

7. Individualized Treatment Planning

This section presents guidelines for working with your participants to develop individualized treatment plans using the GAIN, GRRS, and ICP and to promote developing these treatment plans in a consistent manner. Most of the materials in this section are directly adapted from our earlier manual on Individualized Substance Abuse Counseling (Dennis et al., 1995). A basic tenet of that work and this section is that participant involvement is essential to developing meaningful and useful treatment plans (Dennis, Fairbank, et al., 1995; Sobell, Sobell, and Nirenberg, 1988). Active participant involvement in treatment planning and goal setting can:

- provide the counselor with important information about the desirability, feasibility, and ease with which various treatment strategies can be implemented.
- increase participants' motivation to participate and continue in counseling.
- ensure that treatment goals have been mutually determined.
- boost the morale of participants, giving them a sense of mastery over their problems.

Below are some general recommendations and guidelines for developing an initial treatment plan with participant involvement over the course of the first few counseling sessions. It is important to keep in mind, however, that treatment planning is not limited to the initial formal encounters with a participant. On the contrary, treatment planning is a dynamic process that typically evolves well beyond the first few sessions and should span the entire course of counseling and treatment.

Relationship Between Assessment and Treatment Planning. Ideally, the GAIN and GRRS or other initial assessment summary should flow directly into treatment planning. In practice, however, most assessments focus on diagnosis and do not always take the necessary steps to facilitate treatment planning. In the prior chapters we talked about administration, scoring, diagnosis and placement. Now we turn to the question of what to do with the participant once he has arrived at a primary treatment location.

The GAIN will provide a general overview of problems in specific areas (e.g., logistics, substance use, physical health, risk behaviors, mental health, environment, legal, vocational). In our experience, many instruments can provide sufficient detail to obtain a general picture of the problem presented by a particular participant. The advantages of picking one instrument and standardizing its administration are that it (a) allows counselors to communicate more effectively with each other and their clinical supervisor in case conferences, consultation, and supervision, (b) minimizes information loss when cases are transferred between counselors, and (c) allows for better program planning to meet the needs of participants (including tools to reduce paperwork or make it more clinically useful). The GAIN has additional advantages over other instruments in that it was designed to lead directly into problem definition and treatment planning and facilitate communication with specialists and agencies outside of the participating system (e.g., medical,

psychiatric, or vocational referrals) by using their standards and language.

Transitioning from Assessment to Planning. Clearly communicating that the GAIN will be used for treatment planning and reinforcing this perspective during the assessment will result in getting better information. Throughout the assessment and debriefing phase you should make it clear to the participant that you are listening to them and understand their individual situations and desires. This is an essential step in becoming an effective agent for change. In addition, during the assessment process you will have already been making notes in preparation for treatment planning and possibly have consulted with other staff members about specific requests that the participant will make of you. This means you can reduce your response time. Finally, it is important to realize that the assessment process itself is helping the participant define and communicate problems and desires which he might not have otherwise been able to discuss. This is very different from many diagnostic assessments that focus on trying to categorize people.

It is essential to start an informal treatment plan during the very first session even before developing a formal treatment plan. At the most pragmatic level it is important to check for immediate threats or barriers to the participant's (a) return for the next session, (b) personal safety, and (c) short-term sobriety. After the assessment is completed (or at the end of the first session), you should review the available information and discuss with the participant their plans immediately after leaving the assessment, between now and the next session, and for coming to the next session. Some participants may require admission to one of the ASAM levels of detoxification before they can complete the assessment or be ready for primary treatment. You will also want to carefully probe for any barriers to returning like those found in section B of the GAIN (e.g., transportation difficulties, child care, work schedules, insurance). Clarify any concerns about possible suicidal thoughts (the M1c items on the GAIN-I) or threats to personal safety (particularly item E9 on the GAIN). Next, make sure that the participant has thought through a plan for coming back for the next session (e.g., how he will get there). Finally, it is often desirable to provide some level of intervention or make sure the participant has access to some kind of drug-free environment to reduce the risk associated with relapse between this and the next session (e.g., detoxification, a sponsor or friend in recovery).

Effective resolution of some barriers to care might involve arranging a joint meeting with the participant and a wraparound coordinator, vocational services coordinator, case manager, or other staff member. For example, if the participant is concerned about being unable to keep the next few appointments because of unmet child-care needs, meet with the participant and the case manager together immediately (if possible) to assist the participant in finding a suitable solution to this problem. It is particularly important to cover this issue for new participants when the assessment is being done in their first or second session.

Conceptualization of Core Problems. As part of the GRRS (or other clinical summary) the severity of problems should have been summarized. While useful for diagnosis or placement, translating this into explicit treatment plans often requires further details or understanding. For those areas where there is a current or past problem, clinical staff review the relevant sections of

the GRRS, ICP and GAIN. The GRRS will identify the core problem and give a general description. The ICP gives more explicit statements, scale scores and more detailed answers to narrow down what the issues. It also includes code in [brackets] that identifies the specific questions on the GAIN that were the basis for the information if the clinician wants to go back to the individual items on the GAIN. This information is designed to help clinicians conceptualize a give problem three dimensions:

1. **Recency** – has this problem occurred and, if so, when did it last occur? Things that happened in the past week, month or 90 days will typically play a greater role in current treatment than those that happened 3-12 months or 1+ years ago.
2. **Breadth** – how widespread/diverse is the presentation of clinical symptoms or pattern of service utilization? Typically more diverse presentations are associated with higher severity. For clinical problems, the focus is on the past year (or since the last interview in follow-up assessments). For services, the focus is on the lifetime pattern of service utilization.
3. **Current Prevalence** – how often has this happened in the past 90 days? Typically things that happen more frequently (particularly if they interfere with responsibilities at home, work/school or socially) are going to be more important than those that happened only once or twice.

All three of these dimensions can interact. Obviously, a recent problem with a broad presentation and high current prevalence is going to be the most acute situation. A broad presentation of symptoms over the past year that has not been problematic recently (or only infrequently) has probably been addressed, but should still be monitored. However, a narrow presentation and low prevalence may still be important given the specific symptoms in question (e.g., suicide attempts). Thus the goal of the GAIN review is to identify where the problems are, prioritize which are the most acute, and identify what additional information should be sought during the second session to make an effective treatment plan or referrals. In the multiple dimensions of the individual's life, this tells you about where a problem is and what it is probably related to. You can use this to demonstrate your understanding to the client, but will then want to work with them to get more details. For instance, you might identify that there is substance use and some illegal activity by others in the client's home, which is in public housing. Such an environment is hostile to recovery and puts the family at further risk of eviction or homelessness. Further probing might identify that the activity by others in the home is by a current significant other, spouse, parent, or other person, and you may be able to identify potential interventions (e.g., a women or child being victimized who might be eligible to go into a shelter other form of protection).

Feedback and Targeting of Problems. If you went through a series of tests at the doctor's office or hospital, you want feedback on the results, how to interpret them, and information on what your options are (including pros, cons, and the clinician's recommendations). We therefore recommend that the first clinical session after the assessment be dedicated to conducting a face-to-face review of the core problems identified in the assessment with your participant in order to:

- identify and correct errors, misperceptions, and miscodes regarding answers to specific questions.
- allow the participant to clarify and expand upon the information recorded in the standardized assessment.
- provide the participant with a concise overview of his problems in eight important areas of functioning.
- provide a format for comparing and discussing the severity of problems as viewed by the participant and you.
- provide a logical starting point for developing an individualized treatment plan with active participant involvement.

Begin the session by telling the participant that you would like to review the findings from the standardized interview completed in the previous session because you expect this review to help develop a plan for addressing the problems in his life related to drug use. We recommend you review all modules of the assessment completely, including modules in which the participant and you agree few or no problems exist. We believe that a complete review often provides the participant with a clear “snapshot” of his life that points out areas of relative strength as well as problem areas that may require treatment of some kind.

Introduce each module of the assessment with a brief statement such as, “We began the interview with a number of questions about your substance use,” or “In this next section, we discussed your involvement with the legal system.” Short statements such as these should help focus the participant’s attention on the information to be covered in that module. Briefly review the participant’s response to each section of the assessment modules, including the participant’s and your ratings of the problem severity in each area. Encourage the participant to provide additional information that might clarify the nature of problems in each area. This information can be recorded directly onto the GAIN assessment. Counselors vary in how much additional detail they seek at this point, but most strive to understand any complex situation or what appear to be inconsistent or unlikely answers. Most start by looking at the overall picture in each section and only go item-by-item in the critical areas identified by the participant. Our experience indicates that most GAIN reviews should be completed within a single session.

At first glance such a review may seem redundant because it covers the same information as the original assessment (particularly if it was orally administered). For a given participant, however, it is often a therapeutic experience because it directly demonstrates that you listened and provides a comprehensive picture of their life and situation. Many participants have never taken stock of their own lives, and virtually none has confided so much information to a single person. This review process is a fundamental part of empowering you as someone who understands the participant and facilitates your role as an agent of change.

As an alternative to reviewing the full instrument, many clinicians prefer to use a shorter and more narrative report like the GRRS (see appendix F). Another, more focused report that is often used

is the Personal Feedback Report (PFR) generated from the GAIN for use with Sampl and Kadden's (2001) Motivational Enhancement Treatment/Cognitive Behavior Therapy (MET/CBT).

Prioritizing General Areas for Treatment Planning. The next step is to prioritize the general areas of potential needs and identify specific areas on which to work. Exhibit 7-1 shows both the participant and counselor ratings on one of the GAIN profiles. Both participants and counselors were asked to rate the extent to which a participant needed help in each area; the last line is the sum across areas. In summarizing both the participant's rating and your own, it is important to acknowledge your areas of agreement and disagreement (e.g., risk behaviors and mental health in the example). While the counselor should not dwell on or be sidetracked by areas of disagreement, acknowledging such areas helps establish the appropriate level of rapport. In other words, be supportive but honest.

Exhibit 7-1. Treatment Planning Worksheet

Item (Participant, Staff)	Treatment or Problem Area	Participant (O) Urgency Rating	Staff(□) Urgency Rating	Do Not Need Help	Getting Help Already	Need Help In 3+ mos.	Need Help in 0 to 3 mos.	Need Help Right Away
B9, B10	Tx Arrangement	----	2	0	1	2	3	4
S10, S11	Substance Use	4	4	0	1	2	3	4
P13, P14	Physical Health	0	0	0	1	2	3	4
R7, R8	Risk Behavior	0	3	0	1	2	3	4
M6, M7	Mental Health	1	3	0	1	2	3	4
E16, E17	Environment	4	4	0	1	2	3	4
L10, L11	Legal	1	1	0	1	2	3	4
V12, V13	Vocational	0	0	0	1	2	3	4
	Average	1.7	2.1	0	1	2	3	4

When using the Full version of the GAIN, participants who request help in the next three months (or now) will be asked to identify what kind of help they want using a list of common requests and an open-ended "other" statement. Below is a list of the types of services they are explicitly asked about and that, where appropriate, will be listed in the ICP.

Access to Care

- Making transportation arrangements [B9a1]
- Making child care arrangements [B9a2]
- Scheduling around work, school, or family responsibilities [B9a3]
- Paying for treatment [B9a4]
- Language, religious, ethnic or cultural issues [B9a5]
- Clothing [B9a6]

- Food [B9a7]
- Other issues that need to be addressed for participant to be able to come to treatment [B9a99v]

Substance Abuse Treatment

- Alcohol or drug use [S10a1]
- Family's alcohol or drug use [S10a2]
- Situation at home, work or school [S10a3]
- Self-help and support groups [S10a4]
- Detoxification [S10a5]
- Getting treatment [S10a6]
- Getting methadone (methadose), Antabuse, or other medication (disulfiram, LAAM) for alcohol or other drug withdrawal or cravings [S10a7]
- Anything else related to alcohol or drug use [S10a99v]

Physical Health Treatment

- Getting dental treatment [P13a1]
- Pregnancy or family planning [P13a2]
- Testing, counseling, or education on hepatitis, TB, HIV, or STDs [P13a3]
- Help with sexual or fertility problems [P13a4]
- Getting health care treatment [P13a5]
- Coping with current medical problems [P13a6]
- Paying for health care treatment [P13a7]
- Physical handicap or physical therapy [P13a8]
- Anything else related to participant's health situation [P13a99v]

Risk and Protective Behaviors

- Changing participant's pattern of needle use [R7a1]
- Changing participant's pattern of sexual behavior [R7a2]
- Getting information about health or prevention [R7a3]
- Diet, exercise, or relaxation programs [R7a4]
- Quitting or cutting back on smoking [R7a5]
- Anything else related to risk behaviors [R7a99v]

Mental Health

- How participant has been feeling emotionally [M6a1]
- How participant's mind or body seems to be working [M6a2]
- How participant controls his mind or behavior [M6a3]
- Concerns about suicide [M6a4]
- Memories that disturb participant [M6a5]
- Getting medication to help control themselves [M6a6]
- Anything else related to participant's emotional or mental situation [M6a99v]

Environment

- Housing [E16a1]
- Children participant living with or see regularly [E16a2]
- People with whom participant lives, works, goes to school, or socializes [E16a3]
- How participant spends free time and gets social support [E16a4]
- People participant has been avoiding, arguing, or fighting with [E16a5]
- People who have or might attack or abuse participant physically, sexually, or emotionally [E16a6]
- How participant handles arguments [E16a7]
- Anything else related to environment or social situation or coping [E16a99v]

Legal Situation

- Civil justice proceedings [L10a1]
- Being involved in illegal activities [L10a2]
- Criminal justice proceedings [L10a3]
- Making arrangements with a probation officer, parole officer, or other officer of the court [L10a4]
- Child custody case [L10a5]
- Anything else related to participant's legal situation [L10a99v]

Vocational Situation

- Going to training or school [V12a1]
- Getting a school loan or getting out of default on a school loan [V12a2]
- Getting a (better) job [V12a3]
- Getting or keeping public or private benefits [V12a4]
- Financial situation [V12a5]
- Gambling [V12a6]
- Identification (Social Security card) [V12a7]
- Childcare while in work or school [V12a8]
- Anything else related to school, work, or financial situation [V12a99v]

Following these is a list identifying issues typically required in a treatment plan by agency, accreditation, or state or federal regulations (see below) that includes red flags usually indicating the need for specific services or higher levels of care.

- Coordinate care with existing substance abuse treatment providers [S7f = 1]
- Monitor substance abuse medication compliance [S7c = 1]
- Consider more intensive treatment [(S9c-u, number of 3s > 9) or (S9n-u, number of 3s > 5) and S7f = 1]
- Refer for immediate treatment [(S9n-u, number of 3s > 2) and S7f = 0]
- Refer for treatment or early intervention [(S7f = 0 and S9c-u, number of 3s > 0)]
- Review need for continuing care [S7f = 1 and S9n-u, number of 3s > 0]

- Review need for detoxification or withdrawal services [(sum of S3c1-99 > 12), or (Max S2a-r = 6), or (90-S2s1a > = 45) or (S3a = 1 and sum of S3c1-99 > 0) or (S3c9 or S3c10 = 1)]
- Coordinate care with physical health provider [P11k = 1]
- Monitor physical health medication compliance [P11d = 1]
- Refer for follow-up or additional care related to health problems ([P3, P3a-k, sum of answers > 6] or [P9a > 12] or [sum of R1a-j > 1] or [sum of R2a-n > 2])
- Coordinate care with mental health provider [M5j = 1]
- Monitor mental health medication compliance [M5d = 1]
- Refer for follow-up or additional care related to internal mental distress problems [[max of M1e, M2 = 6] or [sum of M1a1-M1d12, M2a-p, > 23] or [M1f > 44] or [max of M1g, M2q > 12]]
- Follow-up on homicidal/suicidal risk in past year [2+ Sx in M1c]
- Monitor homicidal/suicidal risk in past year [1+ Sx in M1c]
- Refer for follow-up or additional care related to behavior problems [M3 = 6 or [M3a1-18, M3b1-15, sum of answers > 18] or [M3c > 44]]
- Follow-up on self-mutilation [M4z4 > 0]
- Review history of self-mutilation and monitor [M4z1-3 > 0]
- Refer to intervention related to readiness to change ([B4a-h, sum of answers > 3] or [S8a-d, sum of answers > 2] or [S8e-j, sum of answers < 3])
- Refer to interventions related to relapse prevention ([S8k reversed, S8m-q, sum of answers < 3] or [S8s-w, sum of answers < 3])
- Refer to residential treatment or interventions related to reducing recovery environment risk [E5a-g, E6a-g, E7a-g, sum of answers > 39] or [E7a-g, sum of answers > 11] or [4+ on E9a-r {GVI}]
- Review need for reporting child maltreatment ([1+ on E9a-q] and [E9e18 = 1])
- Follow-up on high levels of traumatic victimization [4+ on E9a-r {GVI}]
- Follow-up on recent victimization (E9t > 2 or E9u > 1)
- Follow-up on current concerns about being victimized again in the near future [any 1 in E9n-r]
- Coordinate care with DCFS/CPS [B2b = 7 or E4a4 = 1]
- Coordinate care with probation officer [L7_4 = 1]
- Coordinate care with parole officer [L7_7 = 1]
- Coordinate care with criminal justice system [1+ in L7_1 to 99]
- Follow-up on illegal activity [[L3a1-99, sum of answers > 4] or [L3d > 12] or [L3e > 1]]
- Coordinate schedule with school [V3 > 2]
- Coordinate schedule with work [V6 > 2]

Reviewing the above lists from the ICP can also be very useful in completing the treatment recommendations sections in the GRRS. While the general recommendations that are already there are useful, adding in specific things that the client has asked for or clearly needs will make the report more useful. It will also mean more to the client when you review it with them.