Making Recovery Real:

The Critical Role of Treatment Planning

Approach requires sharing responsibility with client

By Diane Grieder, M.Ed., and Neal Adams, M.D., M.P.H.

The mental health and addictive disorders fields have found a common language and mission in their now-shared commitment to *recovery and resiliency* as the primary goal of treatment services. But translating these principles and values into changes in practice and person-centered outcomes is not always easy. An important question remains: How can providers/organizations *ensure* that their clients are in fact receiving recovery/resiliency-oriented services?

Effecting the changes to truly provide full consumer input and participation — and achieve a partnership approach to the delivery of services — is often difficult. Maintaining a focus on wellness, self-responsibility, empowerment and community integration can be challenging. Goodwill and intentions alone will not likely transform care systems — in most instances, real practice changes must occur to realize the vision of recovery.

There is perhaps no more powerful and effective approach to ensuring recovery-oriented services than a commitment to creating and actually using *person-centered treatment plans* in everyday practice.

We propose that the process and product of planning be essentially redefined. Service plans need to become a valuable clinical tool that:

- Forges an alliance with consumers.
- Results in improved outcomes.
- Is individualized and based on consumer input regarding preferences, abilities, strengths, goals and cultural identity.
- Is written in language readily understandable for the consumer.
- Immediately directs the service delivery and recovery process.
- Instead of creating provider-driven plans that emphasize problems and diagnoses merely to satisfy bureaucratic and administrative requirements (as is common in most practice settings today), providers must seize this opportunity to make recovery real.

As noted in our soon-to-be-published book, *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery* (Elsevier/Academic Press, 2004), in order to be meaningful and effective, a plan must genuinely be the individual's road map. The plan should be a virtual focal point of each session and service provided; it needs to include personally defined goals, realistic objectives that address relevant and immediate barriers and impediments, as well as efficacious services and interventions.

At the same time, plans need to be practical, reasonable and consistent with the individual's preferences, values and culture. The plan should be sensitive to language choices and written in "plain English," or the individual's preferred language. The plan must be culturally sensitive and appropriate while at the same time being outcomes-oriented.

> "Consumers' needs and preferences should drive the type and mix of services provided, and should take into account the development, gender, linguistic, or cultural aspects of providing and receiving services. Providers should develop these customized plans in full partnership with consumers, while understanding changes in individual needs across the lifespan and the obligation to review treatment plans regularly."

Stating the case

The President's New Freedom Commission on Mental Health report of July 2003 made explicit the central role of a plan of care and the need to change current practice (see box at left). Addressing individual and family concerns in describing goals and objectives, as well as the services and supports needed to enhance resiliency and achieve recovery, is essential. Creating plans that are meaningful and relevant — and at the same time support the documentation of medical necessity required for billable services — gives providers an opportunity to demonstrate their commitment to the vision of recovery and wellness.

Yet, problems with assessment and treatment planning are among the most frequently cited accreditation standards and regulatory requirements. Why is it so hard to get it right? Why does person-centered planning seem

to be so difficult to accomplish? Creating person-centered plans really shouldn't be that mysterious or difficult!

Preparation of the workforce is one aspect of both the problem and the solution. Education and training on how to create a person-centered plan is missing from most pre-degree curricula and is not often provided in post-graduate or on-the-job training. There are few if any books or other materials written about this approach to planning, and what does exist is for the most part very "medical model" in its approach and emphasis.

To the extent to which there is training, the focus is often on completing forms rather than the process of involving consumers and families. Coupled with the increasing clinical responsibilities of non-degreed providers who lack skills and confidence in many components of the process, it is not surprising that planning is such a frequent problem. Simply stated, many providers just don't know how to do it!

Lack of time and resources is another often-cited barrier to good planning. This is where leadership and administrative commitment can make a real difference. Providers and teams often feel that they lack the time to involve individuals and families and to get it right — and all too often resources seem too scarce and caseloads too large and overwhelming to permit this. Many providers express frustration with a learning curve that makes a new practice seem laborious and inefficient; this only increases resistance to change. But with practice comes skill and efficiency that is rewarded by improved outcomes and fewer client demands over time.

Creating the solution

The *process* of planning is what's really important — if done properly, the forms will take care of themselves. The education and training needs of providers must be addressed with a mix of didactic and practical experiences that help to model both the relationship and the outcome of good person-centered planning. There are seven key areas in the process that training should address. These include:

- Approach or attitude.
- Assessment.
- Formulation.
- Barriers and priorities.
- Goals and transition criteria.
- Objectives.
- Services, interventions and activities to accomplish the objectives.

This should be a fairly familiar and standard list of planning elements for most practitioners and administrators. The key to ensuring a person-centered approach often lies in re-evaluating — and in many cases changing — the process by which each component is addressed and completed. There are several practical steps that we recommend to help each provider and organization move toward enhancing or transforming their service delivery system:

- **Approach.**

A new/different way of thinking will be required for many providers. Believing in recovery and resiliency is essential. A primary barrier to change can often be found in the historical attitudes of clinicians toward clients. A truly person-centered approach requires the inclusion of the individual as a critical member of the treatment team, with an essential role in developing the plan. But all too often, fear of loss of control of the treatment process (by empowering clients), discomfort in making the clinical judgments entailed in the narrative/interpretive summary, and anxiety about change itself all get in the way. Involving consumers and family members in the training process can be especially effective and powerful.

- **Assessment.**

The focus of assessment should be not only on gathering information, but also should emphasize the importance of establishing a relationship/alliance with the individual and family. Asking a neutral and inviting question, "How can I be of help?", is an easy way of being more positive, inviting and affirming, instead of focusing on problems and deficits.

An accurate understanding of the individual's needs, strengths and goals, as discovered through the relationship with the provider, should shape and form both the process and the product. The plan format (whether completed with paper and pencil or with a computer) should support rather than define the process. How the data are actually gathered can play a role in moving toward a service delivery system that is recovery-oriented. The use of semi-structured interviews (not necessarily filling in the blanks/boxes on the assessment instrument in the order of the form), utilizing Motivational Interviewing techniques, and self-report questionnaires all may prove to be helpful.

- **Formulation.**

Creating a narrative summary that moves the data gathered in the assessment into information is a critical but often-skipped step in plan development. It is essential that we move from the details of *what* to the understanding of *why*, and to share this with the client. The insights that lie in this understanding are often what make the crit-

ical difference between a successful or failed plan.

A recent Substance Abuse and Mental Health Services Administration (SAMHSA) publication on *Cannabis Youth Treatment* emphasizes that the provider should give the client a copy of his or her "Personalized Feedback Form" (based on the narrative summary) and review it together in order to increase collaboration, foster engagement in services, and help develop relevant treatment goals.

Often formulations will include some consideration of the individual's stage (e.g., pre-contemplation or engagement). Utilizing motivational techniques, providers can encourage individuals to assess their own behavior and readiness for change. Providers must remain non-judgmental, while supplying the combination of information and encouragement needed to help the person move to the next stage of recovery. These techniques are particularly effective during the early, trust-building phases of treatment. This is but one way in which creation of the plan can be a significant clinical process.

- **Barriers and priorities.**

Priorities are an important consideration both for establishing goals and setting objectives — but have different significance for each individual and each phase of the service process. Priority in goal setting is really driven by the wishes and desires of the individual and family, with appropriate help from the provider as needed in clarifying those preferences and priorities. If multiple goals are identified, it is important that their priority, order, or sequence be identified. Barriers to achieving goals should be identified in the assessment and narrative summary. Helping to clarify the individual's potential barriers to achieving his or her hopes and dreams may help to identify some of the more short-term objectives for the current treatment episode.

- **Goals and transitions.**

Goal setting is yet another opportunity to demonstrate a recovery-oriented approach. There is perhaps no greater expression of respect, understanding, hope and empathy by the provider than the ability to elicit, acknowledge and accept the individual's and family's goals.

In many respects, this is where individuals may feel most vulnerable — sharing their hopes, dreams and desires. Individuals *and families* often come seeking help feeling overwhelmed, frightened and defeated by their needs and challenges. Rekindling a connection with their highest aspirations is an essential first step in creating a successful and effective helping partnership as well as a plan. Having a written goal statement can go a long way toward helping clients toward success.

- **Objectives.**

Objectives serve to remove or relieve barriers to the individual's goals. Matching objectives in the plan to the individual's stage of treatment or readiness for change, to their development, culture, and age, is a key component of a person-centered plan. Objectives are the sequential or concurrent near-term changes necessary to help the individual and family meet their long-term goals.

Objectives identify the immediate focus of treatment; they are the incremental changes and manageable tasks the individual and family will focus on, bit by bit, as they move toward reaching their goal. Objectives provide both the client and the provider with feedback about progress in attaining goals.

- **Services and interventions.**

Interventions (also referred to as services or strategies) that promote skill building, and emphasize utilization of natural supports in the community instead of just professional supports, are yet other indicators of a genuine person-centered plan. Interventions that promote growth and self-reliance, such as encouraging individuals to self-direct their recovery; providing education on risk behaviors/diet/nutrition/exercise; teaching relaxation and stress reduction; helping to identify triggers/relapse signals; linking to community events/volunteering; and achieving social integration in work and housing, are all part of a recovery approach.

Conclusion

There are a number of strategies available to administrators and direct-care providers to help promote recovery-oriented services. Training on planning techniques and increasing the core competencies of clinicians is essential. In addition, conducting ongoing quality review of records, obtaining regular feedback from clients concerning their satisfaction with services and the planning process, involving consumer advocacy organizations, working in partnership with clients, and providing education about evidence-based practices are all examples of steps that can be taken to strengthen the organization's commitment to recovery-oriented and person-centered approaches to care.

If providers truly believe in and follow the concepts of recovery and person-centered care, the ownership of service delivery and the written plan is then shared with the individual receiving services. This is certainly a gigantic shift from the notion of the provider being the sole source

of expert knowledge and professional experience.

In this environment there is no place for assuming to know what is "best" for the individual, for not sharing the assessment/diagnosis results, for not openly communicating and making shared decisions, for dismissing the individual's preferences and goals (or not soliciting them at all), or for ultimately fostering dependency rather than self-reliance and recovery. Even the most committed providers will sometimes be blind to the negative impacts of these well-accepted, traditional attitudes and approaches.

Person-centered care does not imply that there is no longer any role for the provider to play in the treatment/recovery process. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, shepherd.

The provider builds a partnership with the individual, resulting in a service plan that serves as the road map for recovery. The provider uses the plan as a guide with which to maintain a shared focus on the individual's progress toward goal attainment, as a framework for needed resources, and as a measure of growth and change. The plan is no longer just an administrative requirement, but rather a clinical necessity.

Diane Grieder, owner of AliPar, Inc., a consulting firm in Virginia, has more than 20 years of experience in the behavioral healthcare field, devoted to quality-improvement functions and management of systems. She has been an accreditation surveyor of behavioral health programs with CARF for the past 16 years. She conducts trainings nationally on clinical documentation and treatment planning, performance improvement, and strategic planning.

Neal Adams, M.D., M.P.H., is a board-certified psychiatrist/addictions specialist who currently serves as medical director for adult services at the California Department of Mental Health. He is past president of the American College of Mental Health Administration (ACMHA) and is a frequent speaker and consultant on quality of care and treatment planning.

This November, Elsevier/Academic Press will publish Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery, *a book by Adams and Grieder designed to help professionals understand the value of treatment planning and build the skills necessary to offer person-centered, recovery/resiliency-oriented care.*