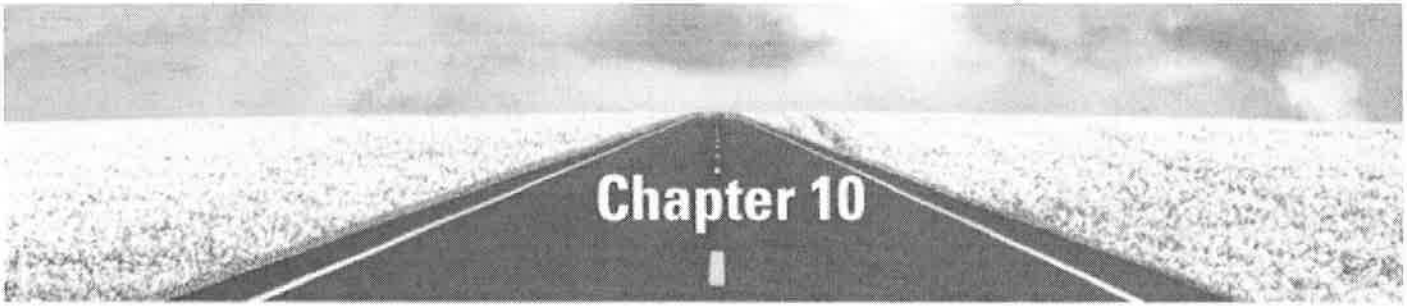

Chapter 10

Utilization of Assessment Information in Treatment Plan Development

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Key Terms: treatment planning, establishing treatment goals, case conceptualization, disability considerations, S.M.A.R.T. goals

Key Objectives: Students will be able to apply information covered in other chapters to develop specific and measurable goals within their treatment plans.

Introduction to Treatment Planning

Treatment planning is an essential component to assist a counseling professional in providing therapeutic services to people who have drug and alcohol obstacles. The goal of treatment is to (a) reduce substance use or achieve a substance-free life, (b) maximize multiple aspects of life functioning, and (c) prevent or reduce the frequency and severity of relapse (Schuckit, 1994). A treatment plan should be developed to assist the client in eliminating or reducing barriers that prevent the individual from having a high quality of life (subjective to the client) and assist in eliminating problems that the client brings to the counseling process (Substance Abuse Mental Health Services Administration, 2009a). The counseling professional and client periodically review the treatment plan, as it can inform both of whether the client is (1) improving or getting better, (2) declining or getting worse, or (3) is stagnant in their treatment recovery (staying the same). There are several factors that might influence why a client is not improving. For example, the timeline of when the goals should be completed may not be realistic, the goals may not be specific enough, the client may not have the tools required to complete the goal. The counseling professional should work with the client in order to identify the barrier to goal attainment. The purpose of this chapter is to discuss the process of treatment plan development by incorporating the assessment information discussed in the previous chapters.

Treatment Plan Development

In order to develop an appropriate treatment plan, a counseling professional must gather vital information about the client seeking services. If the level of care has already been determined for the client, then there should be information available for the counseling professional to review. For example, there are six dimensions established by Mee-Lee (2013), including (1) acute intoxication and/or withdrawal

potential; (2) biomedical conditions and complications; (3) emotional, behavioral, and cognitive conditions and complications; (4) readiness to change; (5) relapse, continued use, continued problem potential; and (6) recovery environment. To establish the appropriate level of care for the individual, there needs to be documented evidence for each dimension aforementioned. As discussed in Chapter 3, administering a valid and reliable instrument to the client to ascertain information related to problems the client has can provide more specific information related to the severity level. For example, if the client presents other psychological-related barriers, a test that measures possible psychiatric diagnoses would be beneficial to assist in isolating symptoms associated with specific diagnoses. Once this is completed, further evaluation can be conducted to determine if in fact the symptoms lead to a clinical diagnosis.

Essentially, a counseling professional will ascertain all of the assessment information gathered about a client, and collaboratively work with the client to define the problem(s) or barriers that are preventing the client from achieving his or her goals. A treatment plan will include a timeline for treatment progress, identifying major treatment goals, and noting important milestones and objectives. Although substance users are primarily in treatment for drugs and/or alcohol, a treatment plan must address barriers such as (a) medical/biological, (b) social, (c) spiritual, (d) vocational, and (e) psychological. Oftentimes, barriers in these areas can lead to the use of substances to avoid or escape the harmful effects of the symptoms associated with these barriers.

It is important that the client is involved in the treatment plan development process, as it will increase the likelihood that the client will be a willing participant in the treatment program, and together the counseling professional and client can establish realistic goals. After comprehensively discussing the presenting issues that the client brings to treatment, a counseling professional can request that the client develop some goals they might have for treatment. Remember, a client may not be as experienced in goal-writing so it is important for the counseling professional to be open-minded when presented with the client goals. Having the client come up with goals helps portray that the client is taking ownership of his or her treatment recovery process and leads to the next step of case conceptualization.

Case Conceptualization

Prior to developing a treatment plan, a case conceptualization may be beneficial because it allows for a counseling professional to develop an overall depiction of the client's overall situation. A case conceptualization is a report that is based on information gathered, organized, and assessed to provide an explanation of a client's behavior (Gilmore, Seirup, & Rubinstein, 2011). Furthermore, case conceptualization is a "bridge between client diagnosis or problem and specific treatments to be implemented" (Sommers-Flanagan & Sommers-Flanagan, 2015, p. 347). Counseling professionals during the clinical interview must look for emotional, stated, nonverbal, and behavioral information that will assist in formulating the picture of the client's experience and this can lead to collaboration when developing goals with the client. Case conceptualization may feel overwhelming for the new counseling professional. However, the process below may be helpful in assisting a counseling professional regardless of experience in fully formulating a case (Eells, 2015):

1. Listen to the client's story/presenting problem
2. Gather information about how the client perceives his/her world
3. Obtain demographic information
4. Explore social, historical, and cultural context
5. Assess client's strengths, coping skills
6. Assess for risk; create problem list
7. Diagnose
8. Apply theoretical orientation and hypothesize about the nature of the problem
9. Develop goals
10. Plan interventions

A counseling professional who can learn to engage in case conceptualization can identify the necessary steps that might be needed to assist a client in pursuing his or her long-term goal. For example, suppose a client named Bryan has the long-term goal of reducing his anger outbursts. A counseling professional should listen to issues related to anger outbursts that the client experiences. One way to accomplish this goal is to learn positive coping skills. Some areas that the counseling professional should consider exploring within a counseling session might include identifying a specific moment in time when the client had an anger outburst (examining the cognitive and affective aspects of the situation). Cognitive behavioral theory outlines three areas that should be explored with a client in order to process irrational thinking, including the cognitive (thought), affect (emotion), and situational (behavioral).

Now pretend that Bryan is discussing a recent event with his counseling professional where he was involved in a verbal altercation with a family member at a recent holiday party. It might be helpful for Bryan to completely describe the situation so that the counseling professional can understand the context of the situation. What led to the verbal altercation? At what point was Bryan getting upset? Who else was present? What was Bryan thinking prior to the verbal altercation? What was Bryan thinking after the verbal altercation? How long after the verbal altercation did Bryan's anger begin to decrease? These are examples of questions that can assist a counseling professional in exploring previous events related to Bryan's goal.

The treatment plan can include specific steps to assist the counseling professional in terms of thoroughly exploring previous coping skills that were used in the past and exploring current coping skills as they are used in practice. In the example below, we are ascertaining information from Bryan throughout his counseling sessions to assist him in reaching one of his goals of reducing his anger outbursts.

Long-term goal #1: Help Bryan learn positive coping skills that his parents neglected to teach him during his childhood. This will be completed by 5/25/xx.

Short-term goal/objective #1: Bryan will learn appropriate coping skills by 4/11/xx.

Intervention/Action step #1: Bryan will develop a list of coping skills that he has attempted to use in the past. This will be completed on 4/4/xx.

Intervention/Action step #2: Bryan will describe the situation/event of each coping skills he had indicated that he has used. Bryan will describe his cognition, affect, and behavior regarding the situation/event. This will be completed on 4/4/xx.

Intervention/Action step #3: After describing each situation/event, Bryan will state what coping skill he used and rate how effective each coping skill was on a scale of 1–7 (1 = not effective, 7 = very effective) with regard to reducing his anger. This will be completed on 4/4/xx.

Intervention/Action step #4: Bryan will review a list of examples of appropriate coping skills provided by the counselor and describe how the coping skills on the list the counselor provided are different than the coping skills that he has attempted in the past. This will be completed by 4/11/xx.

Intervention/Action step #5: Bryan will review a list of appropriate coping skills provided by the counselor and select or develop 10 coping skills that he will use during the next few weeks. This will be completed by 4/11/xx.

In the example treatment plan for Bryan shown above, the first short-term goal is to assist Bryan in learning appropriate coping skills. Although there is flexibility in determining how to proceed with a client, it may be beneficial to first explore how long Bryan has had episodes of anger, and has he used any coping skills in the past. After examining each action step of short-term goal 1, it should become evident that there is a flow in terms of assisting Bryan in examining what was used in the past, what could be used in the future, and determining which coping skills might be most helpful. If Bryan were provided a list of 20 coping skills and attempted to use three or four at the same time, it would be difficult to identify what was the most effective and what was not.

Short-term goal 2 (see below) is related to Bryan demonstrating appropriate coping skills. Oftentimes, a counseling professional will begin with short-term goal 2, rather than first determining if the client understands how to effectively use coping skills and being able to process how these coping skills might be used. After Bryan selects a few positive coping skills to try over the next few weeks, Bryan will have the opportunity to actually attempt to employ these in practice.

Short-term goal/objective #2: Bryan will demonstrate how to use appropriate coping skills by 5/25/xx.

Intervention/Action step #1: From the list of coping skills that Bryan has developed, he will select two coping skills to use in the next few weeks. This will be completed by 4/11/xx.

Intervention/Action step #2: After getting into an argument, Bryan will process the situation/event by writing a short narrative of what happened, what his thoughts, emotions, and behaviors were regarding the event. This will be completed by 4/18/xx.

Intervention/Action step #3: Bryan will use one of the two selected coping mechanisms after he gets in an argument with his girlfriend (trial 1). He will indicate how many minutes after the initial argument did his anger reduce and rate how effective each coping skill was on a scale of 1–7 (1 = not effective, 7 = very effective) at reducing his anger. This will be completed by 4/18/xx.

Intervention/Action step #4: Bryan will continue to use the most effective coping mechanism from (trial 1) and select one new coping mechanism from the list. This will be completed on 4/18/xx.

Intervention/Action step #5: Bryan will use one of the two selected coping mechanisms after he gets in an argument with his girlfriend. He will indicate how many minutes after the initial argument did his anger reduce and rate how effective each coping skill was on a scale of 1–7 (1 = not effective, 7 = very effective) at reducing his anger. This will be completed by 4/25/xx.

As displayed above, there are several action steps within each short-term goal that can provide a visual of how a client might progress in meeting a treatment goal. Sometimes, several interventions/action steps can be completed within the same counseling session (e.g., short-term goal one, action step(s) 1 and 2), and sometimes the interventions are completed over several counseling sessions.

Development of Goals and Action Steps/Objectives

Goal-writing is a skill that can take a counseling professional significant practice to accomplish. Goal setting is an essential part and central to a treatment plan, and should be (Bovend'Eerdt, Botell, & Wade, 2009, p. 353):

1. Individualized to a particular client
2. Allow accurate, unambiguous determination of goal achievement
3. Are flexible enough to cover most situations

In addition to the three bullet points provided above, treatment goals should be written in a positive manner, and be developed collaboratively with the client. Within the counseling field, there has been greater emphasis that counseling professionals develop S.M.A.R.T. goals within their treatment plan. These types of goals stand for specific (S), measurable (M), attainable (A), realistic or results-oriented (R), and Time specific (T). Aligning with this framework will provide more specificity in terms of (1) the services to be provided (e.g., group, individual, family, support groups), (2) the services to be obtained from specific providers, (3) the frequency of treatment, (4) delineate termination criteria, (5) include all domains of functional assessment as needed, and (6) specific goals and objectives. The S.M.A.R.T. framework also assists in making the treatment goals behaviorally oriented and is aimed at client improvement. The short-term goals/objectives are the activities that must be accomplished to reach the short-term goal, directly measurable, unique to the client, concise and precise, and comprehensive. The action steps are the tasks that are needed to carry out or reach objectives.

Case Scenario #1:

Bryan is receiving counseling services at an outpatient facility as required from a court mandate due to a driving under the influence (DUI) charge and his previous history with several DUI charges. During his individualized counseling session, Bryan disclosed that he has had difficulty finding employment because he never completed the 12th grade and has no high school diploma. He stated that he has had previous employment, but due to the increase in computerized equipment, his employment was terminated. Bryan and his counselor developed a goal to assist Bryan in obtaining his general education degree (GED) from his local college:

Long-term goal #1: Bryan will obtain his 12th grade GED by 6/5/xx.

Short-term goal/objective #1: Bryan will go to Illinois Valley Community College on the community bus to get a GED application by 3/5/xx.

Intervention/Action step #1: Bryan will get a bus schedule from the front desk in the lobby and review plans for taking the community bus with his counselor today.

Intervention/Action step #1: Bryan will get a bus pass from the agency transportation department tomorrow.

Short-term goal/objective #2: Bryan will complete the application and review it with his counselor on 3/10/xx.

Intervention/Action step #1: Following a successful review, Bryan will mail his application to Illinois Valley Community College on 3/10/xx.

Case Scenario #2:

Long-term goal #1: Bryan will quit using drugs.

Short-term goal/objective #1: Bryan will avoid all triggers.

Intervention/Action step #1: Bryan will find new friends

Intervention/Action step #1: Bryan will ignore his old friends who use drugs.

As displayed above, we have two separate scenarios. In the first scenario, Bryan had a specific goal of obtaining his 12th-grade GED by a specific date. If Bryan is unable to complete the specific short-term goals/objectives, the counseling professional is able to review with Bryan as to the potential barriers that prevented him from achieving his short-term goals. In the second scenario, there is a lot of information missing. For example, when does Bryan need to complete the goal by? A treatment goal with action steps that are time specific assists a counseling professional in evaluating effort. Another issue with case scenario 2, what does avoid all trigger mean? How might Bryan quit using drugs? The treatment goal needs to be more specific.

Although case scenario 1 is more specific than case scenario 2, additional short-term goals/objectives and action steps can be included. Some additional considerations might be studying for the examination, taking the examination, reviewing results of the examination with his counselor. As provided earlier in the chapter, Bryan wanted assistance with his anger outbursts and several objectives and action steps were provided. As just demonstrated, the more specific the goal becomes, the easier it will become when evaluating why the goal was completed or why it did not get completed. Please consider the following mini-activity:

Mini-activity:

1. After learning about the S.M.A.R.T framework, would you claim that this part of Bryan's treatment plan is compliant with this framework?
2. What specifically do you notice that is problematic?
3. Consider applying the S.M.A.R.T framework.

Utilization Review Process

Once a treatment plan has been established, a counseling professional and client can begin the process of achieving the client's short-term and long-term goals. This will involve periodic review of the treatment goals to determine if goals are being met. As aforementioned, a treatment plan informs us if the client is (1) improving or getting better, (2) declining or getting worse, or (3) is stagnant in their treatment recovery (staying the same). If the agency that the counseling professional is employed by has an accreditation agency (e.g., Commission on Accreditation of Rehabilitation Facilities [CARF], Joint Commission) that provide standards that the agency must abide by, guidance related to treatment review will likely be provided. For example, agencies accredited by the CARF require a weekly review with the client and a monthly review with the treatment team members (2018). Additionally, the counseling professional should become familiar with state legislation related to the utilization process, as some states provide specific details as to the frequency that a treatment plan must be reviewed. For example, some state Medicaid programs (e.g., Vermont) may mandate review every 15 days for adults/30 days for adolescents (Donsel, 2014).

Evaluating Effectiveness of Goals, Continuing Care, and Treatment Termination

During the review process, a counseling professional can determine how effective treatment has been for the client attempting to complete treatment goals. If goals are developed using the S.M.A.R.T. framework, the counseling professional can mark all of the short-term objectives/goals that were completed in the time frame specified and those that were not. A conversation should follow with the client to determine if the time frame for each action step was realistic, if other challenges prevented the accomplishment of the action step, or if motivation was a factor. For example, in the case scenario above, Bryan was planning on obtaining his 12th-grade GED by 6/5/xx. The first short-term goal/objective was for Bryan to go to the local college to obtain a GED application. The intervention/action steps provided were ordered in a step-by-step manner so that the likelihood of accomplishing the goal was successful. For example, Bryan was going to get a bus schedule from the front desk and review it with his counselor. The next step was for Bryan to return to the agency the following day to obtain a bus pass. If Bryan was unable to accomplish this action step, then he would be unable to successfully complete the short-term goal/objective. Some issues that may have prevented Bryan from accomplishing this action step could include (a) lack of transportation to return to the agency the following day, (b) family emergency, (c) Bryan relapsed, (d) Bryan forgot to return the following day for a bus pass, (e) the agency ran out of bus passes. Any of these possibilities might have occurred and the counseling professional can discuss the barriers that prevented Bryan from completing this task. This needs to be accomplished prior to Bryan obtaining his GED application form.

Oftentimes, continuing care for substance use treatment will heavily involve completing treatment goals. For example, individuals who are court mandated through drug courts will often have a probation officer who periodically checks in with the client's counseling professional. If treatment goals are consistently not being met, or if the client is not demonstrating the motivation to complete treatment, the probation officer might suggest that the client is terminated from treatment unsuccessfully, and the drug court may recommend jail time. The counseling professional may be able to verbalize his or her opinion regarding termination or continued treatment. It is important for the counseling professional to determine the factors associated with continued care. Insurance companies, Medicaid/Medicare, and other funding sources may have rules associated with what constitutes termination. Additionally, in the initial phases of counseling, the counseling professional should discuss what factors are associated with termination of treatment. These may include the accomplishment of treatment goals or the lack of accomplishment of treatment goals.

Disability Considerations

A disability is defined as "having a mental or physical impairment (difference) that substantially limits one or more major life activities (e.g., eating, driving, working), having a record of such an impairment or being regarded of having such an impairment" and may include physical, psychiatric, cognitive, psychological, and emotional disabilities (Upton & Harper, 2002). It is estimated that approximately 56.7 million people in the United States (U.S.) [19% of the population] have a disability (U.S. Census Bureau, 2012). As noted by Sprong, Upton, and Pappas (2012), substance use disorders [i.e., abuse or dependence] occur two to four times more often among persons with disabilities in comparison to the general population (Koch, Nelipovich, & Sneed, 2002; Sprong et al., 2012). The Substance Abuse Mental Health Services Administration (SAMHSA) suggested that approximately 4.7 million Americans with disabilities experience coexisting substance use disorders and physical or mental disabilities (Office on Disability, 2010), and approximately 22.3 million individuals in the United States aged 12 or older (9% of general population) met DSM-IV TR diagnostic criteria for substance abuse or dependence in 2007 (Walls, Moore, Batiste, & Loy, 2009). Disability is another essential consideration that needs to be addressed within a treatment plan, as it will likely have an impact on the individual's life in addition to the substance use.

West (2007) assessed the accessibility of substance abuse treatment facilities in the United States for people with disabilities and found that most facilities in their sample self-reported a variety of barriers to physical accessibility and the lack of services and physical accommodations. A counseling professional specializing in drug/alcohol treatment may not be aware of the other issues associated with disability that might need to be addressed within treatment, as curriculum within drug/alcohol treatment programs might not completely cover psychosocial and medical aspects of disability (with the exception of Rehabilitation Counseling programs). Additionally, the most effective treatment planning occurs when a rapport is established between the counseling professional and client. SAMHSA's (2009b) Treatment Improvement Protocol (TIP) 29 provides some examples of disability etiquette to prevent from offending or being disrespectful to clients with disabilities:

1. Ask a client who has a disability if there are any accommodations that he or she may need for successful treatment.
2. Use people-first language when referring to people with disabilities.
3. A service animal should not be distracted from its job (the animal should not be touched or petted).
4. Look directly at a person who is deaf when communicating, so lip-reading and facial expressions can be communicated.
5. Touching the client's wheelchair may be offensive to the individual (e.g., leaning on the chair).

Although there are numerous disability categories, we will provide examples of special considerations when developing a treatment plan when the client has either (a) brain injury (BI) and/or a (b) spinal cord injury. It is estimated that 50% of people with traumatic brain injuries and spinal cord injuries use substances (SAMHSA, 2011). Therefore, special consideration must be given when developing a comprehensive treatment plan. For example, below are some specific examples that could be incorporated into substance abuse treatment (Corrigan & Lamb-Hart, 2004; DeLambo, Chandras, Homa, & Chandras, 2009) provided there are special considerations when working with people with coexisting disabilities (as cited in: https://www.counseling.org/Resources/Library/VISTAS/2009-V-Online/DeLambo-Chandras-Homa-Chandras2.pdf):

1. Modify admission criteria: Remove abstinence from prescription medications (e.g., Valium) as a program requirement.
2. Determine unique learning strategies: Avoid jargon; use concrete written materials and allow tape recording. Give extra time for work, paraphrase and repeat.
3. Determine unique communication styles: Ask how client reads and writes or evaluate samples.
4. Avoid many environmental stimuli: Minimize distractions.
5. Be aware of attention span deficits.
6. Give breaks to combat fatigue.
7. Address inappropriate social behaviors in a gentle manner: Don't assume the individual knows right from wrong.
8. Redirect excessive speech.
9. Be cautious when inferring client motivation levels: Do not assume that noncompliance arises from lack of motivation or resistance.
10. Don't assume a missed appointment is intentional or due to resistance: Punctuality can be due to time management, poor memory, and transportation issues.

11. The single most important factor for successful treatment is the therapeutic alliance between counselor and client: Utilize a proven approach (e.g., Rogerian) that builds this partnership.
12. Enlist the client's social circle (family, friends, and service providers) to reinforce goals.
13. Don't assume that learning will be generalized to other environments.
14. Be delicate and caring during confrontation.
15. Repeat instructions and strategies: Repeat, review, rehearse.
16. Attend to transportation issues: These are often a major treatment barrier.
17. Increase treatment compliance/attendance through incentives: These can be financial, as well as reminder phone calls and related strategies.

Thus, a counseling professional should consider the above information when working with a client who also has a disability.

Brain Injury

A BI usually results from a violent blow to or a jolt of the head, or from an object (e.g., bullet) penetrating the skull (Falvo & Holland, 2018). The structure of the brain, skull, and surrounding tissues makes the brain quite susceptible to injury as a result of blows to or jolts of the head. The intensity does not have to be extreme to cause a BI and small amount of pressure, force, frequency wave, or locations of contact can create conditions in which the skull and cerebrospinal fluid cannot effectively protect the brain from damage. For example, during a car crash, the car comes to an abrupt stop, but a rider's body will still have strong forward momentum. A rapid stop or contact with an external object may cause the brain to move back and forth inside the skull and make contact with the internal surfaces; this is termed a coup-countercoup injury (Young et al., 2015).

BIs occur very often in the United States. For example, according to the National Highway Traffic Safety Administration (2015), there is a motor vehicle accident every 60 seconds. In 2015, these accidents resulted in 2.44 million injuries, with 14.3% resulting in a BI. The prevalence of BI is ever-increasing due to the numerous ways in which traffic accidents occur, including by way of traffic accidents, falls, gun shots, and improvised explosive devices (IED) to name a few. It is estimated that in the United States, 1.7 million people sustain a BI each year. Of this number, approximately 52,000 results in death, 275,000 are hospitalized, and 1.365 million are treated and released from hospital emergency rooms. The leading causes of BI among the general population include falls (35.2%), motor vehicle accidents (17.3%), being struck by/against events (colliding with a moving or stationary object: 16.5%), assaults (10%), and unknown/other (21%).

The relationship between ***BI*** and substance abuse was explored as early as 1987 by the Brain Injury Association of America [formerly known as the National Head Injury Foundation] (Sparadeo, Strauss, & Barth, 1990). At the time, there were limited resources available to assist healthcare professionals and counseling professionals to treat individuals with these coexisting disabilities (i.e., BI and substance-related disorders). More recently, it is estimated that 12% of people who are 16 and older who went to rehabilitation treatment for BI were also using illicit drugs in the months prior to their injury and 23% for alcohol abuse (Cuthbert et al., 2015). The screening, brief intervention, and referral to treatment (SBIRT) model is sometimes used to assess whether a person with a BI may have substance-related barriers that would require additional treatment from a counseling professional (Nilsen et al., 2008). Once substance abuse is detected for the client with a BI, the professional will use motivational interviewing techniques (e.g., scaling) to guide a discussion toward substance use treatment (Holloway, 2012). This step is usually performed in a primary care and emergency setting for individuals with mild to moderate BI. It has yet to be used for people with severe BI due to cognitive and expressive deficits.

If a client with a BI has been referred for substance use treatment, the counseling professional should work with the client's BI rehabilitation team to ascertain what accommodations might be required for the client to successfully complete treatment. For example, the most common symptoms associated with

BI include confusion, disorientation, loss of memory, headaches, dizziness, nausea, visual degradation, irritability, passing out, vertigo, poor coordination, and loss of balance (Falvo & Holland, 2018). Clients with moderate brain injuries may experience the same symptoms aforementioned but may also experience paralysis (e.g., leg function may not be present), seizures, limited control related to bowel/bladder, ability to regulate body temperature, hormonal changes, perseveration, impulsiveness, language processing deficiencies, executive function limitations, aphasia (i.e., expressive and receptive), slurred speech, partial or total loss of vision, partial or total hearing loss, denial or lack of awareness, and increased psychological symptoms (e.g., depression). We recommend an integrated approach where the counseling professional within the substance-related treatment program collaborate with the BI treatment team. Some questions that might assist the counseling professional in identifying other barriers include:

- *Pre-injury life/habits*: What was the client's life like prior to obtaining the BI?
- *Post-injury life/habits*: What is client's life like now?
- *Rehabilitation process*: Where is the client currently in their rehabilitation process for the BI?
- *Adjustment*: How is the client adjusting to having a BI?
- *Classification of BI*: Does the client have a mild, moderate, or severe BI?
- *Support*: Does the client have a strong support team (e.g., family, friends) in place?
- *Activities of Daily Living (ADLs)*: Does the client have caregivers and support?
- *Architectural Barriers*: Identify and modify any physical barriers to treatment.
- *Cognitive Challenges:* Does the client have challenges with his or her long-term, short-term, and working memory?
- *Secondary Challenges:* Does the client have secondary challenges (such as vision, hearing, dizziness, headache) that need to be considered when making a treatment plan?
- *Expressive Challenges:* Does the client have struggles with communicating
- *Medication:* Are the medications causing any challenges or side effects that affect their daily lives?

Spinal Cord Injury

A spinal cord injury is the result of damage to any part of the spinal cord or nerves at the end of the spinal canal and often causes permanent changes in strength, sensation, and other body functions below the level of the injury (Falvo & Holland, 2018). If a client has a complete spinal cord injury, all of the feeling (sensory) and the ability to control movement is lost below the level of injury. Whereas, an incomplete spinal cord injury would still allow for some motor or sensory function below the level of the injury. A client who has paraplegia will have paralysis in part or all of the trunk, legs, and pelvic organs. Tetraplegia (quadriplegia) is when the arms, hands, trunk, legs, and pelvic organs are affected by the spinal cord injury.

Research has shown that people who acquire a spinal cord injury have suicide rates approximately three times higher than the general population during the first 12 years (Yue, Massaro, Krause, Chen, & Devivo, 2014), and significant depression may require pharmacological intervention (Saulino, 2014). Oftentimes, people with spinal cord injuries will use drugs and/or alcohol to cope with the newly acquired disability. Alcohol can increase skin breakdown through dehydration or forgetting to shift positions. Additionally, the client may forget to catheterize, which can increase the change of having a bladder infection or urinary tract infection. Previous research has shown that having a spinal cord injury reduces the likelihood of having a successful substance abuse recovery (DeLambo et al., 2009). Furthermore, a potential factor influencing successful substance abuse recovery is that people with spinal cord injuries are significantly underemployed or unemployed, and this leads to a greater chance of relapse. Melvin, Davis, and Koch (2012) found that employment is a strong predictor of substance abuse treatment, and yet research (e.g., West, 2008) has found that only 31% of substance abuse treatment facilities in the United States prioritize employment by offering a vocational counseling component. Coviello, Zanis, Wesnoski, and Domis (2009) found that incorporating

vocational counseling within treatment not only led to a reduction in drug use but also to a reduction in crime rates and risky behavior. Therefore, a collaborative approach between a counseling professional and a vocational rehabilitation counselor would be helpful in meeting the employment needs of clients with disabilities. In addition to employment-related obstacles, a counseling professional should also consider the following:

- *Pre-injury life/habits*: What was the client's life like prior to obtaining the spinal cord injury?
- *Post-injury life/habits*: What is the client's life like now?
- *Rehabilitation process*: Is the client required to attend post-acute care for continued treatment of the spinal cord injury?
- *Adjustment*: How is the client adjusting to the spinal cord injury?
- *Support*: What support systems are in place for the client?
- *Activities of Daily Living (ADLs)*: Does the client require the use of caregivers to provide support for ADLs?
- *Architectural Barriers*: Identify and modify any physical barriers to treatment such as inaccessible restrooms, parking, doorways.
- *Medication:* What impact will medication have in terms of side effects?
- *Reminder*: The client may have a longer rehabilitation process.
- *Services*: The client may need flexibility with breaks to relieve pressure from sitting in a wheelchair.

Case Scenario

Sheila is a 17-year-old, white female, who currently lives with her mother and younger brother and sister. Sheila started using marijuana at an early age, and eventually she progressed to the use of heroin. Sheila currently reports that she uses it twice daily and reports having tolerance symptoms and experiences withdrawal symptoms such as headaches when not using. She reports that she is not addicted and is capable of quitting at any time. Recently, she was involved in illegal activities (residential burglary), was arrested, and forced to detoxify in the local county jail. As part of her court hearing, she was offered prison for 2–3 years or to enter a 6-month inpatient substance abuse treatment program. She chose the drug rehabilitation program and was admitted into treatment after spending 25 days in the county jail. Sheila reported that she does not want to be in treatment but would rather be in treatment than jail.

Sheila's parents separated at the age of 15 after her father had an affair with another woman, who is now his current wife. Sheila reports that her father has been an active part of her life when it is convenient for him. She feels that her father left her and his family for another woman and suggests that her father does not make attempts to be involved in her life, except when he needs help with his business (restaurant owner). Sheila has opened up about her problems within her family and how it has impacted her drug use. She says her mom has been consulting with her about her own personal problems and Sheila feels that since she is the oldest child, she needs to listen to her mother's issues. Sheila stated that her mother has recently found a boyfriend. However, the boyfriend uses heroin and other drugs.

Sheila reported that she continues to have relationship issues with her father. Furthermore, Sheila stated that her father only views her as a business opportunity, not as a child. While in jail, Sheila's father did not visit her, and while in treatment, Sheila has only spoken with her father a few times on the phone for approximately 20 minutes each time. Sheila mentioned that usually her father will want to hang up after he is finished talking about things going on in his life. Sheila claimed that she never is able to talk about her issues and wants to tell her father but feels uncomfortable doing so. Sheila wants to ask her father questions related to the divorce and why he left for a new family but doesn't want to make the relationship any worse.

Sheila stated that she has a boyfriend named Mickey, who does not engage in drug usage. Mickey is usually present when Sheila uses heroin with her friends, because he is afraid that she will overdose. Sheila reported that she loves Mickey very much and would like to get married at some point in their

lives. She enjoys writing, reading, and listening to music. She was awarded a scholarship for her writing during her junior year of high school. She reported she was kicked out of school for never attending but would like to go to college one day. Sheila reported that her father mentioned several years ago that he wanted her to take over the family business, but this was before he had children with his new wife. Sheila has obtained enough credit hours to be at the sophomore level of high school. She is afraid that if she returns, she will be judged negatively for being behind. She stated she would like to attend college for journalism or creative writing if she ever graduates.

Discussion Questions

1. What are some potential challenges that Sheila faces?

2. What stage of change do you feel that Sheila would be in and why?

3. The scenario states that Sheila was mandated to inpatient treatment. Is this the most appropriate level of care for Sheila? Please provide rationale to support your response.

4. What are some potential goals, objectives, and action plans that the client may have?

5. What other treatments would you recommend for Sheila?

Homework Activity

Movie/Television Series Character Treatment Plan Assignment

Directions:

1. Select a movie or a television series where a main character presents an issue with drugs and/or alcohol.
2. Write a paragraph not less than 250 words about how this movie/television series is personally meaningful to you. Describe the interaction of your chosen character with the other characters. What did you like or dislike about the character? How might your dislikes impact the counseling relationships? Any other observations, patterns, or connections that you think are important to document?
3. Compare the individual to topics discussed throughout this textbook. Does the character meet criteria for substance-related disorders? What behavior is the character displaying that would lead you to this conclusion? Are there any cultural dimensions that should be considered in a treatment plan? Would you use any psychological testing and if so, why would this be beneficial? What are some counseling theories that might be useful when working with this client? What are the primary issues you notice related to the character that might be an obstacle during the treatment recovery process?

Counseling Treatment Plan:

1. Write the counseling treatment plan for the character you have chosen. The treatment plan should consist of 2–3 long-term goals, 2–3 short-term goals/objectives for each long-term goal, and not less than 6 specific treatment-goal-targeted interventions/action steps.

   a. The character I chose as a hypothetical client is:

   Name of Client:
   Name of Movie:

   b. **Presenting Problems:** The movie indicated that this character may have the following clinical issues. These will include any problems or barriers that the character may have. Are there any patterns that the character is displaying that could become problematic?

   Problem #1:
   Problem #2:
   Problem #3:
   Problem #4:

   c. **Treatment Goals:** Oftentimes, once there are several problems identified, treatment goals would be developed to reduce or eliminate these problems. For example, Bryan had difficulty maintaining employment, which he described as being a contributing factor to him using alcohol (cope with lack of stable employment). A treatment goal was developed to reduce this barrier. If I were treating this character as a professional counselor, I would include the following treatment goals in my plan.

   d. **Treatment Interventions:** In order to meet these treatment goals, I would provide the specific, time-limited, observable, logical, and targeted treatment interventions. Remember, we are using the S.M.A.R.T. framework to write our treatment goals. Below is an example of how the treatment goals can be written with the short-term objectives and action steps.

   Long-term Goal #1:
   - Short-term objective#1:
     - Intervention/Action Step 1:
     - Intervention/Action Step 2:
     - Intervention/Action Step 3:
     - Intervention/Action Step 4:
     - Intervention/Action Step 5:
     - Intervention/Action Step 6:
   - Short-term objective#2:
     - Intervention/Action Step 1:
     - Intervention/Action Step 2:
     - Intervention/Action Step 3:
     - Intervention/Action Step 4:
     - Intervention/Action Step 5:
     - Intervention/Action Step 6:

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