Practice*Planners*®

Arthur E. Jongsma, Jr., Series Editor

The Psychopharmacology Treatment Planner

David C. Purselle

Charles B. Nemeroff

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JOHN WILEY & SONS, INC.

The Psychopharmacology Treatment Planner

Practice*Planners*® Series

Treatment Planners

The Complete Adult Psychotherapy Treatment Planner, 3e
The Child Psychotherapy Treatment Planner, 3e
The Adolescent Psychotherapy Treatment Planner, 3e
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The Clinical Documentation Sourcebook, 2e
The Continuum of Care Clinical Documentation Sourcebook

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To Dr. William VanEerden, a psychiatrist whose deep knowledge of psychotropic medications is only surpassed by the strength of his commitment to his patients.

—A.E.J.

To Buffie, a wonderful person, whose encouragement and patience has helped me through many endeavors.

—D.C.P.

To my wife Gayle, thank you for all of your help and support that makes projects like this possible.

—C.B.N

CONTENTS

PRACTICE*PLANNERS*® SERIES PREFACE

The practice of psychotherapy has a dimension that did not exist 30, 20, or even 15 years ago—accountability. Treatment programs, public agencies, clinics, and even group and solo practitioners must now justify the treatment of patients to outside review entities that control the payment of fees. This development has resulted in an explosion of paperwork. Clinicians must now document what has been done in treatment, what is planned for the future, and what the anticipated outcomes of the interventions are. The books and software in this Practice*Planners* series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice*Planners* series is growing rapidly. It now includes not only the original *Complete Adult Psychotherapy Treatment Planner*, third edition, *The Child Psychotherapy Treatment Planner*, third edition, and *The Adolescent Psychotherapy Treatment Planner*, third edition, but also Treatment Planners targeted to specialty areas of practice, including: addictions, juvenile justice/residential care, couples therapy, employee assistance, behavioral medicine, therapy with older adults, pastoral counseling, family therapy, group therapy, psychopharmacology, neuropsychology, therapy with gays and lesbians, special education, school counseling, probation and parole, therapy with sexual abuse victims and offenders, and more.

Several of the Treatment Planner books now have companion Progress Notes Planners (e.g., Adult, Adolescent, Child, Addictions, Severe and Persistent Mental Illness, Couples). More of these planners that provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention are in production. Each Progress Notes Planner statement is directly integrated with "Behavioral Definitions" and "Therapeutic Interventions" items from the companion Treatment Planner.

The list of therapeutic Homework Planners is also growing from the original Brief Therapy Homework Planner for adults, to Adolescent, Child, Couples, Group, Family, Addictions, Divorce, Grief, Employee Assistance,

and School Counseling/School Social Work Homework Planners. Each of these books can be used alone or in conjunction with their companion Treatment Planner. Homework assignments are designed around each presenting problem (e.g., Anxiety, Depression, Chemical Dependence, Anger Management, Panic, Eating Disorders) that is the focus of a chapter in its corresponding Treatment Planner.

Client Education Handout Planners, a new branch in the series, provides brochures and handouts to help educate and inform adult, child, adolescent, couples, and family clients on a myriad of mental health issues, as well as life skills techniques. The list of presenting problems for which information is provided mirrors the list of presenting problems in the Treatment Planner of the title similar to that of the Handout Planner. Thus, the problems for which educational material is provided in the *Child and Adolescent Client Education Handout Planner* reflect the presenting problems listed in *The Child* and *The Adolescent Psychotherapy Treatment Planner* books. Handouts are included on CD-ROMs for easy printing and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues.

In addition, the series also includes Thera*Scribe*®, the latest version of the popular treatment planning, clinical record-keeping software. Thera*Scribe*® allows the user to import the data from any of the Treatment Planner, Progress Notes Planner, or Homework Planner books into the software's expandable database. Then the point-and-click method can create a detailed, neatly organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments.

Adjunctive books, such as *The Psychotherapy Documentation Primer*, and *Clinical, Forensic, Child, Couples and Family, Continuum of Care,* and *Chemical Dependence Documentation Sourcebook* contain forms and resources to aid the mental health practice management. The goal of the series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability—or, to put it simply, we seek to help you spend more time on patients, and less time on paperwork.

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The Psychopharmacology Treatment Planner

INTRODUCTION

Since the early 1960s, formalized treatment planning has gradually become a vital aspect of the entire health-care delivery system, whether it is treatment related to physical health, mental health, child welfare, or substance abuse. What started in the medical sector in the 1960s spread into the mental health sector in the 1970s as clinics, psychiatric hospitals, agencies, and so on began to seek accreditation from bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to qualify for third-party reimbursements. For most treatment providers to achieve accreditation, they had to begin developing and strengthening their documentation skills. Previously, most mental health and substance abuse treatment providers had, at best, a bare-bones plan that looked similar for most of the individuals they treated. Patients were often uncertain about what they were trying to attain in mental health treatment. Goals were vague, objectives were nonexistent, and interventions were applied equally to all patients. Outcome data were not measurable, and neither the treatment provider nor the patient knew exactly when treatment was complete. The initial development of rudimentary treatment plans made inroads toward addressing some of these issues.

With the advent of managed care in the 1980s, treatment planning has taken on even more importance. Managed care systems *insist* that clinicians move rapidly from assessment of the problem to the formulation and implementation of a treatment plan. The goal of most managed care companies is to expedite the treatment process by prompting the patient and treatment provider to focus on identifying and changing behavioral problems as quickly as possible. Treatment plans must be specific as to the problems and interventions, individualized to meet the patient's needs and goals, with measurable milestones that can be used to chart the patient's progress. Pressure from third-party payers, accrediting agencies, and other outside parties has therefore increased the need for clinicians to produce effective, high-quality treatment plans in a short time frame. However, many mental health providers have little experience in treatment plan

development. Our purpose in writing this book is to clarify, simplify, and accelerate the treatment planning process.

TREATMENT PLAN UTILITY

Detailed written treatment plans benefit not only the patient, physician, therapist, treatment team, insurance community, and treatment agency, but also the overall mental health profession. A written plan stipulates the issues that are the focus of the treatment process. It is very easy for both provider and patient to lose sight of what the issues were that brought the patient into treatment. The treatment plan is a guide that structures the focus of the therapeutic contract. Since issues can change as treatment progresses, the treatment plan must be viewed as a dynamic document that can and must be updated to reflect any major change of problem, definition, goal, objective, or intervention.

Patients and treatment providers benefit from the treatment plan that focuses on outcomes. Behaviorally stated, measurable objectives clearly focus the treatment endeavor. Patients no longer wonder what the treatment is trying to accomplish. Clear objectives also allow the patient to channel effort into specific changes that will lead to long-term problem resolution. Treatment is not a vague contract to take medication or talk honestly and openly about emotions and cognitions until the patient feels better. Both the patient and treatment provider concentrate on specifically stated objectives using specific interventions.

Treatment plans aid providers by forcing them to think analytically and critically about therapeutic interventions that are best suited for objective attainment for the patient. Therapists were traditionally trained to "follow the patient," but now a formalized plan guides the treatment process. The treatment provider gives advance attention to the technique, approach, assignment, or cathartic target that forms the basis for interventions.

Clinicians benefit when clear documentation of treatment provides a measure of added protection from possible patient litigation. The first line of defense against malpractice allegations is a complete clinical record detailing the treatment process. A written, individualized, formal treatment plan that is the guideline for the therapeutic process that has been reviewed and signed by the patient and that is coupled with problem-oriented progress notes is a powerful defense against exaggerated or false claims.

A well-crafted treatment plan that clearly stipulates presenting problems and intervention strategies facilitates the treatment process carried out by team members in inpatient, residential, or intensive outpatient settings. Good communication between team members about what approach

is being implemented and who is responsible for each intervention is critical. Team meetings to discuss patient treatment used to be the only source of interaction between providers; often, therapeutic conclusions or assignments were not recorded. Now, a thorough treatment plan stipulates in writing the details of objectives and the varied interventions (pharmacologic, milieu, group therapy, didactic, recreational, individual therapy, etc.) and who will implement them.

Treatment agencies or institutions are looking for ways to increase the quality and uniformity of the documentation in the clinical record. A standardized, written treatment plan with problem definitions, goals, objectives, and interventions in every patient's file enhances uniformity of documentation, easing the task of record reviewers inside and outside the agency. Outside reviewers, such as JCAHO, insist on documentation that clearly outlines assessment, treatment, progress, and discharge status.

The demand for accountability from third-party payers and health maintenance organizations (HMOs) is partially satisfied by a written treatment plan and complete progress notes. More and more managed care systems are requiring a structured therapeutic contract that has measurable objectives and explicit interventions. Clinicians are held accountable to those outside the treatment process.

The mental health profession benefits from the use of more precise, measurable objectives to evaluate success in mental health treatment. With the advent of detailed treatment plans, outcome data can be more easily collected for interventions that are effective in achieving specific goals.

DEVELOPING A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on one another much like constructing a house. The foundation of any effective treatment plan is the data gathered in a thorough biopsychosocial assessment. As the patient presents himself or herself for treatment, the clinician must sensitively listen to and understand what the patient struggles with in terms of family of origin issues, current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, self-esteem, and so on. Assessment data may be gathered from a social history, physical exam, clinical interview, psychological testing, or contact with a patient's significant others. The integration of the data by the clinician or the multidisciplinary treatment team members is critical for understanding the patient, as is an awareness of the basis of the patient's struggle. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

Step One: Problem Selection

Although the patient may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a *primary* problem will surface, although *secondary* problems may also be evident. *Other* problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or the treatment will lose its direction. This *Planner* offers 28 problems from which to select those that most accurately represent your patient's presenting issues.

As the problems to be selected become clear to the clinician or the treatment team, it is important to include opinions from the patient as to his or her prioritization of issues for which help is being sought. A patient's motivation to participate in and cooperate with the treatment process depends, to some extent, on the degree to which treatment addresses his or her greatest needs.

Step Two: Problem Definition

Each individual patient presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular patient. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *Diagnostic and Statistical Manual IV (DSM-IV)* or the *International Classification of Diseases.* The *Planner,* following the pattern established by *DSM-IV,* offers behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize one of the 28 presenting problems.

Step Three: Goal Development

The next step in treatment plan development is that of setting broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. The *Planner* suggests several possible goal statements for each problem, but one statement is all that is required in a treatment plan.

Step Four: Objective Construction

In contrast to long-term goals, objectives must be stated in behaviorally measurable language. It must be clear when the patient has achieved the established objectives; therefore, vague, subjective objectives are not acceptable. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that psychiatric treatment outcomes be measurable. The objectives presented in this *Planner* meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment as to which objectives are most appropriate for a given patient.

Each objective should be developed as a step toward attaining the broad treatment goal. In essence, objectives can be thought of as a series of steps that, when completed, will result in the achievement of the long-term goal. There should be at least two objectives for each problem, but the clinician may construct as many as are necessary for goal achievement. Target attainment dates should be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all the necessary objectives have been achieved, the patient should have resolved the target problem successfully.

Step Five: Intervention Creation

Interventions are the actions of the clinician designed to help the patient complete the objectives. There should be at least one intervention for every objective. If the patient does not accomplish the objective after the initial intervention, new interventions should be added to the plan.

Interventions should be selected on the basis of the patient's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, including pharmacologic interventions as well as other therapeutic interventions (e.g., psychotherapy, substance abuse treatment, physical or occupational therapy). Other interventions may be written by the provider to reflect his or her own training and experience. The addition of new problems, definitions, goals, objectives, and interventions to those found in the *Planner* is encouraged because doing so adds to the database for future reference and use.

Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the patient. Appendix B contains a full reference list of self-help or patient education materials. The books are arranged under each problem for which they are appropriate. When a book is used as part of an intervention plan, it should be reviewed with the

patient after it is read, enhancing the application of the content of the book to the specific patient's circumstances. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Books* (2003) by Santrock, Minnett, and Campbell (available from The Guilford Press, New York, NY).

Assigning an intervention to a specific provider is most relevant if the patient is being treated by a team in an inpatient, residential, or intensive outpatient setting. Within these settings, personnel other than the primary clinician may be responsible for implementing a specific intervention. Review agencies require that the responsible provider's name be stipulated for every intervention.

Step Six: Diagnosis Determination

The determination of an appropriate diagnosis is based on an evaluation of the patient's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the patient presents to the criteria for diagnosis of a mental illness condition as described in *DSM-IV*. The issue of differential diagnosis is admittedly a difficult one that research has shown to have rather low interrater reliability. Mental health professionals are often trained to think more in terms of maladaptive behavior than disease labels. In spite of these factors, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. (However, recently, managed care agencies are more interested in behavioral indices that are exhibited by the patient than the actual diagnosis.) It is the clinician's thorough knowledge of *DSM-IV* criteria and a complete understanding of the patient assessment data that contribute to the most reliable, valid diagnosis. An accurate assessment of behavioral indicators will also contribute to more effective treatment planning.

HOW TO USE THIS PLANNER

Our experience has taught us that learning the skills of effective treatment plan writing can be a tedious and difficult process for many clinicians. It is more stressful to try to develop this expertise when under the pressure of increased patient load and short time frames placed on clinicians today by managed care systems. The documentation demands can be overwhelming when we must move quickly from assessment to treatment plan to progress notes. In the process, we must be very specific about how and when objectives can be achieved, and how progress is exhibited in each patient. *The Psychopharmacology Treatment Planner* was developed as a tool to

aid clinicians in writing a treatment plan in a rapid manner that is clear, specific, and highly individualized according to the following progression:

1. Choose one presenting problem (Step One) you have identified through your assessment process. Locate the corresponding page number for that problem in the *Planner's* table of contents.
2. Select two or three of the listed behavioral definitions (Step Two) and record them in the appropriate section on your treatment plan form. Feel free to add your own defining statement if you determine that your patient's behavioral manifestation of the identified problem is not listed. (Note that while our design for treatment planning is vertical, it will work equally well on plan forms formatted horizontally.)
3. Select a single long-term goal (Step Three) and again write the selection, exactly as it is written in the *Planner* or in some appropriately modified form, in the corresponding area of your own form.
4. Review the listed objectives for this problem and select the ones that you judge to be clinically indicated for your patient (Step Four). Remember, it is recommended that you select at least two objectives for each problem. Add a target date or the number of sessions allocated for the attainment of each objective.
5. Choose relevant interventions (Step Five). The *Planner* offers suggested interventions related to each objective in the parentheses following the objective statement. Select the medication intervention that you believe is most appropriate for the patient. A chart of commonly used psychiatric medications with their indications and dosages can be found in Appendix A. Also, just as with definitions, goals, and objectives, there is space allowed for you to enter your own interventions into the *Planner.* This allows you to refer to these entries when you create a plan around this problem in the future. You will have to assign responsibility to a specific person for implementation of each intervention if the treatment is being carried out by a multidisciplinary team.
6. Several *DSM-IV* diagnoses are listed at the end of each chapter that are commonly associated with a patient who has this problem. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed or assign a more appropriate choice from the *DSM-IV* (Step Six).

To accommodate those practitioners who tend to plan treatment in terms of diagnostic labels rather than presenting problems, Appendix C lists all of the *DSM-IV* diagnoses that have been presented in the various presenting problem chapters as suggestions for consideration. Each diagnosis is followed by the presenting problem that has been associated with

that diagnosis. Providers may look up the presenting problems for a selected diagnosis to review definitions, goals, objectives and interventions that may be appropriate for their patients with that diagnosis.

Congratulations! You should now have a complete, individualized treatment plan that is ready for immediate implementation and presentation to the patient. It should resemble the format of the "Sample Standard Treatment Plan" on page 9.

A FINAL NOTE

One important aspect of effective treatment planning is that each plan should be tailored to the individual patient's problems and needs. Treatment plans should not be mass-produced, even if patients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns *must* be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. It is our hope that *The Psychopharmacology Treatment Planner* will promote effective, creative treatment planning—a process that will ultimately benefit the patient, the clinician, and the mental health community.

SAMPLE TREATMENT PLAN

PROBLEM: ANGER MANAGEMENT

Definitions: Overreaction of hostility to insignificant irritants.
Use of verbally abusive language.
History of explosive aggressive outbursts out of proportion to any precipitating stressors leading to assaults or destruction of property.

Goals: Take the appropriate medication and dose and/or participate in psychotherapy to decrease overall intensity and frequency of angry feelings and outbursts.

OBJECTIVES	INTERVENTIONS
1. Describe the nature and history of anger expression and note its impact on daily life. (5/20/03)	1. Explore the patient's dysfunctional pattern of anger expression (e.g., physical violence, destructive acts, overreaction to irritants, challenging authority figures, problems with legal system) and how it affects his/her daily life. 2. Assist the patient in identifying specific targets of and causes for anger.
2. Patient and/or significant other to describe any current or past violent threats or actions. (5/27/03)	1. Assess the patient's potential for violence and determine the presence of current and past threats or acts of aggression. 2. Arrange for hospitalization, as necessary, when the patient is judged to be harmful to self or others or unable to care for his/her basic needs.

3. Pursue treatment for concurrent medical problems that may contribute poor anger control. (6/05/03)	1. Treat or refer the patient for treatment for any medical problem that may be contributing to poor anger control (e.g., acquired brain damage, elevated testosterone levels). 2. Monitor the patient's progress in recovery from concomitant disorders and the impact of the recovery on his/her anger management.
4. Take prescribed medications responsibly at times ordered by the physician. (6/5/03)	1. Prescribe to the patient a selective serotonin reuptake inhibitor (SSRI) (e.g., paroxetine [Paxil®], sertraline [Zoloft®], citalopram [Celexa™], escitalopram [Lexapro™], fluoxetine [Prozac®], or fluvoxamine [Luvox®]); strongly consider this in patients with concurrent depressive symptoms. 2. Titrate the patient's medication to the minimum effective dose for treating his/her symptoms.
5. Report as to the effectiveness of medications and any side effects that develop. (7/05/03)	1. Monitor the patient frequently for the development of side effects, response to medication, adherence to treatment, and abuse of medication (if he/she is taking benzodiazepines). 2. Evaluate the patient after six weeks of therapy with an SSRI for his/her response to medication; determine if he/she has had a partial response or a full response to the medication.
6. Retain a significant improvement in anger management. (9/5/03)	1. Maintain the patient on current medication indefinitely if he/she has shown an improvement in anger management.

Diagnosis: 312.34 Intermittent Explosive Disorder

ADJUSTMENT DISORDER WITH DEPRESSION OR ANXIETY

BEHAVIORAL DEFINITIONS

1. Depressive symptoms (e.g., sad mood, tearfulness, feelings of hopelessness) that develop in response to an identifiable stressor (e.g., medical illness, marital problems, loss of a job, financial problems, conflicts about religion).
2. Anxiety symptoms (e.g., nervousness, worry, jitteriness) that develop in response to an identifiable stressor.
3. Symptoms cause distress beyond what would normally be expected.
4. Significant impairment in social and/or occupational functioning because of the symptoms.

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LONG-TERM GOALS

1. Alleviate symptoms of stress-related depression through medication and/or psychotherapy.
2. Alleviate symptoms of stress-related anxiety through medication and/or psychotherapy.
3. Stabilize anxiety and/or depression levels while increasing ability to function on a daily basis.

4. Learn and demonstrate strategies to deal with dysphoric and/or anxious moods.
5. Effectively cope with the full variety of life's stressors.

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SHORT-TERM OBJECTIVES

1. Describe the signs and symptoms of an adjustment disorder that are experienced and note their impact on daily life. (1, 2, 3)

2. Describe other symptoms or disorders that may also be present. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Explore the adjustment disorder symptoms that are experienced by the patient (e.g., excessive worry about a current stressor, sad mood, decreased sleep, reduced appetite).
2. Determine what stressors are present and the time course of symptoms in relation to the stressors.
3. Gather information from the patient about the impact of the symptoms on daily life (e.g., impaired social or occupational functioning, neglect of routine chores).
4. Assess the patient for comorbid disorders (e.g., see the Personality Disorder, Psychosis, and Panic Disorder chapters in this *Planner*).
5. Gather detailed personal and family history information regarding the patient's substance abuse and its potential contribution to the adjustment disorder;

refer the patient for in-depth substance abuse treatment, if indicated (see the Chemical Dependence chapters in this *Planner*).

3. Verbalize any current suicidal thoughts and any history of suicidal behavior. (6, 7, 8)

6. Explore the patient's current and past suicidal thoughts and suicidal behavior; check for family history of suicide (see interventions designed for Suicidal Ideation in this *Planner*).
7. Administer to the patient an objective assessment instrument for assessing suicidality (e.g., the Beck Scale for Suicidal Ideation); evaluate the results and give feedback to the patient.
8. Arrange for hospitalization when the patient is judged to be harmful to himself/herself or others or unable to care for his/her basic needs.

4. Outline a complete and accurate medical and psychiatric history, including treatment received and its effectiveness. (9, 10)

9. Explore the patient's history of previous treatment for any psychiatric disorder and the success of, as well as tolerance for, that treatment.
10. Assess the patient for the presence of other medical problems and the medications used to treat them.

5. Cooperate with a physical examination and laboratory tests. (11, 12)

11. Perform a complete physical and neurological examination on the patient and send his/her blood and/or urine for analysis to assess any medical problem that may contribute to the adjustment disorder (e.g., cancer, diabetes, hypertension, cardiovascular disease).
12. Provide feedback to the patient regarding the results and