CHEMICAL DEPENDENCY TREATMENT PLANNING HANDBOOK

ABOUT THE AUTHOR

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By

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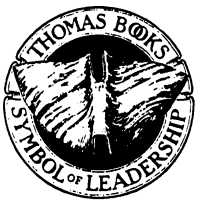

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To my Parents

Dorothy M. Laban

and

Titus Joseph Laban
1920 - 1996

PREFACE

The idea for this handbook was generated from my professional experience as a counselor, supervisor and administrator in the field of addiction medicine. My appeal to this process first began with my training as a registered nurse back in 1978. I maintain an intrinsic fascination with the cause/effect supposition of treatment plans and relish the challenge of assigning interventions to bring about behavioral and attitudinal changes with clients. The treatment plan represents a fluid and operational document that delineates the course of treatment for the client. As the term "fluid" implies, the document is not a static creation, however, it requires ongoing review and revision in order to effectively guide and direct care for the client. Additionally, the plan is often the instructional work sheet given to the inpatient client to assist them in carrying out specific tasks, auspiciously designed to reach an ultimate goal and amelioration of a problem. An inherent flaw in many treatment plans is the absence of sufficient explanation and description of what is expected of the client.

Despite the increasing proliferation of chemical dependency training programs and college curriculums throughout the country, there exists an ubiquitous void in the area of treatment planning training and preparation. Thus, despite having received undergraduate or graduate training in counseling, psychology, or social work, many novice clinicians are faced with the frustrations of how to put together a worthwhile treatment plan. Beyond these exasperations are the more salient matters of relevance and substance of treatment plan content. There is also noteworthy consensus as to the relative scarcity of research and data addressing treatment planning.[1,2] While psychiatric treatment planning has received sizeable attention in research and practical application, addiction-unique treatment planning is scarce. This was further evidenced in my doctoral studies in which I examined the content of treatment plans from an exploratory perspective. The findings illustrate a considerable disparity in the substance and harmonious flow of addiction-based treatment plans.

I remain amazed with the many differences and divergent styles of treatment planning in use for the chemically dependent client. I've found a considerable and pervasive lack of consistency with treatment planning styles and content among clinicians and agencies, in addition to a shortage of reference manuals or guides to facilitate the treatment planning process. The goal and intent of this handbook are to provide the entry-level clinician with a broad data base of treatment planning illustrations from which unpretentious treatment plans for the chemically dependent client can be generated. They were written simple, largely measurable, and purposefully, with language that is cognizant of comprehension and learning needs of clients. These plans were not generated as an outcome of experimental studies, nor do they represent entirely original thought. What they epitomize are implicitly and inferentially sound clinical planning documents that can both expedite a clinician's work pace while providing detailed plans concentrating on early recovery needs. The data base of plans cover a broad cross section of potential presenting problems, each categorized in a domain that is easily correlated with prevailing assessment areas. The appendix contains samples of unpublished collections of viable handouts that can be used as templates for additional assignments and work sheets. A word of acknowledgment and gratitude is extended to the program of Alcoholics Anonymous, given my frequent references to terms and texts published by the organization.[3]

Finally, it is my belief that empirical investigations and controlled studies are both warranted and desperately needed in the area of treatment plan efficacy. Additional difficulties include extraneous variable, ethical issues with control versus experimental groups and defining successful outcomes. Nonetheless, efforts to develop more objective and pragmatically sound treatment plans a move towards more successful treatment.

NOTES

1. Einstein, Stanley. Treating the drug user: Considering the "demands" of therapeutic technologies and their implications for treatment planning, implementation, and outcome. *International Journal of the Addictions, 21* (December 1986): 1339-1358.

2. Kennedy, James. *Fundamentals of Psychiatric Treatment Planning.* Washington, DC: American Psychiatric Press, 1992.

3. *Alcoholics Anonymous (3rd ed.).* Alcoholics Anonymous World Services, Inc.; New York, 1976.

INTRODUCTION

These are sample treatment plans that incorporate behavioral methods and interventions that are implicitly sound and plausibly associated with early recovery needs. The plans are general in form and allow for integration into multiple levels of clinical functioning such as day treatment, partial hospitalization, intensive outpatient and traditional outpatient therapy. There is a compelling inference to support each of the methods as being legitimate and appropriate. They are NOT meant to be used in lieu of original thinking and creativity. To simply interject client names to aid in facilitating plans would constitute a unidimensional exploitation of plans, as well as being unethical. Conversely, counselors are encouraged to use these plans as a companion and adjunct to their clinical practice and to merge systems and strategies with these documents. This could be accomplished by assimilating existing work sheets, patient handouts, handbooks or reading materials, into the applicable domain and corresponding treatment intervention. It is an assumption of the author that the practicing clinicians and organizations using this handbook will be cognizant of the standards and regulatory mandates addressing treatment plan content and chart compliance.

PROBLEM DOMAINS

The treatment plans are categorized into nine problem domains that correlate to common areas of data gathered for customary diagnostic assessments or biopsychosocial questionnaires. The possibilities for potential problem areas are numerous, and this text attempts to address a number of problems often seen in treatment settings. The identification of a problem and matching it with the applicable domain may not be cut-and-dry process. There is often overlap and diffusion into other problem domains. This can stem from confusing problem statements as well as the very nature of "fluidity" and interrelatedness of life areas. It is difficult to identify any one problem that exists in a vacuum, unaffected by (or not affecting) other life areas. For exam-

ple, consider the client who continually uses alcohol at the work site and, despite repeated alcohol-related job injuries, gravitates towards the same work crew with similar drinking habits. There are several problems apparent in this situation, including the following possibilities:

- interpersonal: gravitates towards unhealthy, using peers
- recovery environment: job situation threatens recovery chances
- recovery environment: risk to self/others secondary to injuries under the injuries under the influence

It is of value to the assessing clinician to carefully evaluate the data in order to more accurately identify the problem area and match it to the most fitting problem domain.

PLAN FORMAT

The format of the treatment plan assumes an uncomplicated demeanor, though some explanation is due to facilitate a better understanding. The following is a description of the treatment elements:

Initial/Master/Update

Indicates the type of plan in terms of the chronology of the client's length of time in treatment. The *Initial* problem is ordinarily assigned at the time of admission or within the first twenty-four hours. The *Master* problem normally evolves from a comprehensive biopsychosocial evaluation completed within a specified time frame, established by regulatory agencies and the treating facilities. This ordinarily ranges from twenty-four hours to seven days, depending on the type of setting. The *Update* refers to the plan generated as a review or revision of the Master plan. This may be completed on a certain day in treatment or prompted by treatment complications or lack of progress with the plan.

Problem

A statement of the client's presenting problem. There are one hundred and ten different problem statements in the text, though the list could certainly be infinite. A wide host of problem statements are illustrated with a fair degree of specificity to better illuminate the relationship between goals, objectives and methods.

Indicators

Refers to tangible evidence or data confirming the problem statement. Plans that do not have this section will include supporting data in the problem statement.

Long-Term Goal

This is an abstract statement reflecting a desired outcome that may be realized six months to one year after discharge. The term *abstract* indicates the phrase as not being readily measurable but instead a condition or state of being reached by the patient.

Short-Term Goal

The short-term goal represents an abstract and nonmeasurable assertion that reflects a desired consequence realized during the treatment stay. There is an understandable presumption that the short-term goal will facilitate attainment of the long-term goal.

Objective

A realistic, measurable and mostly behavioral statement of a desired state or condition as a result of successfully completing assigned methods. Because they are measurable statements, due dates (or target dates) are assigned to each objective. Several levels and hierarchies of objectives may be assigned to a particular problem, in order to sequentially attain the desired short-term goal. The plans used in this text primarily use one objective statement for the purpose of illustration.

Methods

These refer to the specific behavioral interventions and tasks assigned to clients in order to fulfill the desired Objective, Short-Term Goal and, ultimately, Long-Term Goal. Target dates have not been assigned but are optional. There will be some degree of duplicity with methods throughout the text, but this should be considered appropriate, given the limited repertoire of resources and presently available methods for the treatment of commonly seen problems in the addiction treatment field. This is analogous to more medically modeled treatment plans that operate on a certain course of prescribed treatment; the plan of care is individualized around the patient needs. Hence, the assignment of a Step One Workbook may take the form of a written, verbal, taped or visual representation, depending on the abilities and character of the client.

Frequency of Services Provided

This section references the particular therapy services that will be utilized to in order to implement the plan of action. A format used in the treatment plan examples has a standarized appearance that is deliberate; its inclusion is solely for the purpose of illustration and is *not* meant to represent specific services for each of the problems, although they may apply in many cases. This

section is excluded on certain plans in order to keep the necessary content to one page. The reader is also reminded to individualize and modify the services and the frequency, if they so choose to employ this element.

Signatures

Signatures areas for the counselor and client reflect a minimum of client review, if not a greater degree of involvement. This field might be expanded upon by the following statement: "The signatures below indicate client involvement in the participation of this treatment plan, as well as a copy being offered to the client." This comment documents client involvement in the treatment planning process and may also serve to meet regulatory and licensing standards. There is evidence that indicates the client's involvement in treatment planning results in reduced length of stays (Harden, 1986), and the author is a proponent for active client involvement in the planning process.

Client/Patient

These terms are purposely used to illustrate interchangeable meanings, although the word *patient* is often used in settings familiar with the medical model. A number of plans use the pronoun "you" to portray a more personalized meaning to the client.

Final Comments

Attempting to include all conceivable problem areas for inclusion in a single text would be a futile task. Although this text attempts to address commonly seen problem areas in addiction treatment, there are many that are not included. There are other texts and primers available in the area of treatment planning that can be referenced for additional ideas and direction. It is hoped that the essence of what this text attempts to elucidate will be applied in the development of treatment planning in other areas; that is, the specificity and detail in the creation of treatment plan methods and the need for clarity and simplicity with methods. This is particularly relevant when the treatment plan becomes a working document for the client. Additionally, in order to avoid sacrificing needed methodologies in several treatment plans, I purposely omitted one or more of the standarized areas on the plan. The reader is referred to the suggested readings below for additional guidance in treatment plan construction.

SUGGESTED READINGS

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Dorothy Laban: my mother and supporter.

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CHEMICAL DEPENDENCY TREATMENT PLANNING HANDBOOK

Chapter 1

INITIAL TREATMENT PLANS