminate the problem.

Examples of Goals, Objectives, and Interventions

Problem 1: Pathological relationship with alcohol, as indicated by a blood alcohol level on admission of .32, three DWIs, and family report of daily drinking

Goal A: Develop a program of recovery congruent with a sober lifestyle, as evidenced by:

Objective 1: Norman will identify with his counselor 10 times when alcohol use negatively affected his life by 6-1-08.

Intervention: Assign the patient the homework of making a list of 10 times when alcohol use negatively affected his life.

*Responsible professional: _____

Objective 2: Norman will complete his chemical use history and share in group his understanding of his alcohol problem by 6-1-08.

Intervention: Assign the patient to complete a chemical use history exercise and then have him share his answers in group.

*Responsible professional: _____

Objective 3: Norman will share his powerlessness and unmanageability with his group by 6-10-08.

Intervention: In a one-to-one counseling session, teach the patient about powerlessness and unmanageability and then have him share what he learned in group.

*Responsible professional: _____

Objective 4: Norman will share in group his understanding of how he can use his Higher Power in sobriety by 6-15-08.

Intervention: Clergy will meet with the patient and explain how he can use a Higher Power in recovery.

*Responsible professional: _____

Objective 5: Norman will take all medications as prescribed and report side effects to the medical staff.

Intervention: Physician will examine the patient and order medications as indicated while the medical staff monitors for side effects.

*Responsible professional: _____

Objective 6: Norman will develop a written relapse prevention plan by 6-25-08.

Intervention: In a counseling session, teach the patient about relapse prevention and help him to develop a written relapse prevention program.

*Responsible professional: _____

Objective 7: Norman will discuss his codependency with his wife by 6-30-08.

Intervention: In a conjoint session, help the patient to discuss his codependency with his wife and understand how this problem relates to substance abuse.

*Responsible professional: _____

In developing goals and objectives, the patient must move through the following events:

1. Identify that he or she has a problem.
2. Understand how the problem negatively affects the patient.
3. Learn what he or she is going to change.
4. Practice the change.

Let's take another problem.

Problem 2: Poor impulse control, as indicated by numerous fights, abusiveness to spouse, and self-report that he loses control when angry

Goal A: Learn to use angry feelings appropriately, as evidenced by:

Objective 1: Thomas will discuss with his counselor five times when he used anger inappropriately by 7-2-08.

Intervention: Assign the patient the homework task of listing five times when he used anger inappropriately.

*Responsible professional: _____

Objective 2: Thomas will share in group his understanding of what he needs to do differently to cope with his anger by 7-10-08.

Intervention: Have the patient share in group five tools he can use to cope with anger effectively.

*Responsible professional: _____

Objective 3: Thomas will visit the staff psychologist to learn and practice stress management techniques by 7-2-08.

Intervention: Staff psychologist will teach the patient stress management techniques such as progressive relaxation, biofeedback, and systematic desensitization.

*Responsible professional: _____

Objective 4: Thomas will keep a daily log of his angry feelings and discuss the log with his counselor once a week.

Intervention: Assign the patient to keep a daily log of angry feelings and to use subjective units of distress to rate each situation on a scale from 1 to 100.

*Responsible professional: _____

Objective 5: Thomas will share his hurt and angry feelings in group by 7-21-08.

Intervention: Encourage the patient to share his feelings log in group.

*Responsible professional: _____

Objective 6: Thomas will practice sharing his hurt and his anger with his spouse in a conjoint session by 7-30-08.

Intervention: In a conjoint session, have the patient share his hurt and angry feelings with his wife, and make a written contract to separate from each other and contact the sponsor or counselor when angry.

*Responsible professional: _____

Objective 7: Thomas will attend an anger management group once a week.

Intervention: Refer the patient to an anger management group and make the first appointment with the patient present.

*Responsible professional: _____

Samples of a complete biopsychosocial, diagnostic summary, and treatment plan are given in Appendix 7.

Treatment Plan Review

The interdisciplinary team reviews the treatment plan at regular intervals throughout treatment. At a minimum, the treatment plan is reviewed at all decision points. These points include the following:

1. Admission
2. Transfer

3. Discharge
4. Major change in the patient's condition
5. The point of estimated length of treatment

Most facilities have a daily staffing where the patient's progress is briefly discussed and a weekly review where the treatment plan is discussed. It is at these meetings that the treatment plan will be modified. Problems, goals, and objectives will change as the patient's condition changes. Treatment team review is where the staff finds out how the patient is doing in treatment and what changes need to be made.

Documentation

The staff keeps a journal of the patient's progress through treatment. This document is called the patient record, commonly called the chart. The staff keeps progress notes that document what happens to the patient during treatment. Progress notes must be typed or written in black ink, have a date and time, and be signed by the author of the note.

Each progress note needs to be identified with one or more treatment objectives. For example, a progress note on Goal A, Objective 7, would begin with the notation *A(7)*. This helps the staff to keep track of how the patient is doing with each objective.

Progress notes include the following data:

1. The treatment plan
2. All treatment
3. The patient's clinical course
4. Each change in the patient's condition
5. Descriptions of the patient's response to treatment
6. The outcome of all treatment
7. The response of significant others to important events during treatment

How to Write Progress Notes

Keep your progress notes short. They must include just enough detail to accurately describe what is going on with the patient. For the most part, describe things in behavioral terms. Any entry that includes your opinion or interpretation of events must be supplemented by a description of the actual behavior observed. What did you see, hear, smell, taste, or touch that led you to that conclusion? Describe exactly what the patient did or said. Direct quotations from the patient make an excellent progress note.

The patient's progress in meeting the goals and objectives must be recorded on a regular basis. The efforts of the staff in helping the patient to meet treatment goals and objectives are recorded. The progress notes will be used by the staff to see how the patient is doing. A person who has never met the patient should be able to know the patient's story by reading the patient record. Before you chart, ask yourself this question: If you were a counselor just coming in to take over this case, what would you need to know? It is a

good idea to write a short progress note on each patient each day. This is not absolutely essential, but it will keep you thinking about the treatment plan and the patient's progress through the treatment plan on a daily basis.

Examples of Progress Notes

6-12-08 (10:30 A.M.)

B(3): Patty discussed her denial exercise in group. She verbalized an understanding of how denial had adversely affected her, stating, "I can't believe how dishonest I was to myself. I really didn't think I had a problem even after all that trouble. I lied to Andy too, about everything." The patient was able to see how denial was a lie to herself and to others. After the session, the patient was able to verbalize her need to get honest with herself and others: "I've been lying about everything. It's about time I got honest with myself."

6-14-08 (3:15 P.M.)

A(1): Patty was tearful in an individual session. She mourned the loss of her love relationship with her past partner. The group helped her to see how destructive the relationship had been for her. The treatment peers reinforced that Patty was worth being treated better than her partner was treating her. Patty expressed that she is extremely angry at her mother: "I hate her. She never spent any time with me. She only wanted me as a slave. She wanted a housekeeper, not me." It seemed to give Patty some relief to hear other patients express that they had similar feelings about their mothers. "I thought I was the only one who felt like that," Patty stated. (Joan Thompson, CCDC)

6-15-08 (11:00 A.M.)

C(2): Patty's facial expression is sad. She has been isolating herself. She didn't eat breakfast. She was seen crying alone in her room. I went in, and she was able to express her feelings: "I'm so ashamed of myself. I'll never be able to live this down." Patty expressed that she was feeling guilty about sharing with group her anger at her mother. I reassured Patty and told her to bring up her feelings in group this afternoon. (Matt Jacobs, RN)

Formal Treatment Plan Review

Once a week, the team will do a formal treatment plan review. This requires a more detailed look at how the patient is doing in each problem area. The staff members present must be identified in the review, along with their credentials, as shown below.

6-16-08 (11:45 A.M.)

Treatment plan review: Present, Dr. Roberts, MD; M. Smith, CCDC Level II; T. Anderson, RN; F. Mark, CCDC Level I; Dr. Thomas; M. Tobas, PhD; E. Talbot, RN; A. Stein, LPN. The staff feels that Patty is adjusting well to treatment. She is more talkative and seems to feel more comfortable. She has made some friends with several treatment peers including her roommate. Her mother came to see her on Sunday, and Patty reported that this visit went well.

Problem 1: Patty continues on her Valium come-down schedule. She has reported only mild withdrawal symptoms. She is sleeping well. She continues to be mildly restless. She was encouraged to increase her level of exercise to 20 minutes daily.

Problem 2: Patty has completed her chemical use history and Step One exercise. She shared in interpersonal group her powerlessness and unmanageability. She was open in group, and she verbalized that she has accepted her disease of addiction. She was somewhat more reluctant to accept her problem with Valium, but the group did a good job of explaining cross-tolerance. The patient should complete the cross-tolerance exercise and report her findings to the group.

Problem 3: The patient continues to take her iron supplement. Her hemoglobin is within normal limits.

Problem 4: The patient is over her cold. Problem 4 is completed.

Problem 5: The patient has written a letter to her mother and father describing how she felt about her childhood. The patient shared her letter in group, and she was surprised to find out that many of the other patients had similar experiences. The patient stated that she is feeling more comfortable sharing in group, and she appears to be gaining confidence in herself. Patty met with her counselor, and the counselor encouraged Patty to accept her new AA/NA group as the healthy family that she never had. Patty expressed hope in becoming involved with this healthy family.

Problem 6: Patty is working on the relationship skills exercise. She has been practicing asking for what she wants. It is still very difficult for her to share some of her feelings, particularly her anger, in group. When she shares her anger, she tends to feel guilty.

Problem 7: Patty completed the honesty exercise and the chemical use history that opened her eyes to how dishonest she has been. Patty made a contract with her group to be honest and asked the patients to confront her if they felt that she was being dishonest. Patty is keeping a daily log of her lies and when she is tempted to lie. She has been able to identify many lies she was telling in her life and is able to verbalize her understanding of how her lies keep her isolated from others.

Problem 8: Patty is working on the assertiveness skills exercise. She is practicing the assertive formula. She tends to feel guilty when she says no, but she is getting better at it. She will say no to someone five times a day for 3 days and keep a log of how she feels about each situation.

Discussion of Continuing Care

During the discussion of the treatment plan, it's always a good idea to begin continuing care planning. This will include a 5-year follow-up plan run by the continuing care case manager. This is a formal contract negotiated with the patient and significant others. The plan includes an agreement that the patient work all aspects of the continuing care plan, with detailed consequences if the patient fails to meet his or her obligations. The plan should include the following:

- Patient sends in a log of 12-step meetings by the 10th of every month. The number of meetings each week is set by the case manager based upon patient needs.
- The patient will meet regularly with his or her 12-step sponsor.
- Patient will agree to attend all therapy recommended by the primary counselor, with a report from the primary caregiver as deemed necessary.
- Patient will agree to up to three random drug screen a week for the first 6 months and up to three random drug screen a week for the next year and a half. The patient can use the PharmChek Drugs of Abuse Patch that lasts for 7 days or longer (www.pharmchem.com), or use an alcohol ankle bracelet (the Secure Continuous Remote Alcohol Monitor—SCRAM) that measures alcohol from the sweat 24 hours a day, 7 days a week Readwood Toxicology Laboratory (www.redwoodtoxicology.com) has also developed an EtG alcohol screen that will show any alcohol use for the last 80 hours.
- Patient will take all medications as ordered.
- If the patient fails to meet any of his or her obligations, he or she is first sent a letter explaining the deficiency and asking that it be corrected.
- If the patient fails to answer the letter, an appointment will be set up with the continuing care case manager.
- If the patient still fails to comply with the contract, the consequences agreed upon will be implemented. This might include contacting the patients, professional board, employer, probation officer, drug court judge, family members, etc. The patient has initially signed a release of information to all such individuals and has written each of them a letter saying he or she has failed to comply with the treatment and asks for intervention such as treatment. The letter is cosigned by the continuing care case manager. These letters are signed, sealed, stamped, and mailed if the consequences must be implemented. The continuing care manager must be very careful to design consequences that lead the patient back into treatment.

