IGDA. 9: Linking diagnosis to care – treatment planning

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9.1

Clinical care starts with the first diagnostic interview. Therapeutic planning and prognosis should be based on competently conducted and documented comprehensive diagnosis, i.e. a standardised multi-axial formulation covering clinical disorders, disabilities, contextual problems and quality of life, as well as an idiographic or personalised formulation articulating the perspectives of the clinician with those of the patient and family on contextualised clinical problems, the patient's positive factors, and expectations about restoration and promotion of health.

9.2

The treatment or care plan involves a listing of clinical problems as targets for treatment and the formulation of a programme of care for each one of them.

9.3

The elements for constructing a list of clinical problems come from the set of clinical disorders, disabilities and contextual factors presented in the multi-axial diagnostic formulation as well as from considerations presented in the idiographic formulation. Each problem should be delineated as a target of a cohesive programme of care. The list of problems should be kept reasonably short to prevent any duplication of treatment programmes and to avoid burdening the clinician with excessive documentation.

9.4

The programme of care planned for each identified problem might include biological (e.g. pharmacological and electroconvulsive therapy), psychological (e.g. psychodynamic and cognitive–behavioural therapy) and social (e.g. family and group therapies, educational and vocational rehabilitation, housing assistance) therapies as well as additional diagnostic studies (e.g. imaging, IQ testing, cultural consultation). Every planned intervention should be specifically and clearly described.

9.5

Although disorder-based treatment algorithms and practice guidelines may be helpful as references, actual programmes of care should be personalised, giving attention to illness complexity (e.g. comorbidity, pattern of disabilities and contextual factors), range of patient's assets, and local treatment resources and health care norms.

9.6

All elements of the care plan – listing of clinical problems and specific interventions – should be worked out collaboratively between the clinician and the patient (and family members where appropriate). Efforts should be made to reconcile expectations about treatment goals and to achieve shared awareness of the likely benefits and side-effects of the selected therapies.

9.7

As multi-disciplinary teams are usually required for effective health care, all key members of the team must participate in the design of the treatment plan. This plan should facilitate professional communication among all team members working with a particular patient, and promote fully coordinated therapeutic efforts.

9.8

Prognosis should be based on a comprehensive diagnostic formulation rather than just on a single disorder. Comorbid psychopathological, substance misuse and personality disorders, concomitant general medical conditions, occupational and interpersonal disabilities, available social supports and therapeutic resources, as well as idiographic perspectives on contextualised clinical problems, patient's assets and expectations, are all relevant to the prediction of illness course and therapeutic outcome. Outcome itself is a pluralistic concept, involving symptom remission, functional improvement, activation of supports and enhancement of quality of life.

9.9

Clinician–patient engagement and partnership is as important for care planning as it is for diagnostic formulation. Such engagement involves awareness of the cultural framework of both the experience of illness and the process of seeking and providing help. Clinical care includes not only curative efforts but also empathic consolation and promotion of healthy behaviour and quality of life. Engaging the patient is critical for the attainment of therapeutic effectiveness and the fulfilment of ethical responsibilities.

9.10

The linking of comprehensive diagnosis to comprehensive treatment can be facilitated by the use of a treatment plan format. This should be completed jointly by all members of the clinical team working with the patient (who should also be involved in the process). A prototype treatment plan form, enabling the listing of clinical problems to be linked with specific interventions and allowing space for special observations, is set out in Fig. 9.1.

FURTHER READING

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https://doi.org/10.1192/bjp.182.45.s58 Published online by Cambridge University Press

TREATMENT PLAN

Name: _____ Record no: _____ Date (d/m/y): _____

Age: _____ Gender: ☐ M ☐ F Marital status: _____ Occupation: _____

Clinicians involved: _____

Setting: _____

Instructions

Under 'Clinical problems' list as targets for care key clinical disorders, disabilities and contextual problems presented in the multi-axial diagnostic formulation, as well as problems noted in the idiographic formulation. After the problem name, consider listing its key descriptors. Keep the list as simple and short as possible. Consolidate into one encompassing term all problems that share the same intervention.

'Interventions' should list diagnostic studies as well as treatment and health promotion activities pertinent to each clinical problem. Be as specific as possible in identifying the type of treatment, doses and schedules, amounts and time frames, as well as the clinicians responsible.

The space for 'Observations' may be used in a flexible way as needed. It might include target dates for problem resolution, dates of scheduled reassessments, and notes that a problem has been resolved or has become inactive.

Clinical problems	Interventions	Observations

Fig. 9.1 Blank form for recording the chosen treatment plan. This form may be photocopied free of charge for use in clinical practice.

https://doi.org/10.1192/bjp.182.45.s58 Published online by Cambridge University Press