Chapter 5
Person-Centered Treatment Planning

5.1 An Overview of Person-Centered Treatment Planning

Treatment planning can be a rich, collaborative process that produces a detailed plan of action designed to achieve a set of client goals that are specific, measurable, actionable, achievable, relevant, recovery-oriented, and time limited. Unfortunately, it is all too common that treatment plans are developed only to fulfill a bureaucratic requirement by providers with little or no client input. These plans are often placed in a drawer and never looked at again until it is time to review them as part of a mandated requirement. However, at their best, treatment plans are person-centered and strength-focused, and guide the therapeutic process (Adams and Grieder 2014; Tondora et al. 2014; Rapp and Goscha 2012). Treatment plans can function as a touchstone in times of confusion, frustration, or inertia. According to Rapp and Goscha (2012), the purpose of a treatment plan is to:

“Create a mutual agenda for work between the person receiving services and their worker, which should be focused on achieving the goals that the person has set.” (Rapp and Goscha 2012; pp. 130)

Part of effective integrated behavioral health practice is to use assessment data to develop coordinated care plans that help people achieve health and well-being. This is done through the provision of: (1) health and behavioral health treatments and interventions to reduce symptoms, improve functioning, and increase coping skills and (2) case management services to address violence, poverty, lack of basic resources, unemployment, inadequate housing, and other social determinants of health through advocacy and the acquisition of resources. These services can be provided as part of a collaborative care team or through structured and formal relationships with relevant outside providers.

A key component of the Patient Protection and Affordable Care Act (PPACA) is the promotion of person-centered care. Person-centered care is a perspective of care that considers the whole person. Providers using a person-centered approach to care
respect and value client perspectives, preferences, needs, and participation in treat-
ment decisions (Mahoney 2011; Patient Protection and Affordable Care Act 2010; Stanhope & Ashenberg-Straussner 2018; Stanhope and Choy-Brown 2018). Person-
centered treatment planning is the written action or service plan that directs all cli-
ent care toward life goals identified by the client. These plans outline a time-limited
course of action designed to help the client overcome barriers (e.g., health and
behavioral health symptoms, lack of resources, skill deficits, social determinants of
health) to achieving of their life goals (Adams and Grieder 2014; Rapp and Goscha
2012; Stanhope and Choy-Brown 2018; Tondora et al. 2014). Person-centered care
planning is a core function of integrated behavioral health care and is defined as
“providing care that is respectful of and responsive to individual patient prefer-
ences, needs, and values and ensuring that patient values guide all clinical deci-
sions” (Institute of Medicine (IOM) 2001, pp. 40). Person-centered treatment plans
are first and foremost collaborative and should be strength-based, accountable,
focused on whole health, and utilize a shared decision-making (SDM) framework in
the selection of treatment goals, objectives, and interventions (Berwick 2009;
Stanhope & Ashenberg-Straussner 2018; Stanhope and Choy-Brown 2018).

Person-centered care orients services toward the goals identified by the client.
Clients participate in clinical care decisions in collaboration with healthcare provid-
ers, toward holistic, recovery-oriented goals and objectives that move beyond symp-
tom alleviation toward holistic well-being (Adams and Grieder 2014). The utilization
of person-centered planning can increase the investment that people have in their
care, motivating them to set and achieve goals that lead to health and positive treat-
ment outcomes. For instance, person-centered planning has been found to signifi-
cantly improve treatment engagement, participation, and medication usage rates in
persons with serious mental illness (Stanhope et al. 2013).

In order for treatment planning to be person-centered, several process-related
criteria need to be met. First, providers meet face-to-face with clients either in per-
son or through telehealth visits to develop plans in collaboration. All aspects of the
plan are agreed to by the client and shared with all relevant persons. The plan acts
as a type of contract or covenant between the client and provider. Second, goals are
in the clients’ own words and all goals and interventions are aligned with the prob-
lems identified in the assessment and case conceptualization. For instance, in the
client record, the assessment and treatment plan including the case conceptualiza-
tion, problems, goals, and interventions should all reinforce each other and be in
alignment. Long-term goals and treatment outcome goals should align with the
assessment and case conceptualization. Objectives or smaller sub-goals should
clearly lead to the achievement of larger life goals and treatment outcome goals.
Interventions should realistically address each problem area or barrier to goal
achievement. Case notes should document how interventions are being deployed to
help the client and the progress being made toward achieving goals in the plan and
so forth. Last, the provider has fully informed the client about the resources avail-
able and the benefits and potential risks or harms of any treatments, interventions,
or services, including the benefits and harms associated with not taking action (e.g., watchful waiting). The client must also fully understand and endorse the plan and can readily recite all goals in the plan (Adams and Grieder 2014; Rapp and Goscha 2012; Stanhope and Choy-Brown 2018; Tondora et al. 2014).

Essentially, treatment planning consists of two components: (1) a case conceptualization that is comprised of a synthesis of the data collected during the assessment and a working hypothesis of the problems encountered by the client and (2) a treatment plan that consists of: (a) a recovery-statement that includes one to three life goals; (b) a series of treatment outcome goals and objectives that lead to the achievement of the larger, long-term life goal(s) identified in the recovery statement; and (c) selected interventions designed to achieve objectives and treatment outcome goals. Each of these aspects of the treatment plan will be reviewed in the sections that follow.

**Collaborative Care Plans**

Collaborative care planning occurs when teams of multidisciplinary professionals work together with clients to develop treatment plans that integrate health and behavioral health treatment in a coordinated and collaborative fashion. This approach has shown positive outcomes for both providers and clients (Collins 2010). Collaborative care plans can also promote health and behavioral health service integration because they include interventions designed to address health, mental health, and addiction issues, as well as social determinants of health. In short, collaborative care planning can integrate care in a way that addresses co-occurring needs. It is best that plans include interprofessional interventions that are integrated into the same team of professionals through a shared plan. Ideally, plans would be in a shared record and all providers would meet as a team to discuss each client, review progress toward goals, and adjust treatment approaches to accommodate progress (Stanhope and Choy-Brown 2018).

For care provided outside of the team, formal treatment relationships with outside providers are established in order to promote coordinated and effective referral, follow-up, and monitoring (e.g., so-called warm referral or hand-off). Cross-site communication and sharing of care plans is very important to coordinate and integrate care, particularly across disciplines and settings that use different practices, theories, and language to understand the problem. This can often be a barrier to high-quality care, but active communication and cross-site training can be an effective way to overcome these barriers. The Electronic Health Record (EHR) can also function as a barrier to person-centered care when the EHR is too rigid (e.g., fixed, strict drop-down menu options) and is not able to be customized to recognize individualized goals, objectives, and approaches to care. It is important for settings to be able to design their EHR systems in such a way as to meet their reporting requirements, while also being flexible enough to allow providers to design customized client care plans and for team members to share those plans with each other across the team and with clients (Stanhope and Choy-Brown 2018; Stanhope and Matthews 2019).
5.2 Formulating Case Conceptualizations and Treatment Plans

Treatment plans should be based on the information gathered through the assessment interview, medical records, family and other collateral contacts, and other relevant sources of information such as school, employment, and criminal justice records. Treatment plans begin with a “bridge” that summarizes, synthesizes, and integrates the information gathered from the assessment in such a way that clients and providers can make informed decisions about relevant treatment goals and the course of clinical treatment. In this chapter, I will refer to this bridge as the *case conceptualization* (Berman 2019; Wright et al. 2017). Case conceptualizations are also referred to as case or problem formulations (Lichner-Ingram 2012) and can be referred by other names. For instance, the Commission on Accreditation of Rehabilitation Facilities (CARF) refers to them as “interpretive summaries.” They are also referred to as “integrative summaries” (Adams and Grieder 2014), or more generally as “summary and recommendations.” Regardless of how they are termed, case conceptualizations follow similar developmental patterns. Adams and Grieder (2014) describe case conceptualizations (they use the term integrative summaries) as follows, “the written integrative summary documents the rationalization, and justification for the provider’s recommendations and suggestions as well as promotes shared decisions about how best to proceed. It creates the platform from which the individual and the team/provider launch into creating the individual plan and charting a course for recovery and wellness.” (Adams and Grieder 2014, pp. 78).

The provider develops case conceptualizations by synthesizing the subjective (e.g., client’s story) and objective (e.g., case records, screening and test results) information collected during the assessment process to develop a working hypothesis of the client’s problems and their potential solutions. This information is then used to develop a set of long-term and short-term goals that guide treatment decisions regarding the interventions, skills, and resources needed for the client to be successful. This process helps the client see their problems and potential solutions more clearly. For instance, the conceptualization should help clients recognize their resources, strengths, and capabilities; how the problem has developed and changed over time; the barriers that need to be overcome; and a path forward to recovery and wellness. The provider and client then use the case conceptualization to build their plan to address identified problems.

**Case Conceptualization and Treatment Plan Components**

**Case conceptualizations:** Case conceptualizations: (1) synthesize subjective and objective data of client’s strengths and needs across biological, psychological, social, and environmental domains to formulate a set of relevant problems, and (2) use that data to develop working hypotheses as to the causes of those problems and their solutions. These components then drive the framing and development of a series of treatment planning goals.

**Treatment plans:** Treatment plans flow from the conceptualization and include three parts: (1) a recovery statement that lists one to three long-term life goals; (2) a set of three to five treatment outcome goals that guide treatment and lead to the
Case Conceptualization and Treatment Planning Process
(Based on: Adams & Grieder, 2014; Berman, 2019; Lichner-Ingram, 2012; Wright et al., 2017)

Fig. 5.1 Case conceptualization and treatment planning process. (Based on: Adams and Grieder 2014; Berman 2019; Lichner-Ingram 2012; Wright et al. 2017)

achievement of life goals; and (3) a series of specific, concrete, actionable objectives (sometimes referred to as sub-goals) whose completion will ultimately lead to achievement of each treatment outcome goal. Figure 5.1 provides a description of the components of the case conceptualization and treatment planning process.

5.2.1 The Case Conceptualization

Summarization of Client Assessment Data
Case conceptualizations begin with a summary of assessment data about the client’s health and behavioral health needs that include presenting symptoms, diagnoses, screening, and testing results and client health and behavioral health history. This section should also identify client insight into problems and their motivation and commitment to address identified issues (e.g., stage of change). The data that should inform the case conceptualization includes a summary and synthesis of at least some of the following areas covered in Chap. 4: (1) strengths and assets; (2) presenting symptoms or problems; (3) summary of current and historical physical and behavioral health conditions, functioning, and diagnoses; (4) substance use history; (5) trauma history; (6) interpersonal relationships and social network; and (7)
relevant social determinants of health related to safety, housing, income, and access to basic resources (e.g., food, utilities, medicine, transportation, clothing). Case conceptualization may not include all of this information—but this is the main information from which conceptualizations are often developed (Adams and Grieder 2014; Tondora et al. 2014).

The data from the above areas are used to create a problem list. The problem list should be a comprehensive list of clear, solvable targets that are relevant to client recovery or well-being. These targets should also align with client preferences and values. The problem list will naturally lead with the presenting problems identified by the client supplemented by results of screening and diagnostic tests and relevant information from the biopsychosocial assessment. Possible domains of functioning where problems emerge include: (1) physical health concerns and illnesses; (2) psychiatric symptoms such as negative thinking patterns, anxiety, stress, depression, psychosis, or trauma symptoms; (3) addictive behaviors; (4) unhealthy relationships; (5) education and occupational functioning; (6) legal and financial concerns; (7) environmental concerns (e.g., housing and neighborhood safety, lack of basic resources, and other SDOH); and (8) a lack of coping skills (e.g., assertiveness, problem solving, social skills, anger management, illness management). Identifying the most important problem areas is vital. Parsimony is also important, as you don’t want to overwhelm the person. The problem list should be limited to three to five priority areas that will lead to the design of specific goals and interventions (Berman 2019; Lichner-Ingram 2012).

Hypothesis Formulation

In the case conceptualization, the provider synthesizes client subjective self-reports and objective data from the assessment about specific areas from the problem list (e.g., problem statement) into working hypotheses regarding the origins of the problems or how and why the problems have emerged (e.g., adverse childhood events and negative formative experiences, hypercritical parenting, trauma, psychiatric symptoms, negative thinking patterns, substance use, interpersonal conflict, lack of coping skills). Providers ground their working hypotheses within a particular theoretical orientation that is most appropriate and best suited to solving the problem. There are several theories that can be relied upon to solve the problem. Usually, these are limited by the training and orientation of the provider; however, providers should strive to utilize the theories and approaches that have been found to be most effective in solving their client’s problems. Below is a list of some of the most common theories and approaches and their application (Berman 2019; Lichner-Ingram 2012).

1. Cognitive theory: These approaches are used when problems can be best explained by cognitive processes that include the development of maladaptive schemas, negative thinking patterns, and self-talk that lead to depression, anxiety, aggressive behavior, social withdrawal, substance use, self-harm, or avoidance. Interventions can include cognitive reframing and cognitive processing therapy.

2. Behavioral theory: Behavioral approaches are used to conceptualize how learned behaviors and thinking patterns are positively and negatively reinforced. These
approaches also focus on developing coping skills to address problematic behaviors. Do client problems stem from conditioned responses (e.g., avoidance) to antecedents in the environment that lead to negative consequences? Is the client so overwhelmed that they feel paralyzed or stuck? Is the client suffering from intrusive memories and hyper-arousal symptoms due to trauma? Does the client lack a particular skill to cope effectively with problems (e.g., anger management, problem solving)?

Interventions designed to reduce anxious feelings, indecision, paralysis, and problem behaviors include behavioral activation, relaxation, and mindfulness-based interventions; coping skill development (e.g., problem-solving skills, assertiveness training, anger management, illness self-management); and exposure-based therapies such as prolonged exposure, EMDR, and trauma-informed CBT.

3. Stage-based approaches: These approaches are used to conceptualize interventions that complement a person’s stage of change (e.g., precontemplation, contemplation, preparation, action, and maintenance). Persons in precontemplation, contemplation, and early preparation stages of change may benefit from harm reduction and motivational enhancement approaches. Persons in late preparation, action, and maintenance stages may benefit from more cognitive-behavioral approaches that focus on directly confronting problems, developing healthier lifestyles, and preventing relapse such as cognitive behavioral therapy, exposure-based therapies, and abstinence-based substance use treatments and approaches.

4. Biological-based approaches: Can genetics, organic processes, family history, or medical illnesses (e.g., diabetes, hyper/hypothyroidism, cancer, cerebrovascular or cardiovascular disease) explain behavioral health symptoms such as severe melancholic depression, psychosis, mania, and severe anxiety? For these sources, approaches that use medications, nutritional, rehabilitative, and other medical interventions to reduce or eliminate symptoms may be relevant. This may include the use of psychiatric medications or electroconvulsive therapy (ECT) to reduce intense psychiatric symptoms as part of a stepped approach to care that also includes application of psychotherapeutic approaches.

5. Family-based approaches: Family-based approaches rely on family systems theory to address relational problems within the couple or family system to improve communication and understanding, resolve conflict, clarify roles, and increase functionality. These approaches may include interpersonal therapy (IPT), brief strategic family therapy, and family psychoeducation.

6. Safety approaches: Safety approaches are used to address immediate safety concerns related to interpersonal violence (e.g., intimate partner violence, community violence), homelessness, non-suicidal self-injury (NSSI), suicidality, homicidality, severe substance abuse or dependence, or severe psychotic or manic symptoms. This will include a range of approaches such as crisis housing, medical or psychiatric hospitalization, legal advocacy, safety planning, and harm reduction (e.g., opioid replacement, needle exchange/safe injection sites, emergency contraception, detoxification services) (Mancini et al. 2008, 2010; Mancini and Wyrick Waugh 2013). They may also include fulfilling mandated reporting requirements, mandated treatment, and involvement of law enforcement.
7. Stress and trauma: Approaches in this domain focus on addressing issues related to the experience of high stress, life crisis, violence, stressful transitions, traumatic events, and the experience of bereavement and grief due to a significant loss. The experience of adverse childhood events, traumatic experiences, and high levels of chronic perceived stress can lead to a range of physical and behavioral health problems. The continuous experience of discrimination, violence, and inequitable access to resources commonly experienced by Black, Indigenous, and People of Color (BIPOC) persons, people in poverty, and members of the LGBTQ community are sources of high morbidity and early mortality. This domain includes a range of approaches and perspectives including (but not limited to): (1) affirming therapeutic practices in the domains of gender, sexual orientation, race, and culture; (2) approaches that help people process grief and loss; (3) accessing resources to address the impacts of violence (e.g., shelter, victim advocacy, childcare, employment); (4) trauma-informed practices; and (5) mindfulness-based relaxation approaches and wellness strategies to reduce stress and anxiety.

Working hypotheses are used to explain client problems and utilize a range of perspectives. Working hypotheses should begin with a clear problem statement that provides a distillation of the client and provider’s perspective of the problem(s), including the main issues(s) that will be addressed in treatment. This should align with the list of problem areas identified by the provider and client. The working hypothesis is the central thread of the conceptualization. These hypotheses can then be used to design goals, service plans, and interventions for clients. The case conceptualization concludes with a set of recommendations about how to solve those problems that are in line with the theories and hypotheses identified previously. Recommendations usually imply what needs to happen to solve the problem (e.g., learning problem-solving skills, cognitive reframing, relaxation techniques, increased social activity). Recommendations then lead to treatment goals and objectives, which then ultimately lead to specific interventions and techniques (Berman 2019; Lichner-Ingram 2012). These areas will be discussed next.

5.2.2 The Treatment Plan

Treatment plans consist of three components. The first is the recovery statement that is comprised of a client’s goal(s) for a happy life (e.g., life goals). These goals are big, broad, long-term goals the client identifies as most important. These goals may include things like “Find a job,” “Go to school,” “Move into my own place,” “Get discharged or graduate,” “Achieve sobriety,” or “Feel more confident in myself.” The second is the identification of specific and measurable treatment outcome goals with appropriate responsibility and timeline for completion. What does the client want to have accomplished by the end of treatment? This may include resolving the perceived barriers to treatment. Treatment outcome goal(s) should be succinct, recovery-oriented, and written in plain language. Treatment outcome goals guide
treatment decisions and are the main goals that are achieved through the specific application of treatment approaches. For instance, if the life goal is “Get a job,” then treatment outcome goals may center on areas like reducing alcohol or substance use, entering and completing vocational rehabilitation or an employment training program, applying for a job, completing resume and developing interviewing skills, and learning a specific vocational or employment skill. Treatment outcome goals are the main, end-point goals related to treatment. These should ultimately contribute to the life goal(s). The third area of the plan is the identification of concrete, specific objectives that lead to the achievement of treatment outcome goals. This will include interventions performed by the provider or provider team as well as referrals to outside service agencies. Objectives (sometimes referred to as “sub goals”) are very specific and include things like, “completing a wellness plan,” “using problem-solving skills to solve a particular problem,” “applying for benefits,” “completing thought change records each week,” and “completing weekly exposure-exercises.” Objectives are the intervention techniques and strategies that lead to the achievement of treatment outcome goals (Adams and Grieder 2014; Rapp and Goscha 2012; Tondora et al. 2014).

Types of Goals and Goal Development
Goal development is a process of identifying large, meaningful goals; breaking them down into manageable segments; and then identifying strategies designed to achieve those smaller parts. One of the most challenging practice areas in behavioral health is working with clients on setting meaningful, measurable, and achievable goals. At worst, care plans consist of goals set by the provider with minimal input or buy-in from the client. These recycled, meaningless goals are rarely reviewed or achieved. This is unethical practice and a waste of valuable time and energy that could be used to actually achieve something. Another problematic practice issue are goals set by the client that are unrealistic, vague, or confusing. These goals are also unlikely to be achieved. At their best, care plans include a series of collaboratively developed goals that are not only relevant, clear, crisp, measurable, and challenging but also achievable. These goals have the best chance of being accomplished and leading to positive outcomes. And so, as a provider, it is important to listen intently on what the client wants and then help them shape those goals into a framework that will lead to success. In the sections that follow, I outline a process and structure of goal development. Figure 5.1 provides a description of how life goals, treatment outcome goals, and objectives align with each other. As can be seen, objectives support treatment goals and treatment goals support achievement of the larger life goals of the client (Adams and Grieder 2014).

The Recovery Statement
The recovery statement is the ultimate purpose of treatment. It guides all goal development and treatment activities. This statement is grounded in the presenting problem list and assessment information and is mainly comprised of one to three “Happy Life Goals” in a concise statement that drives the client and orients treatment. It is the lodestar of the treatment process and acts as an orienting guide when things get confusing. Recovery statements are inherently person-centered and should come...
from the client and be in their primary interest. The life goals that comprise these statements should be clear, succinct, positive, and measurable. It should be apparent when the life goals in the statement are accomplished. The recovery statement is a set of responses or solutions to identified problems and should be of primary interest to the client. Recovery statements are written in complete narrative sentences using the client’s own words and should reflect client preferences and desires.

The recovery statement is a means to build trust, enhance collaboration, and set the general course for treatment. While at times the life goals contained in the statement can seem unrealistic to providers, the goals reflect the hopes and dreams of clients and can build motivation to work toward well-being and recovery. Goals that are important to the provider should not replace client goals, nor should client goals be changed, watered down, or otherwise altered to be more reflective of provider preferences. These are the goals that are important to the client and should guide treatment. However, the provider can help give advice regarding goal selection, wording, prioritization, and sequencing to maximize success. When disagreements arise, it may be helpful to prioritize goals according to Maslow’s hierarchy of needs by first prioritizing urgent medical or safety needs and then prioritizing needs related to belonging and love, followed by self-esteem and self-actualization needs.

**Sample List of Life Goal Statements**

A sample of happy life goals include:

- I want to get a job.
- I want my own apartment or living space.
- I want to move to a better neighborhood where my family and I feel safe.
- I want to increase my income.
- I want to have more independence.
- I want to get an associate’s degree in culinary arts so that I can be a chef.
- I want to be safe.
- I want to get my diabetes under control.
- I want to learn how to better manage my symptoms so that I can … feel better … argue less with my partner … be less fearful … go out more … enjoy life more, etc.
- I want to learn how to assert myself so that I can more effectively get my needs met.
- I want to meet a romantic partner and have more friends.
- I want to stop drinking and get along better with my family.
- I want to learn how to be a better parent and partner.

**Treatment Outcome Goals**

Treatment outcome goals are in service to broader life goals contained in the recovery statement. Each life goal should have one to five treatment outcome goals that address problems and barriers that interfere with achievement of life goals. Treatment outcome goals are the main goals that are worked on as part of treatment and address problems in various domains of functioning. Treatment outcome goals should be S.M.A.A.R.R.T or Specific, Measurable, Actionable, Achievable, Relevant, Recovery-oriented and Time-limited. For instance, treatment outcome
goals should be *specific and measurable*. They should identify an increase in something positive (e.g., skills, number of positive thoughts in a day, number of fruits and vegetables eaten in a day or week, increase in the number of social contacts), a decrease in something negative (e.g., depressive or anxious symptoms, cholesterol levels, number of drinks per day, HbA1c levels, change in weight or BMI levels, nicotine or drug use, negative thoughts), or the achievement of something (e.g., employment, sobriety, an academic or training degree/certificate, discharge from hospital). The client and provider should be able to easily measure progress and know when the goal has been achieved. Treatment outcome goals should also be something that is *actionable and achievable*; that is, something the client can actively work toward that is *relevant to them* and contributes to their overall *recovery* and can be *achieved* in a *reasonable amount of time*. These goals can sometimes overlap with a life goal. For instance, if the life goal is “I want a job,” then clearly one of the goals may be focused on searching, applying, and interviewing for a job. However, other treatment outcome goals may address areas related to that life goal, but are not specifically listed in the recovery statement or identified as a life goal (e.g., reducing substance use, using medication) (Adams and Grieder 2014; Rapp and Goscha 2012; Tondora et al. 2014) (Fig. 5.2).

For instance, a treatment outcome goal may address an area that is a barrier to achieving a life goal such as symptoms related to health or mental health disorders, substance use, or a resource deficit. Using the employment example (e.g., “I want a job”), a set of treatment outcome goals may address barriers to employment such as reducing drug or alcohol use, increasing coping skills, gaining access to transportation or basic resources, or identifying work preferences or skill areas. Resolving these areas might then be included as treatment outcome goals along with the goal

![Fig. 5.2](image-url) Life goals, treatment outcome goals, and objectives
of employment because they are in service to the employment goal. Other examples may include: achieve sobriety, get my diabetes under control, secure child care, reduce negative thinking, use medication, buy a car, move closer to transportation lines, apply for a bus pass, or access to social services). It is often the case that providers identify a treatment approach or strategy designed to achieve the outcome goal such as medication, psychotherapy, coping skill development, or case management. This process of strategizing and problem solving, if done collaboratively, teaches clients how to break large goals down into smaller, more achievable parts and is an intervention in and of itself. Figure 5.3 defines each component of the S.M.A.A.R.R.T goals format and offers some good and not-so-good examples of SMAARRT goals.

Collaborating with Clients to Develop Outcome Goals

Collaboration, education, and communication are the keys to developing goals that are efficient, relevant, and likely to succeed. Client motivation is a vital component in determining goal achievement. If clients aren’t motivated, they are unlikely to pursue goals. Motivation is enhanced through collaboration and education. Sometimes, providers must discuss goals that clients may be less motivated to pursue. It is important to ask permission to discuss these goals. When permission is granted, work together to outline the benefits and drawbacks of a particular goal and be sure to always tie it back to the recovery statement or life goals. Be flexible in

| Domain                              | Definition                                                                 | Good Examples                                                                 | Poor Examples                                                                 |
|-------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Specific                            | The goals are clear, concise, and describe what will be accomplished and who will do what. | Khalid will reduce the number of daily drinks by 50% within the next 30 days. | Khalid will stop drinking.                                                   |
| Measurable                          | You know when it is achieved. It can be counted or measured in some way.    | Clarisse will be able to identify 3 cognitive distortions she typically engages in by next week. | Clarisse will complete psychoeducation about her negative thinking patterns. |
| Actionable and Achievable           | Person has the power to accomplish the goal in a reasonable time frame.     | George will submit applications to two local community colleges within the next month. | George will get an associate's degree.                                       |
| Relevant and Recovery-Oriented      | Goal aligns with recovery and what the client wants.                       | Peter will complete his wellness recovery action plan within the next 30 days and speak to his doctor about lowering his Rx dosage | Peter will take his medication as prescribed.                                |
| Time-Limited                        | Date of completion is specified.                                           | Victoria will experience a reduction in depressive symptoms by 50% within the next 30 days. | Victoria will reduce her depressive symptoms.                                |

Fig. 5.3 Creating S.M.A.A.R.R.T. goals. (Based on Adams and Grieder 2014)
how you might address treatment outcome goals, and assess the client’s motivation to select and structure goals and the interventions needed to achieve them. If clients outright refuse to work on a goal you find important, move on. It is their choice. It is not worth damaging the relationship to insist on working on goals that have little chance of being accomplished. Ask if it is OK to revisit the goal at another time.

**Objectives or Sub-Goals**

Objectives or “sub-goals” are the smaller action steps to achieving the treatment outcome goals described above. Each treatment outcome goal should include a list of smaller objectives (Adams and Grieder 2014). Objectives are accomplished through services and interventions. They are smaller, more detailed, and more specific than treatment outcome goals. They include interventions techniques, tasks, and micro-practices. Objective completion should naturally lead to achievement of one or more treatment outcome goals. Objectives keep clients on track for achieving larger treatment outcome goals. While treatment outcome goals will often identify a treatment strategy or approach such as CBT, objectives will go one step further and identify a more specific technique linked to the strategy such as identifying negative thinking patterns through the use of thought change records or developing problem-solving skills through the completion of a problem-solving exercise or skills group.

For instance, a client with negative thinking patterns that lead to depressive mood may have a treatment outcome goal that reads: “Reduce severity of depressive symptoms as measured through a standardized depression symptoms inventory by 50% through CBT.” A set of objectives linked to this goal might look something like this: (1) understand and identify two to three relevant cognitive distortions through psychoeducation by March 31, 2021 and (2) reframe negative thinking patterns related to perfectionistic thinking by identifying two to three alternative thoughts using thought change records and the “examining the evidence” approach by April 30, 2021 (see Chap. 9 for more information on these methods). These are very specific objectives, but you can see how accomplishing these smaller objectives can lead to a reduction of depressive symptoms. Note that the use of CBT methods here is not random. The use of these methods is rooted in the hypothesis that depressive symptoms are at least partly caused by negative thinking patterns. This hypothesis develops from the assessment and case conceptualization. If the case conceptualization identified biological or medical causes of depressive symptoms, then the client, while maintaining the original outcome goal of reduced depressive symptoms, may have additional objectives focused on selecting and using medication as part of a stepped approach (medication + psychotherapy). If the depressed mood was seen as part of trauma or family conflict, then exposure-based therapy or family-focused approaches would be selected as interventions, respectively.

Like treatment outcome goals, objectives should also be S.M.A.A.R.R.T. (e.g., specific/simple, measurable, actionable, achievable, relevant, recovery-oriented, and time-limited). Objectives should be specific and clearly identify an activity in clear and easy-to-understand language. Objectives should also be measurable and any change should be easily recognizable and observable by others. Change can be
measured by self-report, standardized instrument, or behavioral observation, completion of a task, or counting something. Objectives should be collaboratively developed and be relevant to the client's recovery. Furthermore, there should be a reasonable time frame depending on the goal with a completion date. Time frames should be specific to the circumstances of the person, not the reporting requirements of the agency. Time frames can motivate people, but they can also overwhelm people. Be sure they are balanced. An objective statement should identify an outcome, an activity, and a measurement (Adams and Grieder 2014). Table 5.1 provides examples of life goals, treatment outcome goals, objectives, and interventions for several brief vignettes.

Examples of Objectives
1. Jeff will report an 80% reduction in drinking within the next 30 days as measured by the number of standard drinks consumed per week. Jeff will also report 0 binge-drinking episodes defined as four or more drinks per day during this time.
2. Alexis will demonstrate a reduction in depressive symptoms by 50% as evidenced by lower scores on the CES-D depression scale in the next six weeks.
3. Nora will use the activity scheduling form to schedule and carry out three pleasurable activities during times of low mood in the next week.
4. Jake will use the examining the evidence exercise to explore and evaluate two negative automatic thoughts identified through the thought record this week.
5. Claire will engage in brief relaxation exercises daily for the next weeks and rate her anxiety level before and after the exercises.
6. Michelle will attend three yoga sessions with her friend Jasmine at the YMCA and rate her anxiety level before and after each session.
7. Michael will use the “what went well” exercise nightly for the next 2 weeks and rate his mood before and after each exercise.

Objectives should also be appropriate and relevant to the treatment setting and reflect what is actually happening at the team level. For instance, objectives should be reasonable in regard to number, type, complexity, and time frame given the constraints and realities presented by the setting and the capacities of the individual (e.g., developmental level, age, psychiatric history, skill/functioning level, culture, and stage of change). They should be clearly worded, understandable, and challenging, but not overwhelming. Objectives should identify the actions that people will do. Objectives that seek to help people “gain insight” or “understanding” are too vague and not observable. How will people demonstrate they have gained insight? How will they show you they have benefitted from psychoeducation? Objectives should be in alignment with the assessment, conceptualization, outcome goals, and ultimately the life goals of the client. A thread should connect all of these elements, and they should all exist in harmony with each other (Adams and Grieder 2014).

Provider Traps and Pitfalls When Creating Treatment Plan Goals
Developing goals collaboratively with clients can be challenging, especially when providers and clients disagree on the problem and how goals should be sequenced and prioritized. Here are some ways to prevent or navigate these issues.
| Client description | Recovery statement | Life goal | Treatment outcome goals | Objectives | Interventions |
|--------------------|--------------------|-----------|-------------------------|------------|---------------|
| Johnette, 32, receives case management services from a community mental health center. She currently lives in a group home with other persons with serious mental illness. | I want to have a life! | I want to work. | Client will be employed at least part-time within the next 3 months. | Client will complete resume in 2 weeks. | Supported employment |
| | | | | Client will complete job search and identify 1–3 positions in 1 month. | |
| | | | | Client will apply for 1 to 3 jobs in 2 months. | |
| | I want my own place. | Client will live in own apartment in the next 6 months. | Client will collaborate with case worker to apply for supported housing placement within the next month. | Supported housing |
| | | | | Client will collaborate with peer provider to complete wellness recovery action plan in the 45 days. | Case management |
| | | | | Client will attend independent living skills group with peer counselor twice a week while waiting for placement. | Peer support |
| | | | | Client will complete financial education class within the next 2 months offered at local education collaborative. | Wellness recovery action planning |
| | I want to make some friends. | Client will develop friendships with 1–2 new friends in the next 3 months. | Client will demonstrate skills on how to develop safe relationships after attending peer led socialization group. | Socialization skill development |
| | | | | Client will introduce herself to 3 new people at social club in the next 60 days. | Peer support |
| | | | | Client will go on 2 to 3 social activities (e.g., dinner, outing) in the next 45 days. | |

(continued)
Brody, 40, is an IT specialist. Since his divorce 5 years ago he has experienced depression and hypertension. He engages in harmful drinking (3–4 beers after work per day). He is currently overweight by 30 pounds and is pre-diabetic. He expresses loneliness and chronic thoughts of worthlessness and anxiety.

| Client description* | Recovery statement | Life goal | Treatment outcome goals | Objectives | Interventions |
|---------------------|--------------------|-----------|-------------------------|------------|---------------|
| Brody               | I want to feel healthy, strong, and loved. | I want to lose weight and gain muscle. | Client will lose 20 pounds and reduce glucose level by 20% in the next 6 months. | Client will attend nutritional consultation to get dietary recommendation (i.e., diet) to improve weight and diabetic symptoms. | Behavioral activation |
|                     |                    |           |                         | Client will attend beginner power yoga classes 2–3 times a week. |                          |
|                     |                    |           |                         | Client will join walking group at work and walk 3+ times a week in nearby park. | Relaxation                |
|                     | I want to be less depressed and nervous. | Client will experience a 50% reduction in depression scores in 2 months. | Client will complete activity log to identify times during day they are most depressed. | Behavioral activation |
|                     |                    |           |                         | Client will structure activities to target times when most likely to be depressed. | Cognitive reframing       |
|                     |                    |           |                         | Client will identify 2 cognitive distortions and rational replacement thoughts using thought change records. | Relaxation training       |
|                     |                    |           |                         | Client will demonstrate relaxation skills in-session and practice at home several times a week and as needed |                           |

*Table 5.1 (continued)
| Client description | Recovery statement | Life goal | Treatment outcome goals | Objectives | Interventions |
|--------------------|--------------------|-----------|-------------------------|------------|---------------|
| Jess, 29, is a full-time hair stylist and part-time bartender. They have experienced PTSD symptoms (e.g., nightmares, arousal, avoidance) after a recent incident of violence in which they were verbally threatened and assaulted by a patron at work while closing the bar. The patron pushed them and threatened them and their partner with violence before other co-workers intervened. | I want to feel safe, and I want to move on from this experience so it doesn’t control my life anymore. | Client will go on 1–2 social activities in the next 2 months | Client will report 75% reduction in intrusion and arousal symptoms. | Client will complete online dating profile. | Socialization |
| | I want to be free from these nightmares. | | Client will demonstrate understanding of the CBT model of PTSD in the next 21 days. | | |
| | | | Client will identify specific elements of event that were problematic. | | Safety planning |
| | | | Client will engage in 5–10 sessions of imaginal exposure (EMDR) and report declining subjective distress. | | Advocacy |
| | | | Client will identify external symptom cues in the next week. | | |
| | | | Client will engage in 5–10 weeks of in vivo exposure to identified symptom cues (safety permitting). | | |

(continued)
| Client description | Recovery statement | Life goal | Treatment outcome goals | Objectives | Interventions |
|--------------------|--------------------|-----------|-------------------------|------------|---------------|
|                    | I want to go back to work without being afraid. | Client will go to work each shift and report 75% reduction in subjective distress. | Client will develop personal safety plan to ensure safety in home life. | Client will collaborate with counselor to develop safety plan for re-engaging with work in the next 15 days. |
|                    |                    | Client will develop personal safety plan to ensure safety in home life. | | |
|                    |                    | Client will work with employer to advocate for implementation of safety plan to ensure safe work environment (e.g., different shift, safety protocols for closing) in the next 15 days. | | |
|                    |                    | Client will develop response plan (e.g., legal action, alternative employment) if employer will not comply with safety plan. | | |
|                    | I want to feel calm and less on edge and angry. | Client will report 50% reduction in arousal symptoms | Client will demonstrate competence in practicing mindfulness-based relaxation techniques in the next 30 days. | Relaxation training |
|                    |                    | | | |
|                    |                    | Client will seek out peer support such as joining trans support group and/or advocacy opportunities for trans rights and protections in the next 60 days. | Self-help | |

All names and other identifiers of clients have been changed to protect privacy and confidentiality
1. **Do not substitute your preferences for the clients’** under the guise of what is “realistic” or “appropriate.” Remember, “achievable” is not the same as “realistic.” For instance, if you do not think a client’s goal is “realistic” and you try to steer them away from their goal toward something you think is more “appropriate,” then you are just substituting your goal for the clients’. That’s not being realistic. That’s being paternalistic. Good luck trying to motivate the client to achieve that goal. Why would they? It isn’t their goal. It’s yours. Paternalism has no place in person-centered treatment planning. It is understandable when providers want to protect clients from getting too stressed out and having a relapse. However, this can sometimes result in overprotection of clients. Clients have the right to take calculated risks that can lead to success or failure. It is important to support clients no matter what—win or lose. If they succeed—cheer them on. Failure is also an opportunity to learn something. If they fail, help them get back up and problem solve solutions for what went wrong so they can be successful in the future.

2. **Keep goals measurable.** Goals that are too vague and abstract do not get accomplished. The goal, “I want to be happy,” is a good goal to have, but it is not measurable. Help clients break “happy” down into measurable goals that, if achieved, would lead to happiness. These goals might include: I want my depressive symptoms to be reduced; I want to think more positive thoughts about myself; I want to make new friends; I want my own place; I want to lose weight; I want to stop drinking so much. Goals should always be recovery-oriented, grounded in the needs of the individual, and have a positive impact on the person’s life—that is, when they are achieved, the person is healthier, happier, more fulfilled, and more secure. But more importantly, we need to know when they are achieved. When goals are specific, measurable, and time-limited, we have a better chance of knowing if we are on the right track.

3. **Keep it simple.** When goals and objectives are too detailed, they can become overwhelming and confusing. Goals and objectives should be written with parsimony in mind. Be sure to match the level of detail with the capacities and abilities of your client. Goals should be challenging and exciting, but not overwhelming. If clients have multiple morbidities, goals and objectives can get complex. Helping clients prioritize goals related to basic needs and safety first can be a good way to help clients work toward goals in such a way as to build success. Objectives should also be written in clear language so the client knows exactly what they have to do between sessions for homework. Objectives should be easy to remember, include all the necessary steps, and sequenced in such a way so that they lead to goal achievement. Clients with behavioral health issues often have trouble concentrating and remembering things. Clients who have sequenced tasks and instructions in writing or on a digital device can stay on track and be successful. Conducting check-ins with clients between sessions to see how they are progressing and to give encouragement and feedback is also a good practice.

4. **Keep it concise.** Similar to having too many details, having too many goals can lead clients to feel stuck and demoralized, which then leads to resistance and
eventually loss to follow-up. Stick to three to five treatment outcome goals that are relevant and important to the client. Encourage clients to start with goals that are “low hanging fruit” and can be accomplished quickly. That way they can build momentum and gain some success. Break bigger goals down into achievable steps that can be celebrated as they are achieved.

5. **Keep life goals, treatment outcome goals, and objectives in alignment.** This will make your supervisor and auditors happy. Remember: (1) life goals are the ultimate endpoint for the client; (2) treatment outcome goals are more specific, but still broad and are what is achieved at the end of treatment and lead to the achievement of life goals; (3) treatment outcome goals should be clear, global, and lead to well-being; and (4) objectives are the specific action steps necessary to achieve the treatment outcome goals. They identify who will do what by a certain date.

6. **Pacing is important.** If you’re moving too fast, clients can get overwhelmed and give up. If you are moving too slow, clients can get bored and lose focus and motivation. Providers need to repeatedly check in with clients to make sure that the pacing of change is challenging, but not overwhelming. It is best to start slow and then speed up as needed. If you find that the client becomes overwhelmed and did not complete their between-session tasks, explore with them why they weren’t able to complete the assignment. This usually takes place at the start of each session when you review assignments and set the agenda. Be honest about pacing and be flexible enough to speed up or slow things down as needed. In addition to monitoring assignment completion, check progress on outcome goals through symptom measures or other measurements (e.g., self-report, observation, collateral contacts, records). Is there improvement? Has the client shown any successes or progress? Intermediate success energizes the process and keeps clients motivated as they see their progress. Use these measures as gauges to see if the pacing of intervention is appropriate. Inviting clients to discuss these issues directly is also important.

7. **Avoid “dead person,” “process,” or “participation” goals.** Will your client achieve all of their goals if they just drop dead one day? Then you have dead person goals. A goal list that says the person will stop drinking, stop smoking, avoid sweets, stop being depressed, stop gambling, and not be angry, are unlikely to be successful. While “stop and avoid” goals are inevitable, it is important to mix in “improve, get, develop, and learn goals.” People need something positive to work toward such as employment, independent housing, recreation, making friends, getting stronger. Make goals positive, meaningful, and recovery-oriented (Adams and Grieder 2014).

Also avoid using “process” or “participation” goals as treatment outcome goals or objectives. These goals focus on participation or adherence in some treatment or therapy program. Although they may be related or supportive to a treatment outcome goal or objective, they should not replace them. Treatment outcome goals and objectives accomplish something. Participation goals identify a type of strategy to achieve an objective. You may be required to have participation or process goals such as “the client will attend therapy sessions three times
a week,” “the client will take medications as prescribed 80% of the time,” or “the client will complete a six-week anger management program” as part of your plan—but position them as “sub-objectives”. Do not confuse these with treatment outcome goals or objectives. A treatment plan with only participation goals will not be effective. Think about it this way—imagine that you have a client that wants to feel less depressed and angry, and all of their goals and objectives are related to participating in groups, taking medications, and attending therapy sessions. What if after six months of doing all of these things, they still experience the same symptoms, problems, and issues they did when they started despite participating in treatment? Maybe they have even gotten worse. Yet, all goals would have been achieved. Success! But that’s not success from the client’s perspective since they would be no better off. That’s a great way for clients to become demoralized and pessimistic about future help-seeking. Outcome goals lead to change (e.g., reduced symptoms, increased skills). Objectives accomplish something (e.g., identify cognitive distortions, complete a job application, demonstrate a coping skill). Participation in treatment identifies a means to achieve those goals and objectives—but they are not the goals or objectives themselves.

8. **Respond to setbacks in a positive way.** Setbacks are the expectation, not the exception. Prepare your client for relapse and setbacks since this is a part of the therapy process. Do not react with dismay or disappointment when setbacks happen. Be sincere and supportive, but stay balanced. The task after a setback is to identify what went wrong, adjust the plan, and move ahead.

### 5.3 Selecting Interventions

Interventions are the treatments, services, and resources necessary for a client to overcome barriers, solve problems, and accomplish their goals (Adams and Grieder 2014). When selecting interventions, the provider should have a complete understanding of the best and most effective range of interventions designed to address clients’ identified problems and goals. Providers should also have a complete understanding of the different resources that exist in the community that the client can access either on their own or through referral. Providers should have formal relationships with the most important outside resources to facilitate the referral and follow-up processes, including organizations that address physical and behavioral health, violence and safety, and social determinants of health. And providers should have a complete understanding of their client's preferences, capacities, and stage of change for a particular problem in order to select interventions that are in alignment with those elements. For instance, when selecting a substance use intervention for a client in the contemplation stage of change, motivational approaches would be more appropriate than an intervention designed for the action stage of change such as substance abuse counseling or Alcoholics Anonymous. Clients should have a menu of relevant treatment options to choose from to ensure they select interventions that are effective and compatible with their goals and preferences.
Key elements in intervention selection include: (1) the modality (e.g., cognitive behavioral therapy) including the specific techniques that will be used such as psychoeducation, evaluating negative thinking patterns, or exposure; (2) who will provide the intervention (e.g., discipline, setting, agency, person); (3) when the intervention will be provided and the frequency (e.g., how many sessions and how many times a week or month) including if clients are expected to do assignments or tasks between sessions; (4) intensity (e.g., 30 minutes, one hour), duration (e.g., how many days, weeks, months, or sessions will the treatment last in total); (5) where the intervention will take place (e.g., agency, setting—home, school, work, hospital, clinic, store, center); and (6) the rationale for why the intervention was chosen (e.g., the purpose of the intervention, why was it selected, what problem is it designed to solve, and what goal it serves). The rationale for the intervention should logically match the problem and goal. For instance, how will CBT help a person’s depressive symptoms and how will it help the person meet a particular objective or goal? (Adams and Grieder 2014; Rapp and Goscha 2012; Tondora et al. 2014).

**Shared Decision-Making**

When conducting person-centered treatment planning, interventions in the plan should be selected by clients who are fully informed about the range of options available including the risks and benefits associated with each service. When selecting interventions, providers should rely on a shared decision-making (SDM) approach. Shared decision-making is a process of collaborative decision-making between providers and clients that involves consideration of all available information and options and then supporting and respecting the client’s choices regarding treatment (Charles et al. 1997; Deegan and Drake 2006; Drake and Deegan 2009; Elwyn et al. 2012; Stanhope and Choy-Brown 2018). Like person-centered care, SDM is associated with greater patient participation in treatment and satisfaction with treatment decisions (Glass et al. 2012; Loh et al. 2007). Implementing shared decision-making perspectives, like other recovery-oriented practices, takes intentionality, organizational support, and collaborative learning within practice communities (Macdonald-Wilson et al. 2017; Mancini and Miner 2013). Providers who use a shared decision-making approach are guided by a perspective that prioritizes client self-determination and a strong, supportive therapeutic relationship. Clients are not just coldly given the options for treatment and left to decide for themselves. Providers help clients become aware and informed of the options and choices that exist and give them decision support that is thorough and understandable. They help clients figure out what is most important to them so that they can develop personal preferences that are informed by awareness of the given risks and benefits of all available options, including doing nothing. In this way, clients and providers work in partnership to identify the best options for treatment given according to client preferences and goals (Elwyn et al. 2012).

All aspects of available interventions, including evidence of effectiveness, benefits, and potential adverse effects, should be explained to the person in clear, easy-to-understand language. They should also know the full range of benefits and
adverse effects of any treatment, as well as the risk and benefits of not engaging in a particular approach (e.g., doing nothing, watchful waiting). Providers should use all available evidence including empirical evidence, clinical expertise (e.g., practice wisdom), and personal experiences when informing clients. Iatrogenic effects such as side effects from medication, distress from exposure-based treatments, and experiencing rejection from the taking of social risks can lead to real negative effects. Clients should be fully informed and supported in their decisions. For instance, the adverse effects of psychiatric medications include metabolic problems, weight gain, sexual side effects, dry mouth, drooling, tremors, restlessness, and an increased risk for suicide among other serious adverse effects. These effects should be clearly explained to the client and a plan for monitoring and addressing them should be developed if the client agrees to use them. For instance, if a client decided to take antipsychotic medications because the adverse effects are less problematic than doing nothing, the provider and the client can discuss ways to minimize the adverse effects such as lower dosing, complementary medications, monitoring and planning, and the use of wellness strategies to either replace or supplement medications and reduce adverse or unintended effects of the drug.

Providers should thoroughly explore all areas of concern and ask for feedback and questions that clients may have regarding any intervention. For instance, if employment is a goal for clients on disability, they will need to know the changes that may occur to their entitlement benefits if they gain employment such as a reduction in assistance or changes to their medical coverage. Providers and clients can then collaborate to figure out how to best move forward, considering the given client preferences, needs, and available solutions (Stanhope and Choy-Brown 2018; Tondora et al. 2014).

During sessions, it is important for providers to create a warm, empathic environment in which the client has as much time and encouragement as needed to explore concerns and solutions. Providers should also have a range of information available for clients to take home and review on their own. Practicing from this perspective also requires providers to be culturally competent and responsive. Language interpretation services should be easily accessible. Providers should be representative of the community they serve, and a diverse array of service options that are responsive to the cultural practices and preferences of the client are vital. Community health workers or peer specialists should be utilized to help the clients gain a more authentic understanding based on personal experiences from someone who has undergone the treatment first-hand (Mancini 2018, 2019). Honesty, frankness, and transparency are key attributes for providers as are the skills of active, empathic listening and reflection.

Sometimes clients may make decisions that conflict with your professional opinion. This may include not pursuing an intervention (e.g., watchful waiting) or preference for an alternative approach with limited evidence of effectiveness. In these instances, providers should be honest and clear about interventions they think are ineffective or pose unnecessary risks and work to help the client or family find a solution to their problem. While it is important to be flexible, one cannot endorse interventions that are ineffective or may pose a significant risk or threat to the client. Providers should be transparent about this upfront (Adams and Grieder 2014).
The Importance of Stages of Change

Providers should help clients select goals, objectives, and interventions aligned with a person’s stage of change. For instance, education, harm reduction, and motivational interventions are good for persons in pre-contemplation and contemplation. Motivation and action-related interventions are more appropriate for preparation and action stages. Relapse prevention strategies are ideal for persons in the maintenance stage. Stage assessment is ongoing and should be updated as treatment progresses (Adams and Grieder 2014).

Different Types of Interventions

• Medications and biological interventions
• Psychotherapeutic interventions such as cognitive behavioral therapy, problem-solving therapy, and interpersonal psychotherapy
• Psychoeducation/bibliotherapy
• Skill development: social, assertiveness, anger management, wellness, problem solving
• Trauma-informed interventions
• Brief family therapy approaches
• Psychiatric rehabilitation approaches
• Intensive case management
• Peer support
• Self-help
• Natural occurring resources and events in the community

Mobilizing Supports and Resources

The provider should have a clear understanding of the community resources available to address a range of health, mental health, and social problems. Person-centered planning helps clients access outside resources to address problems. The provider should prioritize the use of existing natural supports within the client’s household and family and then work outward to extended family and friends, neighborhood, and local community resources to help clients get their needs met and address social determinants of health (Rapp and Goscha 2012). Providers should routinely ask: What sources of help exist in the person’s social network that can provide needed resources such as transportation, socialization, basic needs, and other help? Natural supports are the individuals, relationships, organizations, and communities that can help the person achieve well-being. The benefit of natural supports is that they are often low cost, culturally tailored, enduring because they are integrated within the community, and bidirectional, providing benefit both to the client and the supporter (Rapp and Goscha 2012).

For resources that require assistance from outside the person’s natural support network, providers should have close, formal relationships with several important community agencies and resources. These community resources can include different types of health and behavioral health organizations, social service organizations, victim advocacy groups, child care organizations, shelters, housing and employment organizations, community groups, faith groups, self-help resources (e.g., Alcoholics Anonymous or Narcotics Anonymous), mentoring programs, and
programs that provide help with basic resources. Having formal relationships with outside providers can lead to a smooth transition of services and increase the likelihood that clients will successfully engage with services (e.g., warm referral). It also helps enhance the ability of the provider to coordinate services and follow up on progress.

5.4 Documenting Progress

It is important for providers to consistently document the progress clients are making toward their goals in detailed and frequent progress notes. Progress notes should align with the plan for services including the assessment, case conceptualization, and treatment plan. For instance, if you used a cognitive behavioral-based framework in your hypothesis to explain a client’s depressed and anxious symptoms, then your progress notes should document your use of cognitive behavioral interventions to achieve cognitive behavioral-oriented outcome goals and objectives. In short, providers should use progress notes to evaluate and document client progress on activities that are in service to stated goals and the notes should align with the broader plan for services. There are certainly times when new problems arise that require attention. These should be documented, and any problems and new interventions should be linked back to the original goal by describing how the new issues impact the identified goals so as to justify a response. Treatment plans should then be updated accordingly to accommodate the new information. New problems can also signal the need for the creation of new goals and objectives if it is deemed necessary to address to ensure successful achievement of life goals.

Progress notes have several functions. First, they communicate to others the specific interventions and activities of treatment and the progress people make toward the goals identified in the plan. Second, they outline the work of the provider and client toward those goals, and they provide documentation of the things that have been successful and unsuccessful. Third, they hold treatment providers and clients accountable to the plan by evaluating progress and tracking where people are on the recovery journey. This is important for insurance payers and auditors who want to know how the provider is benefiting the client in an efficient and effective manner. Progress notes are essential in the communication, coordination, and evaluation of services and are vital in the continuous quality improvement process.

Several formats for progress notes exist. They all have similar characteristics. First, progress notes always identify progress clients are making toward specific goals. Second, they identify the interventions that are being used to achieve the goals and objectives identified by the client. Third, they assess and evaluate the response to those interventions. And fourth, they identify a future plan of action to address the results of the evaluation. Progress note formats often depend on the setting. For instance, some settings do not have a specific format, but rely on more unstructured narratives. If this is the case, the four areas mentioned above should be included in each and every note. Notes should be taken for every interaction with
the client or family as well as for any new information that comes to the attention of the worker from outside the client or client system (e.g., reports or conversations with probation officers, other providers, teachers, employers, or medical personnel).

### Progress Note Formats

The most common progress note formats are the SOAP and DAP formats. The SOAP format stands for **Subjective**, **Objective**, **Assessment**, and **Plan**. The DAP format stands for **Data**, **Assessment**, and **Plan**. These approaches contain the same information. Another format is the PIE format, which stands for **Problem**, **Intervention**, and **Evaluation**. Figure 5.4 outlines the components of each of the above progress note formats.

|                     | SOAP                                                                 | DAP                                                                 | PIE                                                                 |
|---------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|
| **Subjective Data:** Information that comes from the client in their own words and self-report. | Data: Combination of subjective and objective data                     | Problems: Objective and subjective data, regarding social, behavioral, and physical health symptoms and problems |
| **Objective:** Results of professional observations, tests, medical history, and measures |                                                                       |                                                                      |
| **Assessment/Impact:** Initially this includes diagnoses. Later progress notes include an evaluation of the impact of interventions and results of any subsequent measures or observations. (i.e., “What went well and what didn’t?”) | Assessment: Same as SOAP                                             | Interventions: Description of the interventions for each target problem |
| **Plan:** Next steps in the treatment process based on the results of the assessment/impact section | Same as SOAP                                                          | Evaluation: Evaluation of the impact of interventions               |

*Fig. 5.4 Progress note formats. (Based on: Adams and Grieder 2014)*

**Data** In the SOAP format, subjective and objective data are the comments, observations, and perspectives regarding the problems, goals/objectives, and interventions of the client (subjective), and provider observations and results from tests and measures (objective), respectively. The DAP format combines the subjective and objective data into the Data section. In the PIE format, the Plan section includes the objective and subjective data, observations, and perspectives of the client and provider regarding social, behavioral, and physical health symptoms and problems (Adams and Grieder 2014).

**Assessment of Impact of Interventions** The second domain of the progress note is a description of interventions used by the provider, the target problem that the intervention was designed to address, and the perceived impact of the interventions on the target problem. This assessment can be described through self-report, obser-
vations, or through results of standardized tests, assessments, or measures. Assessment of interventions should also include the client and provider’s perspective on the quality and value of the intervention and what could have been improved upon. In other words, what went well and what didn’t? This data is reported in the assessment section of the SOAP and DAP formats. Description of the interventions on target problems corresponds to the intervention section of the PIE format. Evaluation of intervention impact corresponds to the evaluation section of the PIE format (Adams and Grieder 2014).

**Plan** The plan section of the DAP and SOAP format describes the next steps in the treatment process based on the results of the assessment/impact section. This section also corresponds to the evaluation section in the PIE format. The plan should include documentation that the intervention will continue as planned if the goal or problem areas are still being addressed. If the problem has been solved or the goal achieved, then success should be noted and the next steps in the treatment process outlined. If the intervention was deemed insufficient, then the plan moving forward should be described. This may mean increasing intensity of services, adding or discontinuing services, or extending the intervention for a longer period (Adams and Grieder 2014).

The purpose of the progress note is to offer an easily deciphered description of the work (problem/goal, intervention, response, next steps) between the client and the provider, and the progress made (or not). Continuous documentation of progress ensures that the provider and the client are aware of what is happening in the relationship and what needs to change (if anything). If progress is shown, it can strengthen the relationship and signal when services can end. If progress is not shown, it provides a feedback loop that can signal the need to change approaches or strategies in order to better solve problems. In short, progress notes hold the client and provider accountable to progress.

Progress notes can also be collaborative between the client and the provider. For instance, concurrent or collaborative documentation is an important strategy that involves sharing and reviewing notes with clients and giving clients the opportunity to add input or revisions. This approach increases accountability, transparency, engagement, and accuracy. Progress notes are not a secret. People should be included in the documentation of their lives, and people have a right to read and have input in what is written about them. This can increase client satisfaction in the process and can increase positive outcomes and treatment adherence (Stanhope et al. 2013).

Collaboration can also be across team members, so that if team members are working on various problems, a shared progress note can capture the data, assessment, and plan from each team member to create a more integrated documentation system. Having separate progress notes across areas and in separate records dealing with addictions, mental health, physical health, and social areas can lead to fragmented, disorganized care. Having a shared note in one place organized across
problems, goals, and intervention can lead to better communication and collaboration across team members, enhancing coordination of care.

Treatment Planning Review
Treatment plans should be reviewed on a routine basis, and care settings often have requirements for when treatment plans are reviewed. For instance, community mental health centers are often required to review initial treatment plans after 30 days and then subsequent plans are reviewed quarterly or semi-annually. In general, it is good practice to view the treatment plan as a living document that is continually reviewed, revised, and updated. Reviewing progress toward goals and evaluating the result of specific interventions is good behavioral health practice. This helps hold the provider and client accountable and keep both working toward shared and agreed upon goals. Reviewing the treatment plan on a routine basis can also lead to more efficient treatment because new problems or barriers to treatment can be identified sooner. This can lead to creative and collaborative problem-solving between the client and provider to keep treatment on track.

5.5 Summary and Conclusion

Person-centered treatment planning is a collaborative process that synthesizes the information gathered in the psychosocial assessment to develop a detailed case conceptualization of client problem areas. This information is then used to identify goals and develop a documented action plan to achieve those goals in a set time frame. Person-centered treatment planning is a partnership between the provider and the client who work together to set goals and select the best interventions to achieve those goals based on client preferences and informed choices. Treatment plans guide the service relationship and provide a roadmap for problem-solving and goal achievement. When done well, treatment planning can be a form of intervention that models for the client how to work collaboratively with others, solve problems, set and achieve goals, monitor progress, and can also build client self-efficacy. Treatment planning also offers a way to assess and monitor progress for continuous quality improvement.

Case Study 5.1: The Case of Clarence Smith (Continued)
(See Case Study 4.1 from Chap. 4)

Case Review

Mr. Clarence Smith is a 62-year-old Black man who lost his wife, Angela, suddenly to a stroke 2 years ago. He reports sadness, loss of interest in daily activities, trouble sleeping, and fatigue. He blames himself for not being able to help his wife and reports drinking 2 or more beers a night to help him sleep. He has also experienced

1All names and other identifiers of this case have been changed to protect privacy and confidentiality.
a traumatic event in that he witnessed his wife’s death and could not resuscitate her. He experiences persistent and intrusive thoughts and nightmares, negative cognitions (e.g., self-blame), and emotions (e.g., sadness, anxiety) related to the event. He also avoids the place where the event happened. He has a history of co-morbid diabetes and hypertension. While both conditions are currently controlled with medication, he is experiencing increased vision and neuropathy symptoms. Mr. Smith is a retired postal worker, father of three, and grandfather of four. He has a loving relationship with his family, but they live out of state. He reports a rich social network that includes several friends and a faith community. However, he reports he is not able to socialize with friends and family due to the restrictions related to COVID-19. He reports feeling lonely, sad, and worthless, and he blames himself for his wife’s death. When asked what Mr. Smith would like to improve in his life, he reported that he would like to: (1) feel more useful; (2) see his family and friends more; and (3) reduce ruminative thoughts regarding Angela’s death.

Case Conceptualization

Clarence is struggling with symptoms of PTSD, depression, and grief. His symptoms are complicated by his social isolation and ruminative thoughts about his wife’s death. He has also begun to drink in order to sleep. The combination of depression, loneliness, diabetes, hypertension, drinking, and grief can lead to significant health consequences and early mortality if not addressed. Based on conversations with Clarence about the above symptoms and situation, the following recommendations were collaboratively developed: (1) reduce his depressive symptoms through psychotherapy to accept the loss of Angela and develop healthier thinking patterns around her death (e.g., reduce self-blame and guilt) and behavioral activation to schedule activities during the day; (2) reduce his trauma symptoms by prolonged exposure, EMDR, or cognitive processing therapy in order to reduce intrusive thoughts and negative cognitions and mood; (3) increase his socialization with others through re-connecting him safely with friends, family, and faith community in person through safe outside events like conversing in a park with masks and social distancing and virtually connecting with his faith community and family online or on the phone; (4) get more exercise through daily activity scheduling of walks or through home equipment such as a stationary bike, and completing daily errands; (5) advise him to reduce or eliminate his drinking, particularly before bed, as this can exacerbate depressive symptoms and reduce sleep; (6) explore antidepressant medication as a supplement to psychotherapy to reduce depressive symptoms if needed; and (7) address his diabetes through improved meal planning, a review of his medication, and exploring the use of orthotics, rehabilitative exercises, and other means to reduce pain in his feet.

Questions

What are five SMAARRT treatment outcome goals and relevant objectives that could help Clarence achieve his life goals?

What specific intervention approaches and techniques could be used to help Clarence? What natural supports could be incorporated in the plan?

What strengths does Clarence have that could be used to help him achieve his goals?
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