In the last issue of AM we proposed that an individualized treatment plan is a vital agreement between the client and the treatment agency or counselor. It clarifies the client’s reasons for engaging in the treatment process, the needs or problems that will be addressed, the type or level of care that will be provided, the specific activities in which the client will participate, and the expected outcomes. In this article we will present how to make the plan something both you and the client can use to guide and evaluate the treatment process. We will discuss the essential content and qualities of a useful plan and compare it with traditional characteristics of more boilerplate approaches to mapping the client’s course in treatment.

Our primary source of information is a new NIDA-SAMHSA Blending Initiative training course titled, “S.M.A.R.T. Treatment Planning (SMART) Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful”. Developed by members of the ATTC network and NIDA researchers, this training package uses the ASI as a vehicle for identifying client problems and assessing treatment progress. In reality, the concepts contained within the course are relevant to any standard assessment process you might use in evaluating a client’s readiness and need for substance use disorder treatment. Use of the ASI, while advisable, is not necessary in order for you to benefit from the information contained here. The goal is to help you improve your treatment planning in ways that benefits both you and your client.

All the elements of SMART are applicable to your treatment planning no matter which assessment process or instrument you may use. Of course, one value of the ASI is that it has been tested, studied and validated in hundreds of different treatment settings. It can be scored and summarized electronically, saving valuable clinical time and increasing the objectivity of the assessment findings. And it yields a measure of severity for each of the problems scales, making it easier to prioritize problems identified during the assessment.

Old School Treatment Planning: “One Size Fits All”

In the past, treatment for substance abuse or dependence was often presented in a “one size fits all” approach. Clients typically participated in a set schedule of activities and counselors used a limited set of tools, often without the client’s involvement in the development of the “program-driven” treatment plan. Consequently, the uniqueness of the client’s needs was
not reflected in the plan. The client was simply expected to fit into the agency’s regimen.

In recent years a paradigm shift has moved treatment planning from “program-driven” to “individualized.” Payers, researcher and clinicians all became aware that some clients needed more care, or a different kind of care, than others. With a growing availability of research-tested interventions and medications, treatment providers are now able to target client needs more effectively. Individualized treatment plans can now be designed, or “sized” to match a client’s problems and needs. We know individualized treatment leads to increased client retention and improved outcomes. The data your assessment provides is a tool you can use to measure the “fit” of the treatment plan to your client’s needs.

Client problems are as diverse as the population of clients you serve. We think of substance use disorders as having biological, psychological and social components. Assessment usually examines all three biopsychosocial spheres of the client’s life. The ASI scales include medical, drug and alcohol issues (the biological); psychiatric status (the psychological); and family/social, employment, and legal issues (the social). Most assessments gather information in these areas plus others like cultural, sexual, economic and criminality issues. The treatment plans you develop with the client draw upon all this data. You can see why, if treatment services are to truly meet the needs of our clients, treatment plans and activities need to be individualized.

Individualizing the Plan

Treatment plans typically have these sections: Problem statements, goal statements, objectives and planned interventions. What is included in the plan is often prescribed by a combination of agency policies, state administrative rules, agency accreditation guidelines, and payer demands. The suggestions we make here should be interpreted in the context of the rules and guidelines in place at your agency.

Problem Statements

The best problem statements describe specific, observable, and/or measurable client behaviors or circumstances. When problem statements are clear and observable then treatment goals, objectives and planned interventions will be easier to write. It’s important to pay attention to the language you use when writing a problem statement. Is it judgmental? Does it include professional jargon? Notice the differences in these two sets of problem statements:

“Client has low self-esteem” (judgement) OR
“Client makes several negative self-statements daily, like ‘I am always messing up’ “ (specific and behavioral)

“Client is in denial” (jargon) OR
“Client has been arrested twice for alcohol-related behaviors but states that alcohol use is not a problem” (specific and behavioral)

Can you see the difference? Problem lists often contain judgments and jargon. It is hard to write individualized goals and objective statements if the problem is stated in a fuzzy, unobservable, generalized way. Our suggested guide: The more specific the problem statement, the better.

One final suggestion: List all the problems you discovered during the assessment on the problem list. You will usually need to prioritize the list and recognize that you may not be able to address all the problems while the patient is active in treatment, but the problems should be identified. In doing periodic progress reviews you may discover that problem priorities rise and fall during the course of treatment and across different treatment episodes. It is best to maintain as full an inventory of the client’s problems as possible.

Goal Statements

Setting treatment goals requires you to collaborate with the client. You will want to review the problem list, making sure that you and the client agree on the accuracy of the statements. Then you will prioritize the problems and identify those that need to be addressed initially in treatment. Next, for each of the problems to be addressed, you and the client prepare a goal statement that reframes the problem into a statement of what the client wants to achieve during treatment. Do not be concerned yet about how the client will achieve the goal. Concentrate first on reaching consensus and securing client buy-in to the goal.

Here are some guidelines to follow in developing goal statements:

1. Does the client understand the statement? Is it free of clinical jargon?
2. Is the statement clear and written in a complete sentence?
3. Is the goal attainable during the time the client will be active in treatment?
4. How comfortable are you with the statement? Is it agreeable to the client and other members of the staff?

In the next issue of the messenger we will examine one method of prioritizing problems into goal statements.

Objectives and Interventions
Objectives are statements of what the client will do to meet the goals you have established, while interventions are what you and other staff will do to help the client meet those goals. Here is a brief look at a model for developing statements of objectives and treatment interventions. It uses the mnemonic “SMART” to help you remember the characteristics of effective objective and intervention statements.

**S** - Specific
- Make objectives and interventions specific and goal-focused to allow you and your client to note progress.
- Target specific behaviors which can help the client reduce symptoms and improve functioning.

**M** - Measurable
- Allows you and your client to document change.
- Provides a means of holding you, the client and other staff members accountable.
- Include dates, behavior rates, and rating scale scores in the objectives when appropriate.

**A** - Attainable
- Goals, objectives, and interventions are achievable during treatment.
- Focus on “improved functioning” rather than the “end” of the client’s problem.
- Identify those goals that can be attained given the level of care provided.
- Identify clients that need referrals to outside agencies for services.
- Revise objectives and interventions as needed when the client moves from one level of care to another.

**R** - Realistic
- Objectives are realistic and practical.
- It is reasonable to believe the client can attain the objective in the time period of treatment.
- Goals and objectives are achievable given the client’s environment, support system, diagnosis, and level of functioning.
- Have a good understanding of the steps the client can take on their own behalf to achieve their goals.

**T** - Time-limited
- Emphasize the specific, time-limited nature of the goals and objectives.
- Review progress/achievement of goals, objectives, and interventions periodically.

Our discussion of SMART treatment planning will be continued in next month’s issue of the Addiction Messenger. We will address prioritizing problems statements into goals, provide examples of effective goals, objectives and intervention statements and address frequently asked questions about treatment planning. Stay tuned!
Washington State Institute on Addictions Treatment

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