Perceptions of Treatment Plan Goals of People in Psychiatric Rehabilitation

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Abstract

Collaborative treatment planning is a process by which providers and consumers work together to set goals for treatment, choose between alternative services, and establish a plan. Research has not examined consumers' views of their treatment plan goals. The present study examined ways in which consumers react to their treatment plan goals. Twenty-one interviews with Veterans engaged in psychiatric rehabilitation regarding goals listed in their treatment plan were analyzed using inductive content analysis. Reactions to treatment plan goals are reported. Analyses indicate people do not vary in a linear degree regarding agreement with treatment plan goals. Clinicians and researchers should examine the extent to which treatment plan goals are consistent with the consumer's personal goals and self-concept.

Perceptions of Treatment Plan Goals of People in Psychiatric Rehabilitation

Collaborative treatment planning is a process by which mental healthcare providers and consumers of services work together to set goals for treatment, choose between alternative services, and establish a plan (c.f.).[1] Several groups have attempted to increase the collaborative nature of treatment planning.[2-4] Collaborative treatment planning seeks to empower consumers, increase investment in treatment, and "enhances his or her motivation, investment, self-esteem, and sense of achievement, leading to greater independence and self-mastery." [5(p.5)]

A key outcome in collaborative treatment planning is the production of high quality treatment goals. Substantial research has supported the importance of goal setting in increasing goal-related efforts and performance, and goal setting holds several potential benefits for rehabilitation efforts, such as improving consumer outcomes, supporting consumer autonomy, meeting contractual obligations, and may serve as a meaningful outcome in-and-of itself.[6,7] To this end, Clarke, Oades, Crowe, Caputi, and Deane[8] found that the goal attainment mediated the relationship between symptom distress and self-rated recovery, thus providing an empirical link between goals and consumer recovery.[8] Despite its promise, Levack, Taylor, et al. note that goal setting interventions have had inconsistent outcomes.[9] They conclude that these results may, at least in part, be due to variability in the goal-setting process, which can impact the quality and effectiveness of goals.

Treatment plans are critical to collaborative coordination of mental health services, and the goals can represent an important indicator of shared decision-making within psychiatric rehabilitation. Moreover, treatment plans have intrinsic value as a means by which the treatment team communicates. Despite their importance, extant research indicates treatment plans are often neglected in practice. Research from the intellectual disability literature indicates that treatment

plans are infrequently completed, updated, reviewed, or used to organize care. For example, Mansell and Beadle-Brown found treatment plans often did not reflect a collaborative effort; consumers were typically not present when the plan was created.[10] Additionally, key indicators of quality were lacking (e.g., goal were not specific/measurable). As they summarize, "in this situation, individualized planning becomes a kind of displacement activity, using staff energy, time and resources but not making any differences to people's lives."[10(p.6)] Summarizing a care management reorganization, Cambridge and colleagues state, "despite being person-centered in design and principle, [treatment plans] were in practice led by professionals, operated as a paper exercise or administratively driven."[11(p.1049)]

Despite calls for collaboration in mental health treatment planning, too little research has explored the perspective of the individual receiving services. The consumer is particularly important because his or her agreement with the treatment plan goal, as well as his or her understanding and self-efficacy in accomplishing the goal, should greatly affect success of the plan. To wit, the degree of goal agreement between the individual and provider is linked to increased satisfaction, decreased distress, reduced symptomatology, and improved rehabilitation outcomes.[12,13] The more the individual is actively engaged in setting goals, the better their rehabilitation outcomes.[14] Broadly speaking, agreeing upon common goals for treatment is a core element of therapeutic alliance, a common element of success across diverse psychotherapeutic interventions.[15]

In order to ensure such a shared agenda exists and to reinforce a collaborative goal-setting process, several authors have called for the assessment of agreement or importance of treatment plan goals.[8,16,17] We hoped to inform this process by examining consumers' reaction to their treatment plan goals in the context of a semi-structured interview. More specifically, we

strive to answer two, interrelated questions. What types of reactions do consumers have to their treatment plan goals? For instance, do consumers tend to have dichotomous (agree/disagree) reactions, or are reactions more nuanced and in what ways? Secondly, how does this reaction relate to their personal and clinical context (e.g., their own personal goals and relationship with their treatment provider)?

Method

Study Overview

The present study is a cross sectional, qualitative study of how Veterans engaged in psychiatric rehabilitation talk about treatment plans. We interviewed a sample of Veterans with a recent treatment plan to learn more about how they talked about treatment goals. We used a conventional content analysis to identify common themes across participants.[18]

Sample & Study Context

Participants were Veterans served by one Veteran's Administration Medical Center. The mental health needs within the VA population are great, with higher rates of PTSD, Major Depression, and General Anxiety present in comparison to the general population.[19-24] Although the service needs appear high, studies have shown that the Veteran population encounters barriers to care including perceived negative attitudes and stigma surrounding mental health services; as few as 23-40% of veterans diagnosed with a mental illness seek help for their disorder.[22-24]

Participants included 21 Veterans with severe mental illness served by the psychosocial rehabilitation and recovery center (PRRC) or mental health intensive case management (MHICM) team at the [location] VAMC. Inclusion criteria for these teams include a diagnosis of

major mental illness and a Global Assessment of Functioning (GAF) score of 50 or below. Admission criteria for the MHICM team are more stringent, with additional criteria targeting Veterans with more severe impairments (e.g., 30 days of inpatient hospitalization or 3 admissions within one year). Participants were recruited based on the completion or review of a treatment plan within the past three weeks. Participating Veterans were mostly male (n = 18, 86%) and were either White (n = 16, 76%) or Black (n = 5, 24%), with an average age of 55 (SD = 10.26). Eras of military service included Vietnam and/or Post-Vietnam (n = 18, 85.7%), (n = 7, 33.3%), Persian Gulf and/or Post-Persian Gulf (n = 2, 9.5%), and OEF/OIF (n = 1, 4.7%). Branch of service included Army (n = 9, 42.9%), National Guard (n = 2, 9.5%), Marine Corps (n = 3, 14.3%), Navy (n = 4, 19.0%), Air Force (n = 1, 4.8%), and more than one branch (n = 2, 9.5%). Most participants were served by the PRRC (n = 19, 90%) and primary diagnoses included schizophrenia-spectrum disorders (n = 14, 67%) or affective disorders (n = 7, 33%). Health records indicate that 9 participants had been exposed to trauma (42.9%), 3 of whom had combat related trauma indicated.

Goal setting and treatment planning within these teams is not uniform across providers. Each Veteran is assigned one clinician who is responsible for creating and updating the Veteran's treatment plan. While clinicians are encouraged to meet with the Veteran to collaboratively create the treatment plan, this standard is not necessarily followed or documented in the medical record.

Procedures

In order to recruit participants, clinic staff periodically provided a list of Veterans whose treatment plan had been updated recently. Medical charts were scanned to ensure inclusion criteria were met, and Veterans were then sent letters, followed by a phone call to invite them to

participate. A total of 112 names were forwarded to the research team, of which 48 (42.9%) could not be reached despite numerous attempts, 34 (30.4%) declined to participate, 8 (7.1%) agreed to participate but did not come to scheduled interviews. Interviews were conducted by a clinical psychologist [author 1] or a research assistant. Interviews were capped at one hour. The study was approved by the [university] IRB and VA Research and Development Committee.

Measures

The interview guide was developed based on goal setting theory and developed to elicit information needed to evaluate goal factors demonstrated within that framework to affect goal-related performance (see Table 1). [25-28] Interviews generally took one full hour. An exhaustive list of personal goals was elicited by non-directive prompting (e.g., "what else?"). The participant was asked questions specific to two personal goals and up to two goals listed in the participant's most recent treatment plan (as time allowed). Interviewers asked all questions in the interview guide, but were also encouraged to ask probing questions for better understanding and depth and to ask additional questions to follow sub-themes of interest.

Analyses

Conventional content analysis was used to analyze the data because the aim was to describe a phenomenon in which there as scarce theory to inform analyses.[18] The analysis team consisted of a clinical psychologist and an undergraduate psychology student. Each transcript was read independently in a process of open coding, where text was highlighted for instances in which the participant talked about the treatment plan goal. Text was included if it pertained to the treatment plan goal directly, regardless of whether it was in response to questions specifically about treatment plan goals. Meetings occurred regularly to discuss observations. This procedure continued with new transcripts, developing a set of working codes that were modified, combined,

or deleted as additional transcripts were read and a greater understanding of the data was obtained. Consensually derived codes were independently applied to subsequent transcripts; the research team continued to meet to discuss and refine the coding, until the codebook remained stable and consistent (8 codes; e.g., agreement, explicit link between treatment plan goal and personal goal).

Originally, themes were aligned linearly by varying degrees of acceptance of and agreement with treatment plan goals (e.g., acceptance only, acceptance and distancing/disagreeing, etc.). All transcripts were coded according to these codes and information was placed in a goal by code matrix. This matrix was examined and clusters of reactions to treatment plan goals emerged. Each case within these groupings was examined, allowing for the identification of common themes and, in several cases, groupings that were heterogeneous and fit better with other cases from other groupings. What resulted was the five reactions to treatment plan goals discussed below.

Results

"That's my words" & Agreement

Three participants indicated the treatment plan goal was derived directly from their stated goal. One participant stated "yeah, that's my actual goal" (Participant 19). This participant's treatment plan goal was *absence or minimum experience of paranoia, fear, and anxiety*. The participant described how his fear of leaving the house negatively affected his life: "It's hard for me to go to the grocery, to be out walking. 'Cause I do get paranoid. I feel like I'm going to have an accident. And I just don't know how to take people sometimes. So, I tend to just stay in the trailer, read." He goes on to describe how this his symptoms affect his social life: "Seems like

friends that I have, I only have a couple…if I wasn't fearful or paranoid, I'd be able to ask them to come over."

Another participant responded to hearing her treatment plan goal of *get mentally healthy* with "that's my words" (Participant 11). She described how this goal represented many meaningful aspects of her recovery journey. "Because one time in my life, I was suicidal... when you're doing 'stinking thinking' it's a pity party. You can overcome being suicidal…but you can't do it if you're stinking thinking." Instead, she had learned to "not rely on just one friend," "prayer," and "learn how to be positive." These strategies for overcoming suicidality and depression for her were encapsulated in "get mentally healthy."

A final participant indicated the treatment plan goal was his, "just saying it in a different way" (Participant 16). Interestingly, this participant strongly endorsed the first treatment plan goal, but appeared to have no understanding of his second treatment plan goal: "I'm lost on that. I'm not supposed to…I mean, I don't know" (Participant 16).

Several other participants agreed a goal was relevant, but did not speak of the goals as if they themselves actually created the goal in the way the "that's my words" group did. One participant fully endorsed the treatment plan goal as currently important: "I have a plan but I don't stick to it… jus' to stop and think before I put my mouth in gear. Cause I always end up putting my foot in my mouth. And I'm sorry for what I'd done after I done it." Further, he endorses the importance of working toward the goal as written, stating "if I could just get around [having outbursts] or find a way to get around that, it'd just tickle me to death" (Participant 15). The consumer talks about the importance of the goal, but never refers to it as "my goal" or indicates the words came from him. It rather appears as a goal that was set for him, but with which he agrees.

Another participant agreed with his treatment plan goal, stating "right now [drinking] *can't* be part of my life; everything else is too important." (Participant 20). However, this participant notes that "later on down the road, if I feel ok…maybe I can go back to having alcohol" (Participant 20), indicating that although he endorses the goal now, he reserves the right to change it later. This participant's main focus was on his PTSD and legal and employment difficulties that he sees as secondary to his PTSD. He views his substance abuse in the same light:

> I'm not sure I'm an alcoholic or not. I'll be honest. I go to AA meetings as a way to further my treatment but, I've done extensive research on PTSD and you know, some of the rule of thought is if you can control the PTSD, you can control substance abuse. And I never was a substance abuser before until after this, so I'm optimistic that no matter what, if I fix-, if I'm able to deal with the PTSD, everything else will fall in place, as should.

Conflicting Reports: It Is Not a Problem (Except It Is)

Four participants displayed conflicting perspectives regarding the relevance of the treatment plan goal and/or the origin of the treatment plan goal. One participant outright rejected the treatment plan goal: "Suicide? I don't think I'm going to try to kill myself. I'm not trying to harm myself. Just when we get stuff done, [I will] get the hell away from here. I ain't going to hurt myself, period" (Participant 10). Later in the interview, though, she reports a few months prior to the interview "I told them I tried to drown myself in the water because I was itching real bad. Now that could be what it is." And "No. No. No. I tried [suicide] once when I was 16. But I was young and dumb fool. And I took some pills. And I never done nothing before in my life.

But I am never going to hurt myself." The participant repeatedly states that she would "never" attempt suicide, while reporting prior suicide attempts.

Another participant initially accepted the relevance of the treatment plan goal: "I've been having a lot of trouble with getting upset at my daughter-in-law." (Participant 3) She then proceeded to talk about her anger as if it was a *past* issue that was no longer relevant: "I've gotten into it with my neighbors before…but I haven't done anything so far with against the neighbors that I have now." (Participant 3). However, she admitted that she did "get into it" with another Veteran the previous week.

Two participants did not outright reject the treatment plan goal, but distanced themselves and ascribed the goal to their treatment providers. For one participant his previously stated goal was "To pull my family close…closer, because this kind of pushed us apart a little bit. My immediate family – wife and children-- because of their lack of understanding of the disposition that I have." (Participant 12). The interviewer probed further:

> INTERVIEWER: … the goal in the [treatment] plan is: *the veteran's family relationships will be strengthened*, which sounds familiar from what you said before. Just to kind of review – how did this goal come about?
>
> PARTICIPANT: In the treatment…Um, that was determined by a physician. And that's [clears throat] after having, uh, they diagnosed me uh, certain parameters were established that I should probably follow (Participant 12).

Although the treatment plan goal and personal goal appear to be almost identical, the Veteran did not endorse the treatment plan goal as his own. Upon closer examination, the goals were actually fundamentally different. The treatment plan goal was about "strengthening" the relationships, whereas the Veteran actually talked about his family "understanding" him and his

diagnosis more. Moreover, the Veteran's vision for his family relationship was not one of mutuality: "you might get feedback from the group…but ultimately, the end result should come from myself… It would be dominance" (Participant 12).

It's a Problem, But…

Seven participants agreed that the issue addressed by the treatment plan goal was a pertinent problem for them; however, they altered the targeted goal either in content or level. Two participants had treatment plan goals of reduction of suicidal ideation, which they agreed was an important problem: "I guess it's not good to think of killing yourself or suicidal thoughts" (Participant 1). However, they both reported their actual focus was on something different.

> So, I guess in a way it's not a goal you can directly work on. It's a goal you got to work around kind of. Ok so I mean just thinking, 'ok, I won't think of killing myself' isn't really accomplishing the goal. But accomplishing other goals and occupying time accomplishes that goal…I guess [my goal is] occupy my time…the things I do give me a feel of accomplishment…I guess if you're on an emotional high, you know, it takes out those thoughts [of suicide]. (Participant 1)

Another participant, while agreeing suicidal thoughts has been a problem, reported his main focus was "just [to] keep me from getting locked up" (Participant 4). Reducing suicidal thoughts would accomplish that goal. Another participant agreed it was important to "interact with others without defensiveness or anger" and further stated "well, in the past, when I was drinking, it was very easy to take offense at any slight that was thrown my way, and I would act in an inappropriate way." He is committed to this goal, but it is not his primary focus. Rather, it would aid him in his personal goals: "Well first of all, my job relationships would go better. My

friends and family relationship would go better. And, I wouldn't get fired for doing inappropriate things" (Participant 7).

While the above differed in content or focus, others disagreed in extent. For instance, one participant's treatment plan goal was "minimum experience of paranoia, fear and anxiety," whereas he said his goal was "having none at all" (Participant 6). A final participant agreed quitting substance use was a good idea, but only "in the long term" (Participant 21), but did not intend to pursue this goal presently.

Maintenance

Five participants indicated that the treatment plan goal focused on maintaining the alleviation of past problems. For instance, one participant, who had not been hospitalized for at least the past five years, had a treatment plan goal of *prevention of relapse of mental illness.* The participant agreed with this goal, stating "I don't want to get in that position where I say I'm not taking my medicine…I don't want to end up in the hospital or nothing" (Participant 14). Similarly, one participant stated "Well, I don't have the trouble I used to, but I know I have to maintain with my medicine. As long as I maintain with my medicine, taking my medicine" (Participant 8); however, this participant reported residual symptoms such as "Well, I still hear voices. [A] state policeman follows me home. He's been following me for years. My father's dead, too. He's been dead for 30 years. I still hear from him" (Participant 8). The participant appeared resigned to this level of symptoms.

Another participant, whose treatment plan goal was to *attend psychiatric treatment modalities* initially stated "I had a choice: go there, or go to jail" (Participant 9). He went on to say that he continues with treatment in order to avoid trouble: "If I take some medicine, I can help meet my goal, if I don't take it, I get opinionated and loud; I have an opinion and people

don't like it…I take my medicine. It keeps me out of trouble." This participant seemed to continually come back to the theme of taking his medication for the purposes of avoiding "problems." The participant never voiced any hopes or dreams for the future; regarding his personal goals he stated: "It'd be a normal thing, if I met my goal. And that's when I take my medicine" (Participant 9). This lack of future goals was somewhat common in participants in this category. Desired future states were often vague, such as:

> Okay, bettering myself in the treatment plan probably, as far as knowing what my condition is, okay, bettering myself would probably be taking steps towards what's required to meet my treatment plan, as far as what I need to do, what I don't need to do, as far as like on my treatment, to keep my treatment up to par where I'm in good health and good thoughts, good thinking, and well, just probably bettering myself [Participant 14].

Notably, this was the participant's own goal, as stated before the topic of treatment plan goal was introduced by the interviewer. In general, treatment goals in this category were focused on maintaining use of mental health services without any link between what mental health services would allow them to do that was important to them.

Total Rejection

One participant completely rejected his treatment plan goal, stating "I don't have the paranoia. I have a little bit of anxiety but I don't know if it's from that or what it's really from…I don't know where that came from. I never heard about that before. I didn't do it, so, I don't know" (Participant 13). The participant does not endorse any past or current problem with paranoia and generally rejects his diagnosis: "I don't know. I just-, when I got here it just seemed like everybody wanted to label and that was about it. When you got down to it, 'What? Do you

think I got [schizophrenia]?' This, that, and the other, just fell apart" (Participant 13). This participant's medical records indicated a fixed persecutory delusion and often noted "lack of insight."

Another participant was confused by the treatment plan goal—*Veteran will demonstrate evidence of less negative symptoms*. The participant appeared to not understand the technical language used, therefore the interviewer explained it in layman's terms. After the interviewer explained the terminology, the Veteran rejected the goal: "Yeah. I understand what it means. Yeah. I guess it kind of makes me [at a] loss cause I don't remember going to much depth on it. So…I could have talked about it and forgot, but…" (Participant 1). As with the other participant in this category, the participant showed signs that he struggled building a working alliance with his provider: "I guess I started coming here for counseling almost a year ago so. That's been going, I guess I have some trouble with it. Talking about problems." However, this participant reports progress: "Well, I guess sometimes that maybe I talk to the counselor more. When you set goals and set to do something when you come back and don't accomplish it, it's kind of like, you know, nagged so it kind of helps promote you."

Discussion

The first question posed by the research team, was regarding the nature of consumer reactions to their treatment plan goals. Aanalyses indicate people do not vary in a linear degree regarding agreement with treatment plan goals (i.e., disagree, agree, agree strongly). Some goals appeared to be partially accepted in that they address a problem with salience to the person; however, the level or form of the goal is incongruent with the consumer's perceptions. In these cases, the person may adapt the goal to suit her own needs. Other goals are more complex. For instance, several goals were rejected for not being salient for the person; however, to the outside

observer, the treatment goals very much were relevant. Several explanations for these apparent contradictions should be considered.

A treatment plan goal may seem almost identical to a personal goal; however, upon closer examination the two goals differ fundamentally. One Veteran's goals were both about his familial relationship and to the interviewer appeared the same; however, the treatment plan was about "strengthening" the relationship while the Veteran emphasized understanding and "dominance." This subtle but crucial difference highlights the complexity of the communication process necessary to create a collaborative treatment plan. The consumer has to understand what his goal is and express it, while the provider must understand what the consumer is trying to say, and record the goal in the treatment plan such that the goal will be actionable, understandable by other treatment team members, and meet regulatory requirements. Unfortunately, missteps at any of these junctures can result in a suboptimal treatment plan.

Another issue which affects agreement with goals is often labeled "insight." Anosognosia, or lack of awareness of symptoms or functioning, is a well-documented aspect of psychotic disorders.[29] Some consumers may fail to realize that treatment plan goals are addressing symptoms that do affect their lives. Both of the consumers with goals in the Total Rejection category were diagnosed with psychotic disorders; this reaction could plausibly be related to anosognosia. It is also possible that distancing is more conscious or active. For example, Veterans may feel shame for past behaviors and wish to deny them either to others or to themselves. Veterans with Conflicting Reports, such as the woman who "would never kill" herself, but had multiple suicide attempts and threats, may be more indicative of this phenomenon. Her denial of the relevance of the goal likely arose from her own desire to personally distance from these past behaviors than from an inherent inability to recognize

disease-related deficits. Nonetheless, in situations of anosognosia or distancing, clinicians may be put in a position in which they correctly observe relevant areas for treatment, but the Veteran does not endorse the goal.

The Maintenance group, in particular, highlight the importance of evaluating not just whether the consumer agrees with the treatment plan goal, or whether they believe the goal to be important, but rather *why* they view a goal as important. As outlined by Sheldon and Elliot, while autonomous importance (the degree goals are integrated into the core volitional self) is related to goal pursuit and achievement, importance due to controlled motivation (i.e., motivation due to external reward/punishment or motivation due to feared negative affect resulting from failure) is not.[30] Consumers in the Maintenance group could not articulate any authentic motivation for the goals they endorsed. They maintained treatment in order to "not get in trouble" or "not end up in the hospital." This is in contrast to Veterans in the That's My Words category whose goals were linked to multiple areas of their identity (parent, employee, law-abiding citizen).

This study adds to the growing literature documenting the difficulty in executing collaborative treatment planning.[1,31] Chinman et al. noted that difficulties exist both on the consumer and provider side in collaborative treatment planning.[1] We note ruptures in communication can also take place in the creation of or consumption of the treatment plan itself.

An important methodological implication of this study is that treatment plans should be evaluated at the level of individual goal rather than the overall treatment plan. Two goals on a Veteran's treatment plan were rarely reacted to in the same way. Moreover, one goal may meet certain quality criteria (e.g., specificity, importance, achievability) whereas another goal within the same treatment plan may not.[8] It is unclear how differing qualities of goals on a treatment plan may affect key outcomes such as engagement in treatment, successful discharge, and

therapeutic alliance. The interactive effect between goals is also unknown. For instance, does one high quality goal compensate for other goals being of poor quality?

A final point is that consumer-directedness must often be balanced with regulatory and safety concerns. For instance, one Veteran completely denied suicidal tendencies, but was at risk based on past attempts. The Veteran's treatment plan clearly should address suicidality; however, the Veteran would likely rate this goal as low on importance and take little ownership of the goal. From a clinical perspective, this phenomenon emphasizes the role for stage-wise and motivational approaches to treatment planning.[32,33]

Limitations

The current study has several limitations. The sample was one of convenience and a large percentage of potentially eligible participants could not be reached or declined to participate. Therefore results are not be generalizable to all consumers. Nonetheless, the results elucidate themes relevant to a segment of consumers. Another limitation is the lack of criteria by which to validate the importance of these themes. For example, it is possible that even consumers who reject goals are just as likely to successfully recover as those who claim goal ownership; however, previous literature suggests that goals set by others are predictive of goal striving and success only to the extent that they are internalized.[6] Additionally, in deference to participant burden, interviews were limited to one hour and therefore not all of participants' goals were discussed. Discussion of all goals would have added depth to the discussion and significant information may have been excluded.

Implications for Behavioral Health

This study points to the complex relationship that exists between consumers, providers, and the treatment plan. The study elucidates the non-linearity of consumer endorsement of goals. Not surprisingly, consumers may feel ambivalence regarding goals or may baulk at endorsing the relevance of problem areas that are embarrassing. Future research should explore the relationship between consumers' relationship with treatment plan goals and goal striving and other measures of recovery.

Conflict of Interest Statement

The authors are not aware of any existing or potential conflicts of interest.

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