

# Treatment Planning

## Introduction

### **Welcome to Treatment Planning!**

This course will provide you with the information you will need to write a integrated, strength-based, goal-oriented treatment plan. You will learn the importance of the connection of the Stages of Change and the ASAM dimensions in creating treatment plans that are actually useful and user friendly to your clients.

### **Let's Review**

*Instructor Note: The treatment plan is the bedrock that we build a client's treatment upon and the treatment plan is based upon the information you, the counselor, have obtained through the assessment/clinical evaluation process. We will begin this chapter by reviewing the elements of the Clinical Evaluation. Why you may ask?? The simple and quick answer is: Without a thorough screening, intake and assessment the treatment plan could not be done or done in a way that does not help the clients we serve.*

**Clinical Evaluation** – The systematic approach to screening and assessment

### **Screening and Assessment**

1. Initial Screening – eligibility and appropriateness
2. Assessment – identify specific types of services and intensity of treatment

**Screening - definition 1** – The process through which counselor, client, and available significant others determine the most appropriate initial course of action, given the client's needs and characteristics, and the available resources within the community.

**Screening - definition 2** – is a process used by human services to help determine whether a person seeking services is eligible and appropriate for admission to agency or program or needs to be referred to another agency that can better meet.



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**Essentially screening is designed to answer question “Is there a need for additional assessment or evaluation because it is likely this person has a substance abuse problem?”**

**Assessment** – An ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress.

**Comprehensive Assessment** – includes medical status/problems, infectious disease, psychological status, and history of trauma, social functioning, family and peer relations, education and job performance, legal problems, socioeconomic status and difficulties.

The three basic steps of assessment process

1. Information Gathering
2. Data analysis
3. ***Treatment plan development***

**Information Gathering** – can come from existing information (gathered by other professionals – written reports, previous records, criminal justice, employment evaluation, school reports, can also speak to employers, teachers, family etc.

Existing information

- Drug history
- Medical history and current status
- Mental health history and current status
- Current medications
- Criminal status
- Educational status
- Employment history and current status

**Risk Assessment**



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#### Signs of toxicity

- Nausea
- Vomiting
- Agitation
- Diarrhea
- Lethargy, Stupor
- Increase or decrease heart rate
- Lack of Coordination

**When these signs are present it is appropriate to stop screening or assessment and seek medical intervention.**

#### Violence

- Previous violence
- Young age first violent incident
- Relationship instability
- Employment problems
- Substance problems
- Major mental illness
- Personality traits that deviate from social norm, manipulating or exploiting others
- Early maladjustment or trauma
- Personality disorder
- Failure to respond to clinical supervision or treatment in past
- Lack of insight, difficulty understanding cause and effect



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- Negative Attitude
- Active symptoms of major illness
- Impulsivity
- Unresponsive to treatment

**Suicide**– three guidelines: current presentation of Suicidality, history and risk assessment. Assessing the degree of risk is always the first step. This can be achieved by evaluating:

- Suicidal or self-harm thoughts, plans, behaviors, and intent
- Specific method, including lethality and patient's expectation about lethality, as well as access to firearms
- Evidence of hopelessness, impulsivity, panic attacks or anxiety
- Substance abuse associated with current presentation
- Thought, plans or intentions of violence toward others
- Psychiatric illness
- History
- Previous attempts, aborted attempts, self-harm behaviors
- Family history of suicide, attempts, SA or MH
- Acute psychological crisis
- Family discord, domestic violence, past/current physical or sexual abuse
- Absence of external supports

**Co-Occurring Disorders** is a better term than dually diagnosed as formal diagnosis may have never taken place. Further, co-occurring disorder encompasses learning disabilities and early childhood trauma.

- Acute symptoms of disturbance – hallucinations, depression or delusions



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- Suicidal thoughts or behaviors
- Mood or thought disturbances
- Prior MH treatment
- Use of psychotropic medications
- Recent trauma – physical or sexual abuse
- Family history of MH

**Data Analysis** – interpretation of information, determine severity of problem, possible contributing factors and readiness for intervention. (Diagnostic summary)

**Interviews** – in screening, information is focused on self-reporting, assessment interview is more thorough and systematic method of gathering information. It can also, be used to as a foundation for positive, trusting relationship.

**DSM 5** – Diagnostic Statistical Manual of Mental Disorders is the handbook used for diagnosing mental disorder including:

- substance use disorder (mild, moderate, severe)
- what symptoms must be present (how long) in order to qualify for diagnosis (inclusion criteria)
- symptoms that must not be present(exclusion criteria)

#### **International Classification of Diseases (ICD)**

- International Statistical Classification of Diseases and Related Health Problems
- Although ICD-10th edition is available since 1994, most state and federal government still use 9<sup>th</sup> edition for billing, commonly known as ICD-9.

**American Society of Addiction Medicine (ASAM)** – guidelines for placement, continued stay and discharge.

- Level 0.5      Early Intervention
- Level I        Outpatient



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- Level II Intensive Outpatient and Partial Hospitalization
- Level III Residential/Inpatient
- Level IV Medically Managed Intensive Inpatient Treatment

### **Matching Clients with Appropriate Treatment**

- Factors – psychiatric problems, education, occupation, family and support systems
- Not every type of treatment effective for every client.
- No specific type treatment has a monopoly on effectiveness

*Instructor Note: Let's break it down. I thought a brief, bullet pointed reminder/refreshers of the clinical evaluation process would be helpful ☺*

### **Screening**

A brief process that answers two main questions:

- ✚ Whether a alcohol and/or drug problem is present.
- ✚ If so, whether it is likely to require brief intervention or specialized treatment.

### **Content of Problem Assessment**

- ✚ Examines problems attributable to alcohol and/or drug consumption.
- ✚ Use of alcohol and/or drugs is explored by examining level of use, pattern of use and history of use.
- ✚ Signs and symptoms of alcohol and/or drug use.
- ✚ Consequences of alcohol and/or drug use.
- ✚ These make up DSM 5 criteria
- ✚ Self-report questionnaires can be used.

### **Content of Personal Assessment**

- ✚ Examines problems to determine if they are attributable to use.
- ✚ Medical status

- ✚ **Psychiatric status**
- ✚ **Vocational issues**
- ✚ **Personal problems**
- ✚ **Sexual problems**
- ✚ **Social support**
- ✚ **Family structure**
- ✚ **Use of leisure time**
- ✚ **Demographics**
- ✚ **Family history**
- ✚ **Prior treatment history**
- ✚ **Intelligence**
- ✚ **Cognitive functioning**
- ✚ **Personality**
- ✚ **Treatment Goals**
- ✚ **Social Stability**
- ✚ **Situational Factors**

## **Chapter 1**

### **Introduction to The Treatment Plan**

#### **History**

Treatment planning started in the medical sector in the 1960s and spread to mental health field in the 1970s.

Treatment centers and psychiatric hospitals reached out to accrediting bodies (Joint Commission and CARF) to qualify for third party reimbursement. This meant developing and strengthening documentation. Prior plans were poorly written, goals were vague and objectives were almost non-existent. Interventions applied to all clients. Everyone had the same basic plan.

Managed care in the 80's increases need for better treatment plans.



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Pressure from third party payers, accrediting agencies, and other outside parties have increased the need to produce effective, high quality treatment plans.

### **How can a Treatment Plan Help?**

Detailed treatment plans help the client, therapist, the treatment team, insurance community and the treatment agency.

Therapy is not vague contract to just talk openly and honestly about ones feeling and emotions until the client starts to feel better.

Providers are forced to think critically and analytically about the therapeutic interventions that are best suited for the objective and goal. Advance thought must be given to the techniques used.

- ✚ To protect against lawsuits.
- ✚ To provide uniformity to documentation.
- ✚ Accountability to third party payers.
- ✚ Measurable objectives can make it easier to evaluate success.

**TREATMENT PLANNING DEFINED:** The process by which the counselor and client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide upon a treatment process and the resources to be utilized.

The treatment contract is based on the assessment and is a product of negotiation between the client and counselor to be sure the plan is tailored to the individual's needs. The language of the problem, goal, and strategy statements should be specific, intelligible to the client, and expressed in behavioral terms. The statement of the problem concisely on a client need identified previously. The goal statements refer specifically to the identified problem and may include one objective or set of objectives ultimately intended to solve or mitigate the problem. The goals must be expressed in behavioral terms in order for the counselor and client to determine progress in treatment. Both immediate and long-term goals should be established. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who will provide them, when they will be provided, and at what frequency. Treatment planning is a dynamic process and the contracts must be regularly reviewed and modified as appropriate.





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- ✚ Explain assessment results to the client in an understandable manner.
- ✚ Identify and rank problems based on individual client needs in the written treatment plan.
- ✚ Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
- ✚ Identify the treatment methods and resources to be utilized as appropriate for the individual client.

*Instructor Note: As a way to make clear what is expect of the professional addiction counselor we have broken down the TAP 21 competencies for Treatment Planning(See below). Each competency is broken down into 4 areas which will allow you to easily understand and implement these practices. Throughout this course I hope to provide you with tools that you can refer back to both for studying and for practicing.*

## 1. Use relevant assessment information to guide the treatment planning process

**AWARENESS** Is familiar with general assessment topics and their importance to treatment planning.

**INITIAL APPLICATION** Gathers and review assessment findings prior to sharing with the client and significant other.

**COMPETENT PRACTICE** Integrates all assessment findings and initial placement and treatment recommendations with the client to begin the treatment planning process.

**MASTERY** Establishes a productive rapport with the client and appropriate significant others and engages them in a collaborative review of assessment information and treatment options.

## 2. Explain assessment findings to the client and significant others.

**AWARENESS** Understands the variety of potential assessment findings.

**INITIAL APPLICATION** Presents basic assessment findings to client and significant others.

**COMPETENT PRACTICE** Interprets assessment findings to client and significant others.

**MASTERY** Collaborates with client and significant others regarding assessment findings and implications for treatment planning.



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**3. Provide the client and significant others with clarification and additional information as needed.**

**AWARENESS** Describes the process of rapport building and engagement.

**INITIAL APPLICATION** Engages the client and significant others in a discussion of assessment findings.

**COMPETENT PRACTICE** Provides client and significant others with additional information to clarify results of the assessment.

**MASTERY** Works collaboratively with the client and appropriate others to understand the assessment and enhance motivation to engage in a recovery process.

**4. Examine treatment options in collaboration with the client and significant others.**

**AWARENESS** Is aware of a variety of treatment/recovery options commonly available.

**INITIAL APPLICATION** Reviews locally available options with the client and significant others.

**COMPETENT PRACTICE** Collaborates with client and significant others to assess available treatment options.

**MASTERY** Works with the client and significant others to identify the treatment options best addressing the client's needs.

**5. Consider the readiness of the client and significant others to participate in treatment.**

**AWARENESS** Is familiar with a research-based model of change and how to assess readiness for treatment.

**INITIAL APPLICATION** Uses an accepted model and tool to assess the client and significant others readiness for treatment.

**COMPETENT PRACTICE** Integrates an assessment of readiness into a collaborative discussion of the assessment results and available treatment options with the client and significant others.

**MASTERY** Incorporates a readiness assessment into negotiating best available treatment plans with the client and available significant others.



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#### **6. Prioritize the client's needs in the order they will be addressed in treatment.**

**AWARENESS** Recognizes the need to prioritize the hierarchy of client needs so as to address the most important first.

**INITIAL APPLICATION** Prioritizes severity of client needs and potential resources to meet those needs.

**COMPETENT PRACTICE** Demonstrates skill in prioritizing client needs in an order that addresses the most important first.

**MASTERY** Utilizes practical judgment in prioritizing a complex set of client needs in a way that can be effectively addressed in treatment.

#### **7. Formulate mutually agreed-on and measureable treatment goals and objectives.**

**AWARENESS** Articulates the difference between treatment goals and objectives.

**INITIAL APPLICATION** Assists the client in establishing measurable treatment goals and objectives consistent with the assessment information.

**COMPETENT PRACTICE** Collaborates on mutually agreeable and measurable recovery oriented goals and objectives with the client and significant others.

**MASTERY** Engages the client in negotiating mutually agreeable and realistic goals and objectives which accommodate the client's readiness to change.

#### **8. Identify appropriate strategies for each treatment goal.**

**AWARENESS** Accesses resources that describe a variety of treatment strategies sensitive to the diversity of clients served in the agency.

**INITIAL APPLICATION** Uses community resource information to link client needs with available services, taking into account client readiness for change and hierarchy of needs.

**COMPETENT PRACTICE** Effectively matches client needs and preferences with available community resources and treatment strategies.



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**MASTERY** Demonstrates flexibility in actively matching treatment strategies with client and significant others preferences and available community resources.

**9. Coordinate treatment activities and community resources in a manner consistent with the client's diagnosis and existing placement criteria.**

**AWARENESS** Understands the relationship between the client's diagnosis, placement criteria, treatment activities, and community resources.

**INITIAL APPLICATION** Develops a beginning treatment plan that utilizes assessment information in determining level of care and the appropriate use of available community resources.

**COMPETENT PRACTICE** Collaborates with client and significant others in building a treatment plan, taking into consideration the client's age, developmental and educational level, gender, and racial and ethnic culture in order to utilize community resources and meet client needs most effectively.

**MASTERY** Actively collaborates with community resources, client, and significant others in developing a plan of coordinated treatment activities consistent with the client's diagnosis, needs, preferences, and placement criteria.

**10. Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress.**

**AWARENESS** Appreciates the importance of evaluating treatment progress in the ongoing assessment and renegotiation of the treatment plan.

**INITIAL APPLICATION** Negotiates, comes to agreement, and documents a treatment plan using positive, jargon-free terms that includes clear goals and measureable objectives.

**COMPETENT PRACTICE** Collaborates with client in developing an individualized, measureable treatment plan balancing strengths, resources, deficits, and needs.

**MASTERY** Negotiates and establishes a method for monitoring and evaluating progress in achieving client goals and objectives in the context of an individualized, mutually acceptable treatment plan.

**11. Inform the client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.**

**AWARENESS** Has familiarity with federal, state, and agency confidentiality rules, regulations, requirements, and policies.

**INITIAL APPLICATION** Distributes and discusses written summaries of client confidentiality rights, program safeguards, and the exceptions imposed by regulations.

**COMPETENT PRACTICE** Provides clarification of client rights to privacy and confidentiality, exceptions imposed by regulatory authorities, and how these rights are upheld by the agency.

**MASTERY** Explains and clarifies the roles of various authorities and agency staff members with regard to upholding the boundaries of confidentiality. Interviews on behalf of the client when client rights are threatened.

**12. Reassess the treatment plan at regular intervals or when indicated by changing circumstances.**

**AWARENESS** Appreciates the need to periodically reassess the treatment plan.



**INITIAL APPLICATION** Utilizes existing measures of treatment progress to evaluate and discuss client's response to treatment.

**COMPETENT PRACTICE** Based on client progress, modifies the treatment plan in collaboration with client and significant others.

**MASTERY** Assesses client progress toward treatment goals utilizing a variety of measures and input from client, significant others, and community resources, making adjustments when indicated.

**Treatment Plan should reflect ...**

Involvement of . . .

-  Client ( a must)
-  Significant Other ( a plus)

**Did You Know a Treatment Plan ... ?**



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Helps you and the client stay . . .

- + Focused
- + Goal-oriented

#### **Did You Know a Treatment Plan ...?**

- + Maximizes use of counselor time in session or activity
- + Offers protection from possible litigation

#### **Individualized Treatment Plan is “Sized” to Match Client Problems and Needs**

- + Not all clients have the same needs or are in the same situation
- + The individualized treatment plan is made to “fit” the client based on her/his unique:
  - Abilities
  - Goals
  - Lifestyle
  - Socioeconomic realities
  - Work history
  - Educational background
  - Culture
- + When treatment programs do not offer services that address specific client needs, referrals to outside services are necessary.

## **Chapter 2**

### **The Purpose of 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.

Treatment plans define the scope of the client's particular areas of concern and determine the severity of each area across the six Dimensions of the ASAM PPC-2R. The treatment assessment helps the counselor identify the client's immediate needs that will provide the basis for the treatment plan.

Treatment Plans are one of the most important tools to utilize when attempting to engage a client in treatment. Treatment Plans should be a collaborative, creative, client driven activity between the counselor and client that focuses on the client's view of their stated problems. The focus of a client driven Treatment Plan is on building a relationship between the counselor and the client (the Treatment Alliance). The treatment alliance generally begins during the assessment phase of a client's treatment episode. The relationship is strengthened or strained based on the level of "buy-in" the client experiences at the treatment planning stage. A client driven, individualized Treatment Plan is the basis for doing good treatment and gives the client a sense of accomplishment and success.

It is important to establish briefly stated, individualized problem statements because the creation of useful goals and action steps will easily follow. A counselor must be patient, empathetic, and understanding during this creative process. Rushing to get something down just to fill out all the paperwork will most likely not result in an individualized plan. When a counselor utilizes their training, creativity, and personal skills, they can create a collaborative atmosphere. This collaboration can enhance the client's motivation to look at the current, relevant problems they are motivated to work on resulting in a client driven, clinically guided Treatment Plan.



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*Instructor Note: Over the several years the field of addiction treatment has steadily moved toward strength-based, positive, goal directed treatment and that, especially, includes treatment plans. Historically agencies have struggled with getting staff to write a complete, accurately done, measureable treatment plan. Because of this many agencies have adopted “pre-completed” treatment plans. Meaning the problem, the goal and the objectives are already typed into the plan and the counselor only needs to review the goals & objectives with their clients and have the client sign and date. Thankfully for all concerned but especially the client, agencies are again moving away from this and appropriately training their staff on how to write a master treatment plan that, most importantly meets the needs and goals of the client but also meets the requirements of the standards set forth by the licensing body, the accrediting body and whoever else may audit client charts. So.....it is so so so important to write a treatment plan that reflects what the client sees as their problem, their goal to solving that problem and their objectives (ways) to achieve their goals. CLIENT SELF-DETERMINATION!*

It is hoped that the information in this guide will prepare clinicians to create treatment documents that are useful, clinically driven, and that meet the standards of care expected by the Florida Certification Board.

### **What you should know about a Treat plan in a nutshell!**

- client driven with clinical direction
- the importance of a treatment plan: good treatment(tx), directs tx, helps tx, keeps tx focused, builds treatment relationships
- gives client a sense of accomplishment and success
- treatment focus
- treatment relationship starts at assessment
- if you get the problem statement right – the rest will come.

### **What may be addressed in the Plan?**

- Possible Mental Disorders
- Mental Status
- Risk Assessments





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- **Treatment History**
- **Reasons for Treatment**
- **Physical Health & Nutrition**
- **Substance Use History**
- **Obstacles to Recovery**
- **Work History**
- **Family History**
- **Sexuality & Intimate Relations**
- **Beliefs and Values**
- **Education History**
- **Finances History**
- **Military History**
- **Legal Problems**
- **Free time**
- **Special Issues**
- **Assets**
- **Liabilities**
- **Readiness to learn**

Below is a breakdown of the TAP 21 competencies for treatment planning and the matching steps for utilizing the clinical evaluation information and formulating the treatment plan.

## **Bridging Assessment with Treatment Planning**

- ✚ Obtain and interpret all relevant assessment information.

- ✚ An integrated treatment plan addresses substance abuse and mental illness through concurrent treatment.
- ✚ First address pressing needs.
- ✚ Evaluate client motivation to address substance abuse.
- ✚ Identify treatment goals and target behaviors.
- ✚ Select interventions for achieving goals.
- ✚ Choose measures to monitor outcomes of goal setting.
- ✚ Follow up and modify treatment plans as necessary.

**Obtain and interpret all relevant assessment.**

- ✚ Stage of change and readiness for treatment
- ✚ Motivation and motivating factors.
- ✚ The role and importance of client resources and barriers to treatment.
- ✚ The impact that the client and family systems have on treatment decisions and outcomes
- ✚ Other sources of assessment information

**Prioritize client needs in the order they will be addressed.**

- ✚ Treatment sequencing and the continuum of care.
- ✚ Hierarchy of needs
- ✚ Interrelationship among client needs and problems.

**Formulate mutually agreed upon and measurable treatment outcome statements for each need.**

- ✚ Levels of client motivation
- ✚ Treatment needs of diverse populations
- ✚ How to write measurable outcome statements

**Identify appropriate strategies for each outcome.**

- ✚ Intervention strategies
- ✚ Level of client's interest in making specific changes



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**Develop with the client a mutually acceptable plan of action and method for monitoring and evaluating progress.**

- ✚ The relationship among problem statements, desired outcomes, and treatment strategies.
- ✚ Short- and long-term treatment planning
- ✚ Evaluation methodology.

**Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.**

- ✚ Evaluate treatment and stages of recovery.
- ✚ Review and revise the treatment plan

**A. PROBLEM STATEMENTS**

✚ **The Problem List**

The treatment plan is built around the problems that the patient brings into treatment. Problem statements are created as a direct result of the Treatment Assessment. 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 Problem List - the counselor uses to identify the client's most immediate areas of need.**

**The Problem List - serves as the springboard from which the problem statements on the treatment plan are taken.**

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 patients's needs and come up with clear ways to of dealing with each problem. The treatment plan flows into discharge planning, which begins from the initial assessment.



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A good way to check yourself is to compare the completed treatment plan with the last page of the Treatment Assessment; you should find every problem from your treatment plan contained within the Six Dimensions of the Problem List.

### **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 should be no longer than one sentence and 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



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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

#### **Client "Buy-In" to the Problem**

Always ask whether the client agrees with the problems on their treatment plan. What the counselor believes is a problem may not be seen as a problem by the client. When clients are in the Pre-contemplation or Contemplation stage it is especially important to meet them where they are. When a counselor adopts a neutral attitude in relation to the client's readiness for change, the client feels safe to express their ambivalence or their belief they do not have a problem. It is crucial for the client to have this degree of rapport with their counselor. If the counselor has a bias that the client "should" recognize their "problem", it often comes across in the way the counselor writes the problem statement and goal and does not support the client and the treatment alliance.

An example of this discrepancy is a client in contemplation that is given the following problem: *"My drug use causes me to go to jail"*; and goal: *"Understand why my drug use causes me to go to jail"*. It is obvious the counselor believes the client has a problem, but the client would likely not agree, and therefore would not "buy-in" to the treatment plan. This creates a lack of trust in the counselor-client relationship that is hard to repair. A more appropriate problem statement would be, *"The court believes I need treatment for my drug use, but I don't think I need help."* The goal might be, *"Prove to the court that you don't need help."* The client is far more likely to "buy-in" to this problem and goal, which in turn enhances the treatment alliance.

#### **Things to include in a Problem Statement in a nutshell**



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## Problem Statement

- Still a problem today?
- Narrow down/specific
- Negative Consequences directly related to the problem – thought, feeling, behavior that occurs before you use or as a result of using
- What made you say that?
- Current
- A problem the client is willing to work on
- Informative
- Individualized

## **B. THE STAGES OF CHANGE**

In writing effective treatment plans, the counselor takes the client's Stage of Change **for each problem statement into account**. The Stages of Change model describes a five-stage process that clients will cycle through (*not necessarily in order and may be at different stages for each problem....or not*) during their recovery process. This allows for a problem, goal, and action step(s) to be created that (1) match the client's own perception of the situation, (2) provides a motivational (personal) reason to address the situation, and (3) lays out a framework of tasks and actions that are understandable and reasonable to the client.

***Instructor Note: A detailed list of the Stages of Change is listed below. You will see this list and read about the Stages of Change in many of the courses you will be studying. The Stages of Change are a staple of counseling, treatment, placement, case management and discharge planning. The more comfortable you are with these stages the greater your understanding and client rapport will be.***

1) PRECONTEMPLATION: The client has no intention to change. Often this is due to a lack of awareness. Typically, the client will present to substance abuse services in this stage because of

outside influences; however, the client does not recognize the situation as their problem. They don't believe they have an addiction problem.

2) CONTEMPLATION: The client is willing to consider that there is a problem but does not believe they have an addiction problem. The client begins to consider that he or she may want to overcome the problem, but at best, remains ambivalent about change.

3) PREPARATION: This stage combines an intention to change with a clear definition of the problem behavior; the client has made a commitment to act and is making plans to do so in the near future.

4) ACTION: At this point in the process the client modifies his or her behavior, experiences, or environment to overcome the problem(s).

5) MAINTENANCE: The behavior that occurred in the action stage is maintained as the client works to prevent relapse and to consolidate the gains that have been made.

6) RELAPSE: The client returns to the problem behavior. At this point the current stage of change must be re-assessed relative to the return of the problem behavior and its consequences. (Note: people do not have to cycle through the relapse stage although many people do.)

### **Assessing for the Current Stage of Change**

The current stage of change can be a difficult assessment task. The information comes from listening to the client's description of the problem, as he/she sees it, and from asking questions that give you more and more specific information about the client's behavior relative to the problem.

In determining a Stage of Change for a particular problem it is generally a good idea to first determine whether the client is in the Pre-contemplation or contemplation stages or the in the preparation, action, maintenance stages. Clients will often give the impression that they are in the preparation and action stages when they first enter treatment. It is very important at that time to dig a little deeper. Listen without judgment and see the problem(s) as they see it. It is important to compare what the client is saying with the client's non-verbal behaviors. Non-verbal behaviors often provide very accurate information regarding a specific SOC. Curiously questioning or "noticing" the difference between what your client is saying and what your



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client is doing, or equally important, what your client is not doing; usually provides a wealth of useful information regarding the SOC. Taking a curious “devil’s advocate” position, or using the reflective listening technique can also be useful to differentiate between the pre-contemplation/contemplation and preparation/action stages.

Here is a sample dialogue between counselor & client:

**Counselor:** *“So you’re saying that you are ready to stop all this, huh?”*

**Client:** *“Yea. It’s become a nightmare. I just can’t drink and party all night and get up in the morning like I used to. I guess I’m too old for this. I have to give it up”.*

**Counselor:** *“You’re going to stop completely?”*

**Client:** *“Yea, I’ve got to change my lifestyle. Those guys in AA are right. You have to stop all of that stuff completely. Stop hanging out with the drinking buddies, stop keeping stuff around the house and at work...you know.”*

**Counselor:** *“So, you’re saying that...hold on, let me ask you this – if you go to a wedding are you saying that you wouldn’t have a glass of champagne to toast the bride and groom?”*

**Client:** *“Sure, that’s OK. One glass of champagne at a special event, I mean that’s not like 10 or 12 beers after work”.*

So, what stage is this client in – pre-contemplation or contemplation – or preparation or action?? Remember, the earlier stages are not signs of failure or resistance. They aren’t a diagnosis. **They are just two of the stages in a cycle of five stages that all people go through when they attempt to make significant life changes.**

What is a realistic goal for a particular problem **given the client’s stage of change? It’s what the client wants to accomplish.** Having an open-ended conversation with the client during the interview helps the counselor see that clearly. Some easy-going, truly curious questions (e.g. “Devils Advocate”), can lead the interviewer right to the heart of the matter.

There are some basic strategies that a counselor can employ in working with each stage of change. There are some fairly specific, standard interventions used in the substance abuse treatment field for each stage of change, e.g. the “pro and con” or “cost-benefit” exercise for people in contemplation. These examples can help you use the Stages of Change as an assessment tool and as a treatment-planning tool.





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***Instructor Note: As the counselor, once you understand that your problem is to understand how your client understands their problem, you are in the driver's seat!!!***

Determining the appropriate Stage of Change (SOC) leads you straight to a realistic goal and then on to action steps that are meaningful and can be accomplished by your client. The current Stage of Change is a vital piece of information in creating the most effective and efficient treatment plan for your client.

## **Things to remember when assessing for Stage of Change in a nutshell**

### **Stages of Change**

- **Specific for each problem**
- **Current**
- **Assessment not judgment**
- **Client's SOC not counselor's diagnosis**
- **Assess both words and actions**

### **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.

The client ultimately determines the goal(s). However, the counselor uses his or her interviewing and counseling skills to help guide the client towards a goal that is achievable and pertinent to the problem and the particular stage of change.

Goals are individualized, specific and applicable to the client's needs and abilities. The client should be able to see how working towards the goal will help to resolve the stated problem.

This gives the client a sense of self-esteem and helps them feel they have accomplished something worthwhile in their recovery process. For instance, a goal like “become abstinent from illicit drug use” is not specific enough for a client in any stage.

It is important to create a goal that is not simply a re-statement of the problem. Goals are related to but opposite from the identified problem and are logical outcomes of the action steps. The goal should be current, informative, and relevant to addressing the problem. The goal should be stated in measurable terms using action-oriented language to illustrate the direction of change.

### **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.



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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.

Regarding the issue of short-term goals vs. long-term goals, keep in mind that long-term goals are generally for treatment modalities of 6-months or more. In other words, try not to use goals that require extended time frames to solve a problem. Help the client choose goals that are realistic and obtainable within the current level of treatment. This supports the client to experience a successful and positive view of their treatment and gives them the motivation to move successfully through the continuum of care.

### **Things to remember when formulating goals in a nutshell**

#### **Goals**

- **Reinforces SOC**
- **Keep the goal out of the problem**
- **Current**
- **Needs to be relevant to the problem**
- **Long term or short term**
- **Informative**
- **Individualized**

### **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 him 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])

Objectives are the nuts and bolts of the treatment plan. They are the specific elements that combine to produce change for a given problem. Like problem statements and goals, objectives need to be current, relevant to the client, and achievable during the current treatment episode. Objectives are better if they are informative of the treatment. They should explain the direction of the treatment and not just be lists of things to do. (E.g.: “Read the chapter on relapse issues” versus, “Read the chapter on relapse issues and list three ideas that were new to you. Bring the ideas to group in 2 weeks on 6/2”).

By now the counselor and client have completed the assessment and the counselor thoroughly understands the client's Stage of Change. The problem(s) and goal(s) are established. Guided by the Stage of Change for that problem, the client and counselor brainstorm what new thoughts, feelings, actions, and/or experiences, if practiced, would help the client achieve his/her goal. The counselor uses his or her expertise to formulate the two objectives so that they are directly related to the problem and are specific tasks the client can report back on. The objectives are incremental and logically built on each other so that the client can strategically accomplish the goal. If the objectives are on target, the treatment plan will make sense to the client and validate the client's own perception of the problem.

***Instructor Note: Steer clear of generic treatment plans. Most clients in treatment may need help with relapse prevention or a safe, supportive living environment; but avoid the pitfall of using the same objectives over and over for each client. Repeating problems, goals, and objectives creates generic treatment plans, which do not take into account the individual differences of the clients in treatment and cannot measure the client's response and***



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***movement during their treatment process. They fail the client in treatment because the client's personal motivation and purpose of treatment are missing.***

*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:*



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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 the following skills

1. Learn how to say positive things to themselves.
2. Develop recreational programs to add fun to their lives.



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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

Use your creativity. Think about the person for whom you are writing. For example, if they are in preparation or action stage of change for a certain problem, you will want to provide them with the means to help them accomplish their goal. For example, the objective “Develop a relapse prevention plan”, is not incremental. Some steps might be: 1) Read the handout describing ways to prevent relapse, 2) From the handout choose 2 relapse prevention ideas listed and discuss in group how you would use them, and 3) Begin practicing the relapse prevention ideas and write a brief note daily about when you use them and the result.

Objectives are treatment interventions and as such, are unique to each client. They are creative and informative. These new steps that the client has agreed to act on must be interesting and challenging enough to elicit the client’s attention and motivation. They must make sense and be meaningful to the client. And perhaps, most importantly, they need to be achievable by the client. Objectives should not intimidate, overwhelm, or insult the client. Objectives that are completed give the client a sense of competency and confidence to carry out more difficult tasks toward their improvement in the future. It is important that we create action steps that help our clients succeed.

It is essential to good treatment that client outcomes can be assessed. Objectives need to be measurable and verifiable in order to determine their effect on client outcome. Objectives are tasks that have been agreed upon by the client to try in order to change/create new behaviors. Obviously, it is important to know if the client tried. This is why objectives must be measurable and verifiable. It is important to know if they had an effect. If the client didn’t attempt to try out the new actions what was the reason? If there was no effect from the new actions what was the reason?

The objectives you create become a set of individualized directions that the client can follow to reach their goal. Imagine yourself to be the “YAHOO! Maps” program for your client. The client sits before you just like you sit in front of your computer and do a MAPS SEARCH for Driving



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Directions. The client knows where he/she wants to go. You have an enormous amount of street information at your disposal, but – you need to know the specifics of where the client wants to go first. If they say they want to go to San Jose, and you don't ask for more specific, individualized information, you could send them to Costa Rica!

The objectives are the directions we give to a client. It is vital to the success of their journey that we give them effective and efficient directions to solve their problems.

### **Things to remember when establishing objectives with your client**

#### **Objectives**

- Reinforces goal
- Incremental
- Specific
- Realistic to client
- Matches SOC
- Measurable outcome
- Current
- Objective client can complete within treatment episode
- Creative
- Informative
- Individualized

#### **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.





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Interventions should be selected by looking at what the patient needs. They may include every treatment available from any member of the multidisciplinary team. This 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.



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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 blood alcohol level on admission of .32, three DWI's, 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 6-01-14.

*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 6-1-14.



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

\*Responsible professional: \_\_\_\_\_

Objective 3: Norman will share his powerlessness and unmanageability with his group by 6-10-14.

*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 6-15-14.

*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 6-25-14.

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

\*Responsible professional: \_\_\_\_\_

Objective 7: Norman will discuss his codependency with his wife by 6-30-14.



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*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 7-2-14.

*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 7-10-14.

*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 7-2-14.



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*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 7-21-14.

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

\*Responsible professional: \_\_\_\_\_

### **Therapist Qualities During Treatment Planning**

- **empathy**
- **understanding**
- **patience**
- **tolerance**
- **focus on tx relationship**
- **validation**

### **Treatment Plan Review**

The interdisciplinary team (whoever is participating in the treatment plan) 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



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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.

***Instructor Note: In addition, and perhaps most importantly, in Florida (and most other states) there is a regulation standard that a formal treatment plan review must be conducted every 30 days from the initiation of the master treatment plan. At this time ASAM criteria for continued stay must also be performed and met if client is to continue in current treatment level of care.***

### **Documenting the Treatment Plan**

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

#### **Examples of Progress Notes**

**6-12-14 (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."

**6-14-14 (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, Cap)

**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)

#### **The Role of the Treatment Plan in Clinical Records**



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The Treatment Plan is the pivotal point in which all other documentation activities revolve. The plan is like the hub of a Wheel—without the hub, the spokes have no way to connect.

- ✚ **The assessment** is the first step in treatment planning - problem areas are identified leading to a Master Problem List. Problems are addressed in goals, objectives, and interventions of the treatment plan.
- ✚ When managed care (private or public) is involved in authorizing client services, the **initial service authorization** determination is based on the assessment information. Progress notes reflect the treatment plan.
- ✚ **Treatment plan reviews/continued stay reviews** reflect the client's progress in relation to the problems/goals identified in the most current treatment plan and may also adjust the level of care.
- ✚ Most program certification/licensing practice guidelines require a **discharge plan** be developed soon after admission to a treatment program. Discharge criteria are determined by the problem and goals addressed in the treatment plan.



## **Chapter 3**

**Treatment planning actually begins in the interview.**

**Some of the questions include:**

- What are some of the things you like to do or feel that you do well?
- What are your friends like (ages, gender)? What are some of the things you all like to do together?
- What might your friend's say make you a good friend to them?
- How do you handle difficult situations? Give an example of the last difficult situation you faced and how you handled it?
- When you complete our program successfully, what will be different about you and those around you?
- On a scale of 1 to 10, how motivated are you in wanting to try our program out?

Many of these questions echo the differing types of solution-focused questions that are identified as integral parts of a strength based interview.

These same questions can be asked again during the treatment planning session.

### **The Initial Treatment Plan/Initial Service Plan**

The Initial Service/Treatment Plan is used to guide treatment during the first week or month (depending on the length of the treatment program) of treatment. It also forms the foundation of the main Treatment Plan. Initial treatment planning occurs during the assessment and engagement processes.

The diagnostic presentation sets the stage for the development of the Initial Treatment Plan which typically involves developing an abstinence contract, a schedule of treatment activities, and an initial structured recovery program that will support the client during initial days treatment. The initial treatment is designed to resolve the motivational crisis, provide bio-psycho-social stabilization, get the client involved in a setting and systematic process in which they can develop a comprehensive treatment plan. This can involve:

1. **The Abstinence Contract:** The abstinence contract is an agreement to abstain from alcohol and other mood altering substances for the duration of treatment and to abstain from behaviors that exacerbate the symptoms of coexisting mental or personality disorders. The abstinence contract results from the process.
2. **Schedule of Treatment Activities:** The therapist recommends an initial schedule of treatment activities that includes an intensity of care recommendation (how frequently sessions are scheduled), and the modality of care recommendation (either individual therapy, group therapy, psycho educational programs, supervised participation in self-help programs such as Alcoholics Anonymous, or a combination of two or more).
3. **Structured Recovery Program:** An initial structured recovery program is developed by collaboratively identifying the recovery activities and other acts of daily living that are required to support initial abstinence, mental status stability, and lifestyle stability during the period of active treatment. The structured recovery program is an important tool for monitoring a client's motivation for treatment and identifying relapse warning signs.

*Instructor Note: Below is chart of the difference between a “Traditional/Problem Focused Treatment Plan and the Strength-Based Treatment Plan. Lined up side by side you can see how the strength-based treatment plan is more client centered and set up for client change. The strength-based treatment plan allows for client self-determination and for clients to see their issues as possible to manage and recover from.*

	<b>“Traditional” or Problem-Focused Treatment Plan</b>	<b>Strengths-Based Treatment Plan</b>
Purpose of the Treatment Plan	List of Problems that the Client must address. Inflexible	A framework designed to guide the Treatment Process. A living document that can be adapted to client's needs.
Role of the Client in developing the plan	Little to no client involvement. Very little client input.	Client is directly involved in developing the plan. Plan is centered on client's input—what it is they want to work on.

Outside or community resources	Underutilized or not utilized at all—may even be seen as a hindrance.	Resources that can be integrated into the treatment plan.
Presenting Problems	Form the foundation of the Treatment Plan. Problems are viewed in terms of pathology— often the plan is developed to address the problems alone.	Problems are still addressed in the plan; however, problems are seen as unsuccessful attempts to manage issues.
Strengths	Minimized or relegated to a back part of the plan. Assessments do not measure strengths. Viewed as opposite of weakness.	Placed in the beginning of the plan. Assessments measure strengths as well as problems. Contextual.
Treatment Goals	Focus mainly on the Presenting Problems. Often worded negatively: (i.e., “The client will stop doing [something negative]”). Language follows a clinical or medical model.	Integrate client’s strengths and problems. Worded positively: (i.e., “The client will do more of [something positive]”). Language is understood by all participants in the process including the client.

## Chapter 4

### The Transtheoretical Model (TTM)

*Instructor Note: Throughout this course we have presented why a treatment plan is important, how to write a solid, working treatment plan, the definitions of all the various parts that make up a treatment plan and how the stages of change are utilized in creating the treatment plan with your client. Many programs still do not require the Stages of Change to be represented/utilized in their treatment plans but I can tell you that soon it will be a requirement of all programs! Using the Stages of Change to help guide the clinician in establishing goals & objectives that match the client's current reality just makes good clinical sense – not to mention that statistics have already shown significant improvement in outcome measures. So...I have included the following brief review of the Transtheoretical Model.*

TTM focuses more on dynamic processes that affect a client's readiness for change, while traditional methods of treatment planning focus more on pre-existing client characteristics. TTM identifies four transtheoretical dimensions of change (Prochaska & DiClemente, 1984, 2005; Prochaska & Norcross, 2002, 2007):

1. **Processes of Change:** These are the overt and covert activities that various therapy systems use to initiate change, such as consciousness-raising, catharsis, counter-conditioning, contingency management, and reevaluation of the self or the environment.
2. **Stages of Change:** Clients make attitudinal, intentional, motivational, and behavioral changes as they move through the precontemplative, contemplative, preparation, action, and maintenance stages of readiness for change.
3. **Pros and Cons of Changing:** The relative pros and cons of changing undergo a shift as clients move through the stages. Cons outweigh pros in the precontemplative stage, become equivalent by the contemplative stage, and lose relevance by the action stage. Pros gain strength and motivation increases as clients move through the stages.
4. **Levels of Change:** More intensive intervention is required depending on whether problems are conscious or unconscious. Some problems are symptomatic responses to a difficult situation, but more complex problems may have nested levels: e.g., symptoms may be supported by maladaptive cognitions, which create interpersonal

conflicts that repeat childhood family conflicts, which were internalized in the form of intrapersonal conflicts.

Stages of change that indicate when different intervention principles may be useful have strong empirical support and has had a significant impact on the field. The following describes TTM's recommended change processes for the different stages of readiness for change (DiClemente, 2003; Prochaska & DiClemente, 1984): Pre-contemplation, Contemplation, Preparation, Action, and Maintenance (the definitions of the Stages of Change are listed earlier in this course and will be reviewed in several other courses).

### **Pros and Cons of Changing**

This dimension is where the client weighs the pain caused by their problems against fears of the unknown and the social stigmas of not solving one's own problems or being labeled "mentally ill." Not surprisingly, 40–50% of pre-contemplative clients terminate prematurely, but consciousness raising helps reduce that percentage. Pros and cons are equivalent by the contemplation stage, but pros outweigh cons by 0.7 standard deviations by the action stage. Clients are more likely to complete therapy if change processes are appropriate to their current stage of change (Prochaska et al., 2001).

### **Levels of Change**

This describes problem depth or complexity, ranging from symptoms or problematic situations to internalized conflicts that are recurring themes throughout the client's life.

### **Treatment Planning**

Intervention processes shift in TTM treatment planning as the appropriate level of change is discovered and as clients move from one stage to the next.

Three strategies exist for choosing interventions as a function of level of change:

1. **Shifting Levels:** Initial interventions focus on symptom or situational change. If this does not work, therapists progressively shift to deeper levels until the client responds.

2. **Key Levels:** Interventions are targeted for a clearly indicated level; e.g. family therapy is needed for parents in conflict over discipline for an out-of-control child.

3. **Maximum Impact:** With the most complex cases, interventions target multiple levels; e.g., long-standing interpersonal conflicts that reflect family of origin problems and affect most areas of life have probably been internalized as intrapersonal conflicts. Symptoms and situations may be targeted for immediate relief and then used to raise awareness about patterns of maladaptive thoughts, interpersonal conflicts, or family of origin influences.

Therapists shift their approach to address the increased resistance to change that results when clients discover they need to process problems at deeper levels.

Final thoughts about the great benefit of the Transtheoretical Model.....

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But “treatment is an adjunct to self-change rather than the other way around.” “The perspective that takes natural change seriously...shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change.” (DiClemente, 2006)

*Instructor Note: I don’t know about you but this approach re-ignited my clinical interest and commitment to my clients. It breaks away from the old school way of practicing and generates hope and belief in recover, healing and wellness in both the client and the counselor. Don’t be afraid to try new things that have been proven to work like TTM.*

## **Appendix A:**

### **SAMPLE TREATMENT PLAN GOALS / OBJECTIVES**

**Note:** Always make objectives measurable, e.g., 3 out of 5 times, 100%, learn 3 skills, etc., unless they are measurable on their own as in “List and discuss [issue] weekly...”

*Instructor Note: I have compiled a list of sample problems, goals related to those problems and objectives for those goals. This is a great “cheat sheet”. Save and print for your future use and/or review.*

### Alcohol/Drugs and Other Addictions

Goal: Be free of drug/alcohol use/abuse

- Avoid people, places and situations where temptation might be overwhelming
- Explore dynamics relating to being the [child/husband/wife] of an [alcoholic/addict] and discuss them each week at support group meetings
- Learn five triggers for alcohol & drug use
- Reach \_\_\_\_ days/months/years of clean/sober living

### Anger

Goal: Increase and practice ability to manage anger

- Walk away from situations that trigger strong emotions (100%)
- Be free of tantrums/explosive episodes
- Learn two positive anger management skills
- Learn three ways to communicate verbally when angry
- Be able to express anger in a productive manner without destroying property or personal belongings
- Be able to express anger without yelling and using foul language
- Explore and resolve conflict with \_\_\_\_ (list triggers)
- Get through an entire day without an angry mood swing (or breaking/punching...)
- Get through a whole week without fighting with \_\_\_\_
- Take a time-out when things get upsetting
- Learn and practice anger management skills especially in situations where people are not treating him/her respectfully

### Anxiety

Goal: Develop strategies to reduce symptoms, or

Reduce anxiety and improve coping skills

- Be free of panic episodes (100%)
- Recognize and plan for top five anxiety-provoking situations
- Learn two new ways of coping with routine stressors
- Report feeling more positive about self and abilities during therapy sessions
- Develop strategies for thought distraction when fixating on the future

### Behavior Problems

Goal: Improve overall behavior (and attitude/mood), or

Maintain positive behavior (and attitude/mood)

- Be free of \_\_\_\_\_ behavior
- Develop a reward system to address \_\_\_\_ (target problem)
- Learn two ways to manage frustration in a positive manner
- Share two positive experiences each week in which X is proud of how he/she has behaved
- Stay free of fights
- Stay free of drug & alcohol use and abuse (100%)
- Be free of violent behavior
- Be able to keep hands and feet to self
- Be able to express anger in a productive manner without destroying property or personal belongings
- Be free of threats to self and others
- Complete daily tasks (e.g. chores, pet care, self care, etc.)
- Avoid leaving clothing/toys/personal stuff all around the house
- Listen to parent and follow simple directions with one prompt
- Put all dishes, glasses, cups, and food items back in the kitchen after meals/snacks
- Clean up after himself/herself
- Admit and accept personal responsibility for own actions/behavior
- Be respectful of adults and avoid talking back
- Get through a whole week without fighting with \_\_\_\_\_
- Avoid behavior that would result in a loss of custody
- Be able to play with others peacefully for \_\_\_\_\_ minutes
- Come home each day by \_\_\_\_\_ (time)
- Keep parents informed about where you are and when you will be home
- Be in bed by \_\_\_\_\_ each night
- Be free of bedwetting
- Be free of wet/soiled underwear
- If an accident happens, be responsible and clean it up
- Be free of any behavior that could result in loss of job
- Remain free of behaviors which would lead to arrest
- Comply with all aspects of probation/parole and avoid behavior that could violate



- Eat/swallow only items intended to be food

### Communication Skills

Goal: Learn and use effective communication strategies

- Talk nice or do not say anything at all
- Learn three ways to communicate verbally when angry
- Be able to express anger in a productive manner without destroying property or personal belongings
- Be able to express anger without yelling and using foul language
- Be able to express wants and needs through spoken language
- Be able to ask questions and tell about instances
- Be able to stick up for self assertively
- Speak in a clear and concise manner so others fully understand him/her
- Learn to express feelings verbally without acting out

### Decision Making

Goal: Improve decision making skills

- Make short and simple “to do” lists and complete three tasks each day
- Celebrate little successes each day using positive self talk and/or journaling
- Be able to weigh options and make simple decisions within 5 minutes
- List three options for any major decisions and then discuss with therapist or family

### Depression

Goal: Improve overall mood

- Be free of suicidal thoughts
- Call crisis hotline if having suicidal thoughts
- Report feeling more positive about self and abilities
- Get 7-8 hours of restful sleep every night
- Avoid napping/sleeping to escape other people and activities
- Shower, dress, and then do something every day
- Report feeling happy/better overall mood
- Make short and simple “to do” lists and complete three tasks each day



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- Celebrate little successes each day using positive self talk and/or journaling
- Get through a day/week without a crying spell
- Develop strategies for thought distraction when ruminating on the past

### Expression of Feelings, Wants and Needs

Goal: Learn appropriate ways to express different feelings

- Share two positive experiences each week in which client is proud of how he/she has behaved
- Gain knowledge of different feelings
- Turn to adults for help when feeling sad, angry or negative feelings
- Express feelings verbally rather than whine and/or cry about them
- Learn to express feelings verbally without acting out

### Family Conflict

Goal: Learn and use conflict resolution skills

- Recognize patterns of family conflict discuss weekly in therapy
- Avoid angry outbursts by walking away from stressful situations
- Get through X days out of 7 without fighting with siblings
- Be respectful of \_\_\_\_: Listen, follow directions and avoid talking back
- Be able to live together peacefully, free of all angry physical contact
- Learn three ways to communicate verbally when angry
- Be able to express anger without yelling and using foul language
- Explore and resolve conflict with \_\_\_\_
- Be able to stick up for self assertively, not aggressively
- Be respectful of adults/don't talk back
- Get through a whole week without fighting with \_\_\_\_
- Speak in a clear and concise manner so others fully understand him/her
- Learn to express feelings verbally without acting out

### Grief and Loss

Goal: Explore and resolve grief and loss issues

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- Give sorrow words - discuss issues of grief weekly with therapist
- Continue to explore and resolve issues of grief/loss as they arise
- Get through a week without a crying spell
- Learn about the typical 2-7 year process of grieving the loss of a loved one
- Explore spirituality and the role it plays in redefining views about the meaning and purpose of life
- Create (write/draw) a soul sketch of the deceased loved one
- Plan a memorial service for the anniversary of the loss
- Develop appropriate rituals to remember and honor \_\_\_\_\_

### Health Issues

Goal: Manage physical healthcare conditions and cope with related stress

- Learn as much as possible about the condition(s) and needed treatment
- Take medications/treatments as prescribed on a daily basis
- Attend all scheduled appointments with the doctor
- Maintain good overall physical health and healthcare practices
- Report any medication concerns to the prescribing doctor ASAP
- Seek additional advocacy services from \_\_\_\_\_
- Seek additional support from \_\_\_\_\_

### Mood Management

Goal: Maintain stability of mood, or

Improve overall mood, or

Maintain even mood, or

Increase ability to manage moods

- Learn two ways to manage frustration in a positive manner
- Be free of suicidal thoughts; call crisis hotline if having suicidal thoughts
- Report feeling more positive about self and abilities
- Report feeling happy/better mood (4 days out of 7)
- Get 7-8 hours of restful sleep every night
- Get through a week without a crying spell

### Parenting

Goal: Improve parenting skills

- Set two limits and stick with a plan that will require more responsible behavior
- Focus on positive behavior and give attention then, rather than focus on negative things
- Learn and be able to effectively use transactional analysis to stay in “adult” mode
- Use “I” statements rather than “You” when communicating with \_\_\_\_\_
- Develop and consistently use a behavior modification plan, to increase/eliminate

### Physical Health Issues

Goal: Cope with stress of physical health issues and chronic pain

- Explore and resolve thoughts and feelings that arise as a result of medical conditions and medications
- Learn two new strategies for coping with the above thoughts and feelings
- Reduce weight by \_\_\_\_\_ pounds
- Exercise for 20 minutes every day
- Learn strategies to advocate for him/herself with medical personnel
- Quit smoking (or drinking)
- Take medications as prescribed on a daily basis
- Attend all scheduled appointments with physicians
- Maintain good overall physical health and healthcare practices
- Report any medication concerns to the doctor ASAP
- Make and keep an appointment with \_\_\_\_\_ (dentist) for needed diagnosis and treatment

### Relationships

Goal: Establish/maintain civil and supportive behavior

- Avoid angry outbursts by walking away from stressful situations
- Be free of affairs
- Be able to live together peacefully, free of all angry physical contact
- Learn three ways to communicate verbally when angry



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- Explore peer and dating relationships to improve X's chance of staying safe and legal
- Be able to keep hands to self
- Be able to express anger without yelling and using foul language
- Explore and resolve conflict with \_\_\_\_
- Be able to stick up for self assertively
- Be respectful of parents/don't talk back
- Get through a whole week without fighting with \_\_\_\_
- Speak in a clear and concise manner so others fully understand him/her
- Be able to play with others peacefully for \_\_\_\_ minutes
- Learn to express feelings verbally without acting out
- Associate with healthy people and continue to make new friends
- Continue to explore relationship issues and slowly see new opportunities for dating
- Figure out why relationships fail and better plan for finding next partner
- Associate with people outside of work and make one or two new friends

### Self Image

Goal: Explore and resolve issues related to self image

- Discuss life events that led to and/or reinforce a negative self image during weekly therapy
- Use positive self talk daily
- Exercise daily (or \_\_\_\_ times per week)
- Drop \_\_\_\_ pounds
- Report feeling more positive about self and abilities
- Return to school and work on getting \_\_\_\_ (degree/diploma/GED)
- Change jobs to one that...(offers more pay and/or better suits skill set)
- Openly discuss issues relating to sexuality and become comfortable with sexual identity
- Explore spirituality and the role it plays in the meaning and purpose of life
- Engage in volunteer work and/or other meaningful activity at least three hours each week

### Sleep Problems

Goal: Get 7-8 hours of restful sleep each night

- Limit consumption of food and drinks before bed
- Limit intake of caffeine (coffee, tea, soda) and chocolate after \_\_\_\_\_ (noon meal)
- Cut back on things that may impede normal sleep patterns (e.g., alcohol and some medications)
- Be in bed by \_\_\_\_\_ each night
- Have 30 minutes of quiet time before going to bed each night (e.g., read, meditate)
- Avoid overly stimulating shows/movies/video games before bedtime
- Avoid watching TV and chatting on the phone while in bed
- If not asleep in 20 minutes, get up and do something for a bit, rather than try to force sleep
- Leave a paper and pen to write worries down instead of ruminating on them
- Learn best practices for sleep (cooler room, limit caffeine, calming time before bed)
- Listen to relaxation/meditation music to aid falling asleep

### Social Skills

Goal: Improve social skills

- Speak in a clear and concise way so others fully understand him/her
- Learn to express feelings verbally without acting out
- Make a new same-age friend
- Spend two hours playing with peers each week

### Stress

Goal: Be able to cope with routine life stressors and take things in stride

- Assess personal risk traits and resiliency traits and discuss the role each plays in coping with daily stresses during the time between therapy sessions
- Learn two ways to manage frustration in a positive manner
- Get 7-8 hours of restful sleep every night
- Talk out routine stress events during weekly therapy sessions
- Explore and resolve residual stress from \_\_\_\_\_ (e.g., years as a first responder)
- Foster two new activities/interests that will help mitigate stress



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- Exercise 20-30 minutes per day
- Learn and use meditation and relaxation techniques daily

### Suicide

Goal: Be free of suicidal thoughts/attempts

- Explore and resolve stress from \_\_\_\_\_
- Call crisis hotline if having suicidal thoughts
- Develop a crisis plan and share it with key people
- Remove weapons from the home [and other means]
- List three emergency contacts who will be able to stay with you till a crisis passes

### Vocational/Educational

Goal: Find a new job, or Keep present job, or Re-enter the work force

- Earn G.E.D.
- Explore options for returning to school/training
- Become an active member of a local clubhouse
- Complete college/technical school
- Develop a resume
- Seek two people who will serve as references
- Be free of any behavior that could result in loss of job/educational grants
- Find and settle into a new job