

Treatment Planning

INTRODUCTION

Treatment planning is a collaborative process of working with a client and his family or support system to specify personal goals and the means by which treatment can help a client reach his or her goals. This chapter describes a man with schizophrenia and alcohol abuse and how his team helped him and his daughter to develop goals and to select treatments to address those goals. The discussion elaborates a six-step process to develop and follow up with integrated treatment plans for persons with substance abuse and mental illness.

VIGNETTE

Ferdinand is a 59 year-old, widowed, unemployed man with schizophrenia, alcohol abuse, and diabetes. He recently moved to New York from North Carolina to live with his daughter, who wants to help in caring for him. According to his daughter and medical records from North Carolina, Ferdinand spent the last 30 years living in a small apartment with his wife, until her death five years earlier. While she was alive, he took an antipsychotic medication and was able to take care of his basic needs. After his wife's death, however, he became quite isolated in his apartment, and his health rapidly deteriorated. He drank heavily in his early 20s but had no further history of alcohol problems.

According to his daughter, over the last year Ferdinand developed trouble with urinary incontinence and also appeared to be losing his memory. He was frequently angry and confused, and often talked to himself. The restaurant owners across the street where he ate most meals kicked him out and refused to serve him, and he lost weight rapidly. Soon thereafter, he was involuntarily hospitalized. On admission to the hospital, his blood alcohol level was above the state limit for intoxication, and his medication level was undetectable. His blood sugar was higher than normal, which led to a diagnosis of diabetes. He was started on intramuscular insulin, as well as an antipsychotic medication.

When his daughter brought him in to the mental health center in New York for treatment, he appeared disheveled, irritable, and distracted. He did not talk to himself, but admitted that he heard voices. His memory was poor. He was angry about the insulin shots, which he did not believe he needed. He was willing to take medication for his "nerves." He said he was grateful to his daughter for caring about him, but upset about moving. He denied drinking any alcohol and said that drinking had never been a problem for him. He said that the urine test in the hospital must have been a mistake. When the clinician asked him what his goals for himself were, he said he "just wanted things to get back to normal" and wasn't able to articulate any more specific goals.

Ferdinand's daughter was concerned about his drinking: She had found numerous empty vodka bottles in his apartment in North Carolina, but she didn't

think he was drinking now that he was living with her. When asked about the bottles, Ferdinand became upset and said he didn't remember any vodka bottles. His daughter was also concerned about his physical health and his incontinence, which was better than before but still an occasional problem at home.

At the end of two meetings, and after reviewing records from his previous treatment in North Carolina, Ferdinand, his daughter, his psychiatrist, and his case manager agreed on five treatment goals. First, Ferdinand wanted to be able to take care of himself at the house while his daughter was at work. Second, he wanted to stay physically healthy and find out more about his diabetes by seeing a doctor. Third, he wanted to work with the mental health team to "keep his nerves in check." Fourth, he agreed to make his daughter happy by avoiding alcohol. Fifth, Ferdinand acknowledged that he was lonely without his wife and needed to meet some people in his new town. As the following figure shows, these goals led to specific action targets.

Figure 1. Treatment Plan for Ferdinand

Client name: Ferdinand

Mental Illness Diagnosis: Schizophrenia, probable alcohol abuse

Clinician Rating Scale Alcohol: Probable Alcohol Abuse

Substance Abuse Treatment Scale: Early persuasion stage

Problem #1: Hasn't been taking care of himself

Goal: Take care of himself while daughter is working

Targets: Get up, shower, eat breakfast and get dressed in clean clothes every day by 9:30; Make himself a sandwich or soup for lunch every day.

Intervention: Outreach to home by case manager; practice skills with case manager; set up cues in room to complete tasks. Make chart to check off meals.

Treatment modality: Case management, mental illness management

Responsible clinician: Joe (case manager)

Problem #2: Physical health including diabetes, incontinence, and memory problems

Goal: Stay physically healthy

Targets: Make and keep medical appointments; take meds prescribed by doctor

Intervention: Nursing assistance in setting up pill box, coordination with internist

Treatment modality: Mental illness management

Responsible clinician: Patricia (nurse)

Problem #3: "Nerves," auditory hallucinations, irritability

Goal: Keep nerves in check, i.e. reduce frequency of hallucinations, irritability

Targets: Keep appointment with psychiatrist; take prescribed medications; meet with case manager once a week

Treatment modality: Medication, case management

Responsible parties: Joe (case manager), Phil (psychiatrist)

Problem #4: Possible abuse of alcohol

Goal: Avoid alcohol use

Intervention: Meet with case manager weekly to learn about and discuss alcohol use; meet with case manager and daughter monthly to discuss her concerns

Treatment modality: Case management, education, family intervention

Responsible clinician: Joe (case manager)

Problem #5: Social isolation, loss of wife, move to new community

Goal: Establish social contacts

Intervention: Attend senior center three days a week, talk with members

Treatment modality: Case management, family intervention, social intervention

Responsible clinician: Joe (case manager)

TREATMENT PLANNING GUIDES TREATMENT

Treatment planning is a collaborative process that guides treatment. It involves working with a client and his or her family (or other supporters) to consider the assessment information, to establish individual goals, and to specify the means by which treatment can help a client to reach those goals. Initial treatment planning occurs during the assessment and engagement processes, typically over weeks or months. The process results in a written document like the one in Figure 1. Remember that treatment and recovery must focus on the client's goals, which must be measurable and meaningful. For persons with dual disorders, the treatment plan will always address mental health and substance abuse, and will typically involve building both skills and supports for recovery goals. For Ferdinand, there are multiple areas of concern in addition to his mental health and his drinking: his physical health, his memory problems, the loss of his wife and home, the transition to a new community, and social isolation.

We assume that clinicians are already familiar with the general approach to treatment planning. This chapter focuses on treatment planning for substance abuse.

SIX STEPS FOR SUBSTANCE TREATMENT PLANNING

Treatment planning involves six steps, which we will describe in detail below: (1) evaluating pressing needs, (2) determining the client's level of motivation to address substance use problems, (3) selecting target behaviors for change, (4) determining interventions for achieving desired goals, (5) choosing measures to evaluate the effects of the interventions, and (6) selecting follow-up times to review the implementation of treatment plans and their success.

1. Evaluating pressing needs. When clients are in crisis, such as in danger of hurting themselves or others, these issues need to be addressed first. Helping clients to develop safety and stability is usually a precondition to helping them move towards sobriety. In many cases, like Ferdinand's, the crisis situation cannot be resolved without addressing substance abuse, and the clinician must address both the pressing needs and the substance abuse.

Common pressing needs include dangerous behaviors, homelessness, victimization, violence, severe symptoms, medical problems, legal problems, and acute intoxication. For Ferdinand, his medical problems, weight loss, and confusion were pressing issues that endangered his life. His ability to take care of himself has been a serious problem, but he may be able to do much better with supports, medical attention, and medications. Taking medications and avoiding alcohol may resolve his confusion.

2. Determining motivation to address substance use problems. The level of a client's motivation to address substance abuse will determine the most appropriate interventions. The Substance Abuse Treatment Scale (SATS) (Figure 7 in the previous chapter) describes the different stages of treatment based on the client's substance use behavior and involvement in treatment. The team uses all available information in making this rating, using the most recent substance use and involvement in treatment over the past six months. In Ferdinand's case, his self-report, his daughter's report, the clinical records, and the team's observations suggested that he was in the early persuasion stage of treatment. He had regular contact with his team and was willing to discuss his drinking, though he denied that it had occurred. It was unclear whether he was drinking at present.

3. Selecting target behaviors for change. In making a treatment plan, the clinician asks, "What changes are necessary to decrease substance abuse or to minimize the chances of a relapse?" The client's stage of treatment is important to setting goals because it reflects the person's motivation to change his substance use behavior. The factors that maintain ongoing substance abuse or threaten a worsening or relapse of substance abuse should be the targets for change.

To identify suitable targets for intervention, the team should consider problems that are preventing the person from progressing to the next stage of treatment as well as factors that maintain ongoing substance use or threaten relapse. Once these are identified, concrete changes or goals that would address these factors are specified. Examples of common problems, target behaviors, and interventions for stage-wise treatment goals are listed in table 1.

Ferdinand's history, for example, suggests that he began drinking after losing his wife and that loneliness and isolation may have been the precipitants. The clinician should watch for signs of unresolved grief and depressive symptoms and consider with him the likely relationship between these moods and his drinking. To address the factors that led to relapse, the clinician should work towards increasing social support and daily activity for Ferdinand. To address the stage of treatment, persuasion, the team should help Ferdinand to learn how substance use interferes with personally valued goals, such as controlling diabetes and improving memory.

Table 1: Examples of common problems, target behaviors and interventions

Stage	Problem	Target behavior	Intervention
Engagement	??Lack of regular contact with dual diagnosis clinician	??Regular contact with clinician	??Assertive outreach ??Practical assistance(housing, entitlements, other) ??Family education
Persuasion	??Substance use interferes with personally valued goals	??Efforts to reduce substance use to make progress towards personal goals	??Motivational counseling ??Persuasion groups ??Basic social skills training ??Vocational supports
Active Treatment	??After abstinence achieved, craving to drink	??Use imagery to cope with craving ??Use self talk to cope ??Use distraction or replacement activity to cope	??Cognitive-behavioral counseling
Relapse Prevention	??Loneliness due to distance from substance-using friends	??Improved skills for making friends	??Social skills training ??Self help group referral

4. Determining interventions for achieving desired goals.

Different interventions are helpful at different stages of treatment. In early phases of treatment, clinical work does not focus on giving up substance use because clients are not yet interested and motivated to do so. Attempts to push a client to stop using a substance before he is ready are usually ineffective. However, once a client is interested in giving up a substance, interventions should be targeted at helping the client do so.

In Ferdinand's case, he is willing to discuss alcohol use, but isn't admitting it's a problem or even that he is using. Demanding that he attend AA at

this point would not make sense. The team and his daughter are hoping, however, that his drinking was situational and that he will be able to stop with supports. They will continue to observe him for potential abuse, to educate him about the effects of alcohol on aspects of his life that matter to him, and develop a more specific treatment plan if the need arises.

5. Choose measures to evaluate the effects of the interventions. When specific interventions have been selected to change the targets, progress must be measured. Assessment should be For example, if the target for Ferdinand is to avoid alcohol completely, his daughter and case manager can help to monitor his appearance, behavior, and house closely for two weeks. There should be no signs of alcohol use.

6. Select follow-up times to review the plan. Treatment plans are only useful when the team follows through with the proposed interventions. Monitoring will help the team be aware of any problems with the planned interventions early on, so that they can be resolved and the interventions can be delivered. Also important is that the planned interventions may not have the desired effects on the target behavior. For example, Ferdinand may relapse to drinking when he is alone at night. A new treatment plan would need to address that reality.

THE WORKING ALLIANCE

A key to successful assessment and treatment planning with persons with dual disorders is a positive relationship, which is often called the working alliance. This is especially important in Ferdinand's case, because he does not have much insight into his drinking or his mental illness, in addition to being psychotic, angry, and confused. The clinician working with Ferdinand should convey genuine caring and respect. It would be important to find ways to build a relationship within which Ferdinand feels safe and valued, and senses that the clinician has his best interests in mind. Examples of such activities might include conversing with Ferdinand about topics in which he is interested and assisting him with his own self-determined priorities (e.g., helping him obtain new clothing or helping him get to a doctor's appointment).

The clinicians should continually assess whether Ferdinand feels threatened or alienated, and back away if necessary. Because Ferdinand actively denies any alcohol use, the appropriate intervention might be to make sure he gets education from the doctor and nurse about how alcohol might affect his mental illness, his diabetes, and his memory, and to watch for any clues of alcohol use. If at a later time he acknowledges use and expresses an interest in talking about drinking, the clinician could encourage the client to monitor himself for cravings, triggers, and drinking behavior.

In addition to asking about the drinking and other problems, it would also be important to talk with Ferdinand about positive aspects of his life, such as activities he enjoys, his hopes, and his goals. He may have lost sight of his own plans and hopes, and asking about these areas may be a first step toward helping him to recover a sense of possibility. Treatment should encourage and facilitate the client's aspirations and use individual strengths and resources to attain recovery goals

TREATMENT PLANNING IS CONTINUOUS

Though this vignette describes the process of developing an initial treatment plan, remember that *treatment planning is an ongoing process*. The plans are adjusted as one develops a better understanding of the client and of which interventions are effective. Treatment plans also change over time because as people move through the different stages of treatment, different interventions are appropriate and effective.

COGNITIVE PROBLEMS

Ferdinand's vignette illustrates numerous interesting problems, like the common problem of diabetes and the onset of alcohol abuse in older age, but we will address just one other aspect here, and that is his confusion. *Cognitive problems such as confusion or memory loss can be due to a variety of difficulties*, e.g., old age, dementing illnesses like stroke, schizophrenia, antipsychotic medications, diabetes, or alcohol use. Obviously, one or more of these might be relevant for Ferdinand. The most important point is that confusion and memory loss are often reversible and should be assessed thoroughly by a psychiatrist and an internist.

Intoxication with or withdrawal from alcohol and other substances cause reversible changes in memory and concentration during the time of use or withdrawal. Cognitive problems can persist for weeks or months and gradually clear up once a person stops using. Unfortunately, alcohol can also cause permanent changes in memory function, and the only way to know if the memory problem will get better is to observe the client carefully during prolonged abstinence. In Ferdinand's case, the team hopes that the recent history of alcohol abuse, medication non-adherence, uncontrolled medical problems, and situational stress are accounting for his cognitive problems. All of these factors should improve with good care, and Ferdinand should be able to function at a much higher level if he recovers his cognitive functioning.

When a dual diagnosis client has problems with memory and concentration, the first step is to measure the problems by using simple tests, such as the Folstein Mini-mental Status exam (see figure 2 below). If the problems are severe (score less than 20) or are moderate (score

less than 25) and do not improve within a month of sobriety or improvement in physical illness, the client should be evaluated medically to assess other medical problems that could be causing the changes.

Recommended Reading

The textbook, Integrated treatment for dual disorders: Effective intervention for severe mental illness and substance abuse, has a chapter on treatment planning with many examples that you may find helpful. The book is by Kim Mueser, Douglas Noordsy, Robert Drake and Lindy Fox. Another helpful book on treatment planning is Substance Abuse Treatment and the Stages of Change by Gerard Connors and others (Guilford, 2001).

Figure 2: **Mini Mental Status Exam:***

Instructions: Each question is scored based on the number of items tested in that question. The highest possible score for each question is noted in italics in the column preceding the score boxes. The number of correct responses given by the client is recorded in the appropriate box. The number of points given for each question varies from 1-5 for a total possible score of 30. Question 9 asks the client to read a sentence and do what it says. Question 10 asks the client to write a sentence. Question 11 asks the client to copy a design. The sentence, a blank for question 10, and the design can be found on the next page of this manual. Read the following aloud to the client:

“I’d like to ask you some questions about to assess your memory. The questions may seem unusual, but they are routine questions we ask of everyone. Some of the questions are very easy and some are difficult, so don’t be surprised if you have trouble with some of them.”

Orientation *Maximum Score*

1. “What is the (year) (season) (day) (date) (month)?” *5*_____

2. “What is your address? (state) (county) (town) (street) (number).”*5*_____

Registration

3. “I am going to say three words. After I have said them, I want you to repeat them.”

“APPLE TABLE PENNY”

“Could you repeat the three words for me?”

(NOTE: SCORE 1 POINT FOR EACH CORRECT REPETITION ON FIRST TRY. REPEAT WORDS UNTIL ALL ARE LEARNED. # of Trials_____.).....*3*_____

“Remember what they are, I am going to ask you to name them again in a few minutes.”

Attention and Concentration

4. Serial 7's, backwards from 100. (93, 86, 79, 72, 65) Score 1 point for each correct.

Stop after 5 answers. Alternatively, spell WORLD backwards.

.....5_____

Recall

5. Ask for the 3 words repeated above. Give 1 point for each correct.

.....3_____

Language

6. Point to, and ask to name: a pencil and a watch.

.....2_____

7. Repeat the following "No ifs, ands, or buts".

.....1_____

8. Follow a 3-stage command:

"Take a paper in your right hand, fold it in half, and put it on the floor".

.....3_____

9. "Read and obey the following": CLOSE YOUR EYES (**See next page**)

.....1_____

10. "Please write a sentence." (**See next page for blank space**)

.....1_____

11. "Please copy this design." (**See next page**)

.....1_____

Total Score: (Total Possible=30)

>23 - Normal

18-23 - Mild Cognitive Impairment

<18 - Moderate to Severe Cognitive Impairment

**Questionnaire is the Mini Mental Status Exam, Folstein, 1975*

(9) CLOSE YOUR EYES

(11)

