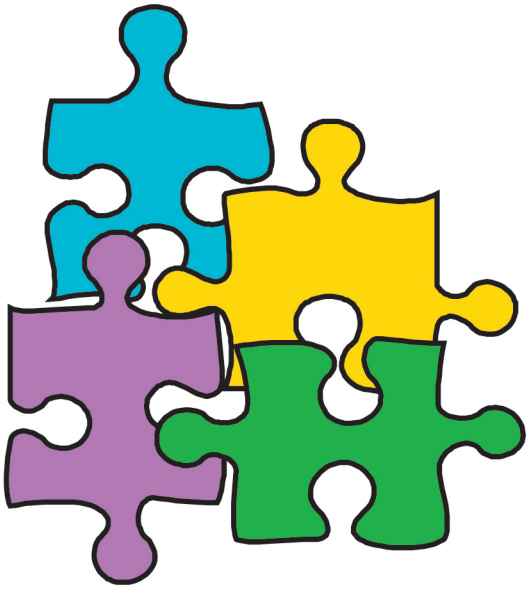
Treatment Planning M.A.T.R.S.:

Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful



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blending initiative
NIDA•SAMHSA

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At the time of publication, Terry Cline, Ph.D., served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as CSAT Director; Catherine D. Nugent. MS, LGPC, Senior Public Health Advisor serving as the CSAT Project Officer; and Nora D. Volkow, MD, served as the Director of NIDA.

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Introduction

This curriculum was developed as part of a collaborative initiative designed to blend resources, information, and skills in order to encourage the use of evidence-based methods by professionals in the drug abuse treatment field. The Blending Initiative was developed in 2001 by the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The interagency agreement was designed to meld science and practice together to improve drug abuse and addiction treatment.

"Blending Teams," comprised of staff from CSAT's Addiction Technology Transfer Center (ATTC) Network and NIDA researchers, have been charged with the development of plans and resources for promoting diffusion of particular research findings using a number of different mechanisms for effective adoption and implementation, such as trainings, self-study programs, workshops, and distance learning opportunities.

The Addiction Technology Transfer Center Network is pleased to release the 2007 revised "ASI-Based Treatment Planning" Blending Team product: *Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index to Make Data Collection Useful.* All of the elements of this Blending Team product are referred to as "ASI-Based Treatment Planning" materials.

This Blending Team product, initially published in 2005 as *S.M.A.R.T. Treatment Planning Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful*, was revised in 2007 and reflects the current best practices as outlined in the 2006 updated version of the *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (The Competencies/TAP 21).*

The Competencies/TAP 21 has become a benchmark by which curricula are developed and educational programs and professional standards are measured for the field of substance use disorders treatment in the United States. Two of the eight Practice Dimensions outlined in *The Competencies/ TAP 21*—specifically Clinical Evaluation and Treatment Planning—were revised in the 2006 edition to reflect current best practices. These revisions to *The Competencies/TAP 21* are incorporated into the 2007 edition of the "ASI-Based Treatment Planning" Blending Team materials.

The outpouring of interest and feedback we have received from training participants and the focus on updating best practices in treatment planning in the newest edition of *The Competencies/TAP 21* confirms what we already know: helping practitioners develop excellent treatment planning skills ***matters*** for consumer's recovery.

More information on the "ASI-Based Treatment Planning" Blending Team products may be obtained on the Addiction Technology Transfer Center Network Web site at http://www.nattc.org.

Background and Rationale for the Course

This course seeks to transform required "paperwork" into clinically useful information. The Addiction Severity Index (ASI) is one of the most widely used tools for the assessment of substance use-related problems. Addiction counselors working in community-based treatment centers administer the ASI yet often fail to use findings to identify client problems, develop individualized treatment plans, and make referrals matched to client needs. Intake workers, counselors, supervisors, and managers often view the ASI assessment as time consuming and not clinically useful. From a program management perspective, supervisors and administrators often do not utilize treatment plans to monitor treatment outcomes and/or client retention. This course will review how to use the ASI to integrate these clinical processes.

Curriculum Development

This *NIDA/SAMHSA-ATTC Blending Initiative* is based on the work of a team comprised of staff from CSAT's Addiction Technology Transfer Center (ATTC) Network and NIDA researchers. The Blending Team members for the initiative were:

SAMHSA/CSAT:

Pat Stilen, Mid-America ATTC
Nancy Roget, Mountain West ATTC
Dick Spence, Gulf Coast ATTC

NIDA:

Deni Carise, Treatment Research Institute
Tom McLellan, Treatment Research Institute
Meghan Love, Treatment Research Institute

Pat Stilen of the Mid-America ATTC is the primary author of the classroom version of this one-day training package. An expanded team of persons who contributed to this curriculum are listed in the Acknowledgements page.

Training Objectives

1. Examine how Addiction Severity Index information can be used for clinical applications and assist in program evaluation activities.
2. Identify differences between program-driven and individualized treatment planning processes.
3. Gain a familiarization with the process of treatment planning including considerations in writing and prioritizing problem and goal statements and developing measurable, attainable, time-limited, realistic, and specific (M.A.T.R.S.) objectives and interventions.
4. Define basic guidelines and legal considerations in documenting client status.
5. Provide opportunities to practice incorporating the Addiction Severity Index information in treatment planning and documentation activities through use of the Addiction Severity Index Narrative Report and case examples.

Course Limitations

This is not a course on administering, scoring, or understanding the Addiction Severity Index. This curriculum assumes that trainees already have a basic understanding of the ASI, but there are no pre-requisite skills required in administrating the ASI instrument. A sample ASI Narrative Report and Master Problem List will be provided as handouts for reference purposes.

Course Themes

- Addiction Severity Index (ASI) Applications in Treatment Planning
- Individualized Treatment Plans vs. Program-Driven Plans
- Evaluation Uses for Program Directors and Clinical Supervisors
- Role of Treatment Plan in Clinical Records
- Experiential Writing Exercises

Other Resources Available

Visit the Web site of the Treatment Research Institute (TRI) for additional information on the ASI, the DENS automated assessment and reporting system for the ASI, and other related instruments and manuals. The TRI Web site may be accessed at www.tresearch.org for these and other resources.

Course Specifications

Number of Trainers: 1 or 2 (Training Teams of two or more are recommended.)

Trainer Experience and Knowledge Base:

Co-trainers' **combined professional experiences and knowledge base** should include experience in:

1. Administering and scoring the ASI
2. Providing clinical treatment and clinical supervision
3. Application of regional and state clinical record requirements
4. Presenting both didactic information and skill-based training in classroom settings
5. Creating and utilizing treatment plans
    - Differentiating between program-driven and individualized treatment plans
    - Developing a Master Problems List
    - Generating goal, objective, and intervention statements
    - Involving the client and/or significant others in developing treatment plans

Recommended Number of Participants: 15 to 35

Recommended Audience: Addiction counselors, clinical supervisors, and program managers

Time Required: 6 hours

Instructional Materials: Participant handouts for Modules 1-4
Slide handouts (optional)

Equipment/Supplies:

- ☐ LCD projector for slides or printed overhead transparencies
- ☐ Flipchart/newsprint pads, masking tape, and felt tip markers for every 5-6 participants
- ☐ Handout package for each participant (Slide handouts optional)
- ☐ Name tags, sign-in sheets, course evaluation forms, Continuing Education Certificates

Set-up: Room large enough to allow tables of 4-6 participants with adequate space between tables to accommodate small group work sessions

Acknowledgements

This curriculum was made possible because of the dedication and commitment of many individuals and organizations. The *NIDA/SAMHSA-ATTC ASI Blending Team* gratefully acknowledges the following contributions:

For pioneering efforts in developing the ASI DENS and Treatment Planning Software:

- **Deni Carise, PhD**, Treatment Research Institute, Philadelphia, Pennsylvania
- **Tom McLellan, PhD,** Treatment Research Institute, Philadelphia, Pennsylvania
- **Meghan Love**, Treatment Research Institute, Philadelphia, Pennsylvania

For primary authorship:

- **Pat Stilen, LCSW, CADAC**, Director of the Mid-America ATTC

For contributions in writing and editing materials:

- **Deni Carise, PhD,** Treatment Research Institute, Philadelphia, Pennsylvania
- **Nancy Roget, MS**, Director of the Mountain West ATTC
- **Alicia Wendler, MA,** Research Associate and PhD Candidate at the University of Missouri, Kansas City

For facilitating pilot training:

- **Lisa Carter, MA,** of Emporia, Kansas
- **Leigh Church, MS, LADC,** of Reno, Nevada
- **Jennifer Helgren, BA,** of the Mountain West ATTC

A special thanks to the three pilot training groups. Their feedback and willingness to complete extensive pre/post-training surveys was vital in designing this product.

- ***COSIG Missouri Pilot Sites,*** Kansas City, Missouri, July 27, 2004
- ***Reno, Nevada Area Treatment Providers***, Reno, Nevada, September 2, 2004
- ***ODAPCA Conference Participants***, Oklahoma City, Oklahoma, October 20, 2004

Sample Training Agenda
6-Hour Format

8:30 am – 10:00 am **Module 1**

- Trainer Introductions
- Participant Introductions
- Training Objectives
- How Do Practitioners View Treatment Planning: What Research Says
- Who, What, When, and How of Treatment Planning
- Addiction Severity Index (ASI) Applications in Treatment Planning

Module 2

- Recap of Module 1
- Program-Driven vs. Individualized Treatment Plans (Old Method vs. New Method)

10:00 am – 10:15 am **Break**

10:15 am – 11:00 am **Module 2 (continued)**

- Biopsychosocial Model of Addiction
- Treatment Plan Components
- Tips on Writing Problem Statements
- Practice Writing Problem Statements

11:00 am – Noon **Module 3**

- Recap of Modules 1, 2
- Methods in Prioritizing Problems

Noon – 1:00 pm **Mid-Day Break**

1:00 pm – 2:30 pm **Module 3 (continued)**

- Practice Writing Treatment Goal Statements
- Building Treatment Objectives and Interventions
- Review Treatment Planning Process
- Clinical Example: Treatment Goals, Objectives, Interventions

2:30 pm – 2:45 pm **Break**

2:45 pm – 4:00 pm **Module 4**

- Recap of Modules 1, 2, 3
- Special Features of ASI Treatment Plan Format
- Other Considerations in Treatment Planning: Client Involvement and Readiness to Change
- Practice Writing Treatment Objectives and Interventions Using the Acronym M.A.T.R.S.
- Documentation Note Guidelines and Legal Issues
- Practice Writing Documentation Notes
- Role of Treatment Plan in Clinical Record
- Closure: Organizational Considerations in Making Clinical Paperwork Useful

TRAINER FOCUS Module 1

EMPHASIS AREAS:

FOCUS

- Trainer Introduction
- Participant Introductions
- Training Objectives
- How Do Practitioners View Treatment Planning: What Research Says
- Who, What, When, and How of Treatment Planning
- Addiction Severity Index (ASI) Applications in Treatment Planning

Overhead 1.1

Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful

MODULE 1

Training Package

- Presentation Slides Handouts
- ASI Instrument
- ASI Narrative Report & Master Problem List
- Blank Alcohol/Drug/Medical/Family ASI Treatment Plan Templates
- Teaching Aids, Recommended Readings, Reference List (See Table of Contents for Complete Handout Master List)

Training Development Sources

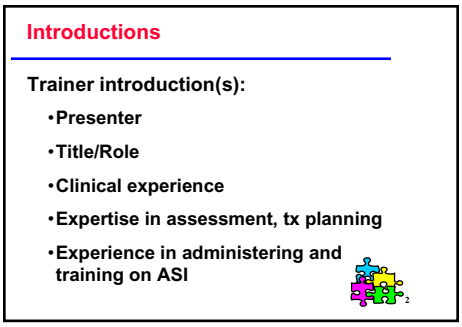
- Joint Commission on Accreditation of Healthcare Organizations (JACHO)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- CSAT's TAP 21: *Addiction Counselor Competencies*
- Medicaid Regulations
- Addiction Severity Index (ASI)
- Other public domain resources and research

Module 1 Handout

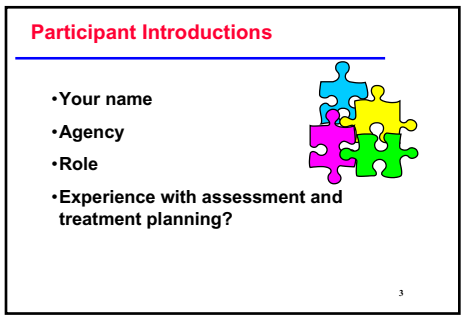
1. "The Car Game" Interactive Exercise Worksheets A-Z

Note on LCD/Overhead Slides

The PowerPoint slides provided with this curriculum package may be customized to suit the trainer's needs and may be viewed on an LCD projector or converted to overhead transparencies.



Overhead 1.2



Overhead 1.3

TRAINER(S) INTRODUCTION / WELCOME

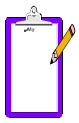
Introduce Self

- Educational background
- Clinical experience
- Expertise in assessment and treatment planning
- Experience in administering and training on the ASI

Participant Introductions

- Participant name
- Agency affiliation
- Role
- Experience with assessment and treatment planning

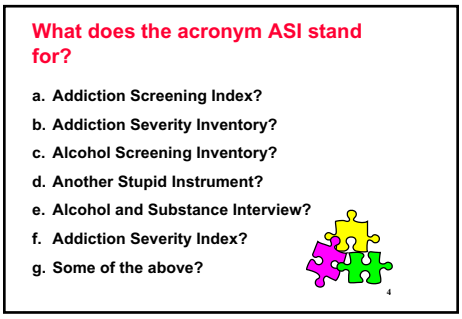
Trainer Notes:



✓ The trainer opens the session by first introducing himself/herself to participants and providing background information to assert his or her credibility in this topic area. The trainer introduction may include educational background, clinical experience, expertise in assessment, treatment planning, and/or experience in administering the Addiction Severity Index (ASI) in clinical practice.

✓ It is important to emphasize that treatment planning process guidelines have evolved over time with changes in state policy, federal regulations, and program certification requirements. This training emphasizes the process a practitioner may use to develop a treatment plan using ASI information.

✓ The ASI (McLellan, Luborsky, Woody, & O'Brien, 1980) is the most widely used assessment tool in the field and has been shown to collect reliable and valid information. Other assessment tools often incorporate ASI domains and questions. For these reasons, the ASI is used as an example assessment throughout this training.

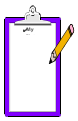


Overhead 1.4

Warm-up Exercise
What Does the Acronym "ASI" Stand For?

Trainer Notes:

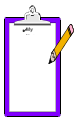
- ✓ Pass around a copy of the most recent version of the ASI (5th edition).
- ✓ Provide participants with the official ASI Web site.
- ✓ Engage in a brief discussion about the re-emergence of the ASI as a useful clinical tool for treatment planning purposes and utility of DENS software.

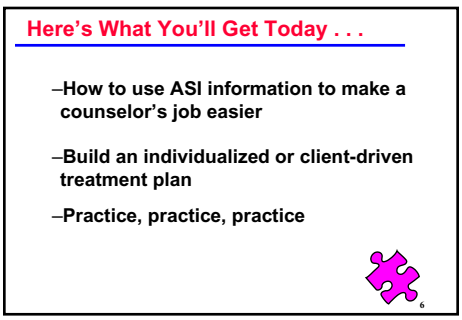


Overhead 1.5

Trainer Note:

- ✓ Describe the training process to participants, including:
  - An overview of the training content to be presented
  - The types of practice exercises included in the training
  - Time frame for the training (e.g., when breaks will be taken)

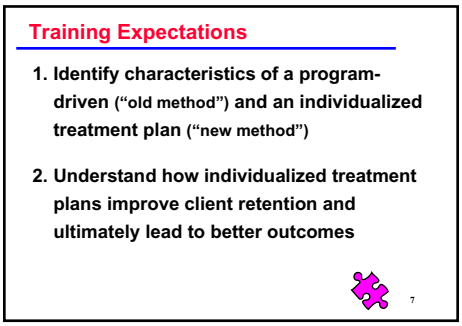




Overhead 1.6

What To Expect from this Training

- How to use ASI information for treatment planning and paperwork.
- Identify differences between program-driven and individualized treatment plans.
- Demonstrate and practice building an individualized or client-driven plan.



Overhead 1.7

Optional Slides

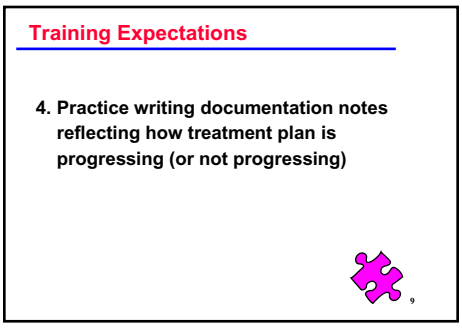
A more comprehensive look at what is expected from this training:

- Identify characteristics of a program-driven ("old method") and an individualized treatment plan ("new method").
- Present research that supports individualized treatment planning, which can improve client retention and ultimately lead to better treatment outcomes.

Overhead 1.8

Optional Slides

- Focus on formulating treatment plans using ASI information and developing:
  - Problem Statements using ASI narrative information
  - Goals based on Problem Statements
  - Objectives based on Goals
  - Interventions based on Objectives



Overhead 1.9

- Practice writing documentation notes reflecting how the treatment plan is progressing.

What is Not Included in Training

–Administering and scoring the ASI

–Administering any other standardized screening/assessment tool

–Training on clinical interviewing

Overhead 1.10

What is Not Included in This Training

- Administering or scoring the ASI or other standardized assessment/screening instruments is not the focus of this training.
- Training is focused on the process of treatment planning rather than on clinical interviewing skills.

Trainer Note:

✓ There are no prerequisite skill requirements for this training (e.g., be trained in ASI administration). A sample ASI Narrative and Problem List will be provided.

The Goal of this Training is . . .

–To "Marry" the assessment and treatment planning processes

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Overhead 1.11

The Goal of this Training is to "Marry" the Processes of Assessment and Treatment Planning

- By focusing on "marrying" the ASI and treatment planning processes, the treatment plan serves as a real guide to service delivery.

A 2003 report, *Can the National Addiction Treatment Infrastructure Support the Public's Demand for Quality Care?* documents **the substance abuse treatment field's general frustration with paperwork**:

- "Treatment programs are choking on data collection requirements . . . almost none of the data collected were used in clinical decision-making or program planning—it was just paperwork" (McLellan, Carise, & Kleber, 2003, p. 120).

Treatment Plans are . . .

"Meaningless & time consuming"

"Ignored"

"Same plan, different names"

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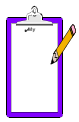
Overhead 1.12

Frequently Heard Comments About Treatment Plans

- *It's meaningless and time consuming.*
- *It's never seen again or ignored in the treatment process.*
- *I copy the same form and just change the name at the top of the form. All our clients go through the same program, so they have the same plan.*

Trainer Note:

✓ Emphasize that supervisors often have not trained counselors to "marry" the assessment and treatment planning processes. Counselors are practicing what they have been trained to do. This training is an introduction into new methods of individualizing treatment plans.



We're going on a trip . . .

Let's do the "Car Game"

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Overhead 1.13

The "Car Game" Interactive Exercise
Letters A-E

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
A		
B		
C		
D		
E		

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Overhead 1.14

Interactive Exercise: "Car Game"

Material Option 1: Use water color markers and large newsprint paper with letters A through Z written down the left side. Depending on group size, have approximately 4-5 letters on each page. (See example Overhead 1.14)

Material Option 2: Use 8x11" pages provided in Resource Section (Module 1, Handout 1)

Method, Process, and Directions:

1. Divide participants into small groups of 4 – 6 people.
2. Assign a portion of the alphabet (e.g., Letters A – E and so on).
3. Provide small groups with materials listed in either Option 1 or Option 2.
4. Ask for a volunteer to be the recorder for each group.
5. Explain Exercise Process:
   - This activity is similar to the game families play on long car trips. One player begins the round by stating, **"I'm going to the grocery store and I am going to buy a _____** (something that begins with the letter A, e.g., apples)." The next player has to think of a food item that starts with the letter B and so on.
6. Exercise Directions: Lead-in line is: **"I have to write a treatment plan and _____."**
   - **What is negative about treatment planning?** (e.g., time-consuming, boring, meaningless). Responses from A through Z denoting negative aspects of treatment planning or paperwork involved.
   - **What is positive about treatment planning?** (e.g., successful outcomes, rapport with clients, less relapse). Responses from A through Z denoting positive aspects of treatment planning or benefits of well-written treatment plans.

Time for Activity: Approximately 15 minutes

Trainer Note:

- ✓ Positive responses typically take less time for the participants to formulate than do the negative responses.

Module 1 | **Trainer Guide**

The What, Who, When, How of Treatment Planning

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Overhead 1.15

What, Who, When, and How of Treatment Planning

What is a Treatment Plan?

A written document that:

- –Identifies the client's most important goals for treatment
- –Describes measurable, time sensitive steps toward achieving those goals
- –Reflects a verbal agreement between the counselor and client

Center for Substance Abuse Treatment, 2002

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Overhead 1.16

What is Treatment Planning?

Treatment planning is a collaborative process in which a team of professionals and the client develop a written document that:

- Identifies important client treatment goals.
- Describes measurable, time-sensitive action steps towards achieving those goals.
- Reflects the verbal agreement between the counselor and client.

Trainer Note:

✓ In Module 3, there will be more focus on writing components of a treatment plan (i.e., problem, goal, objective, and intervention statements).

Who Develops the Treatment Plan?

- –Client partners with treatment providers (ideally a multi-disciplinary team) to identify and agree on treatment goals and identify the strategies for achieving them

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Overhead 1.17

Who Develops the Treatment Plan?

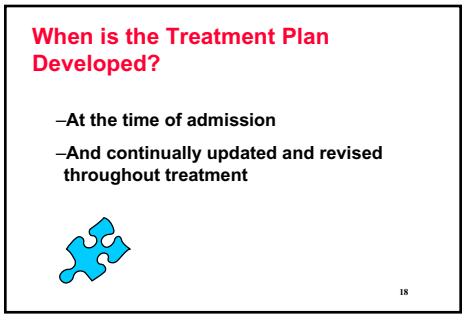
The client partners with treatment providers (ideally a multi-disciplinary team) to identify and agree on treatment goals and identify the strategies for achieving them.

Why Involve the Client in Treatment Planning?

A key to a successful treatment plan includes the client:

- Understanding the treatment care instructions
- Being allowed to give feedback to the counselor
- Stating other specific problems, goals, or needs he/she may have

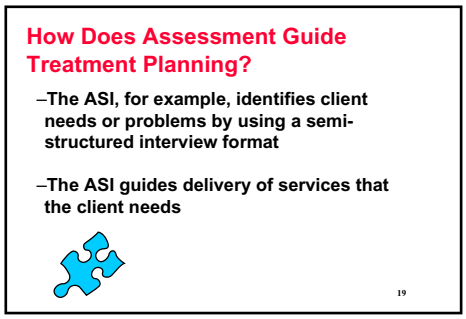
It is simply not enough to provide the client with a copy of her/his plan.



Overhead 1.18

When is the Treatment Plan Developed?

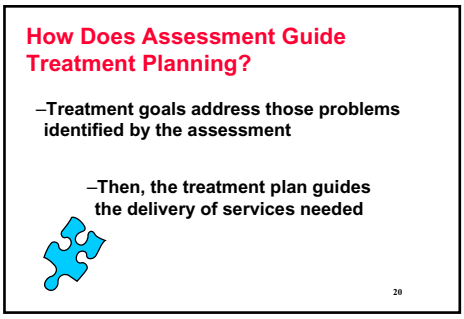
- It is developed at the time of admission.
- An agency may require a preliminary treatment plan at admission, followed by a comprehensive treatment plan shortly thereafter.
- The plan is continually updated and revised throughout treatment.
- Timing of revisions is guided by regulatory and credentialing requirements.



Overhead 1.19

How Does the Assessment (ASI) Guide the Treatment Plan?

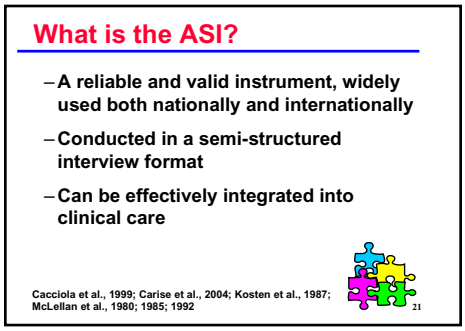
- The ASI identifies the client's needs or problems using a semi-structured interview format. (Both closed and open-ended questions are asked.)
- The treatment plan guides the delivery of services for those problems by establishing goals to address them.



Overhead 1.20

Assessment Guides the Treatment Plan (continued)

- Treatment goals are established to address problems identified by the ASI and other assessment information.
- The treatment plan objectives and interventions further map the course of treatment for both the counselor and the client.



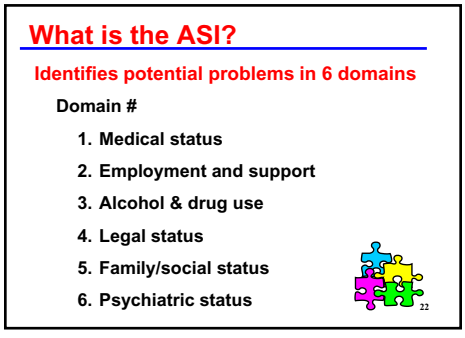
Overhead 1.21

What is the ASI?

The ASI is one of the most reliable and valid measurements of the nature and severity of client problems:

- Has been tested and retested over time.
- Has been studied in "real world" settings.
- Information can be effectively integrated into clinical care.

(Cacciola, Koppenhaver, McKay, & Alterman, 1999; Carise, Gurel, Kendig, & McLellan, 2004; Kosten, Rounsaville, & Kleber, 1987; McLellan et al., 1980; 1985; 1992)



Overhead 1.22

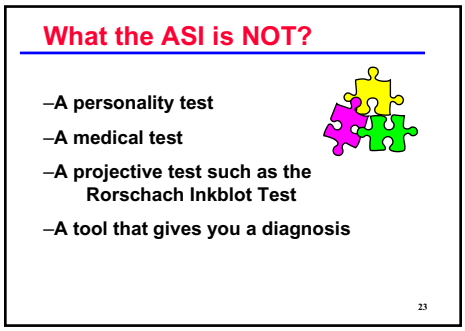
ASI Identifies Potential Problems in 6 Domain Areas

- Clients are asked a series of questions in the following domains:

1. Medical status
2. Employment and support
3. Alcohol & drug use
4. Legal status
5. Family/social status
6. Psychiatric status

Trainer Note:

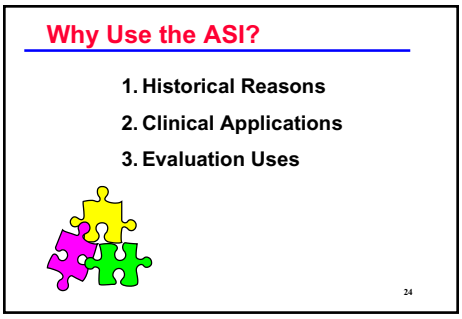
- ✓ The ASI is not all encompassing. Questions do not ask about homelessness or pregnancy, for example, which may be central to the client. Rather, the ASI provides a baseline for all counselors to ask the same questions (reliability), and additional questions can be tailored for the client. Using a standardized instrument (ASI) can "level the playing field" by building consistency between agencies and counselors.



Overhead 1.23

What the ASI is NOT

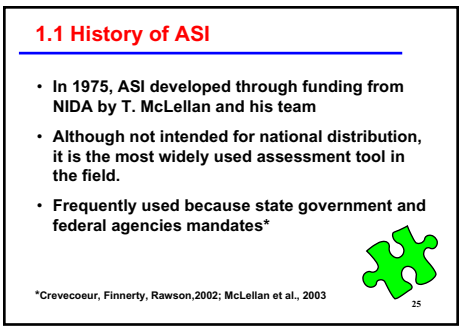
- The ASI is not a personality or medical test.
- It is not a projective test such as the Rorschach Inkblot Test.
- Findings from the ASI do not lead to a DSM-IV-TR diagnosis of substance abuse or dependence.



Overhead 1.24

Why Use the ASI?

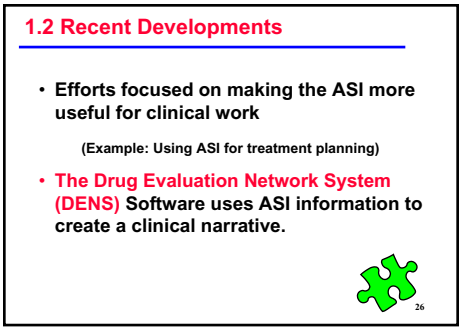
- Historical reasons
- Clinical applications
- Evaluation uses



Overhead 1.25

1.1 Historically . . .

- In 1975, with funding from NIDA, Thomas McLellan and his team developed a new assessment instrument that had practical use for both researchers and treatment providers.
- The first version of the ASI was released in 1977 and formally adopted in 1980.
- The ASI standardized assessment and has become a foundation for scientific study. Today, the ASI is the most widely used assessment instrument in the field of addictions.
- It is now in its fifth version (ASI-V5) with a sixth in development.
- Many state governments and federal agencies mandate the ASI as part of their evaluation procedures (Crevecoeur, Finnerty, Rawson, 2002; McLellan et al., 2003)



Overhead 1.26

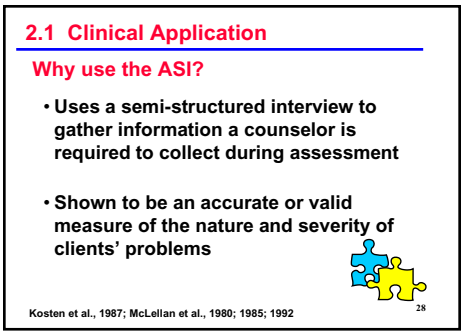
1.2 Recent Developments

- Based on clinician feedback, efforts are under way to make the ASI more clinically useful. For example, this training is one of those efforts to make the ASI useful by "marrying" ASI information to treatment planning.
- The Drug Evaluation Network System (DENS) software was developed to make the ASI easier to administer and document.
- The DENS takes the ASI information and creates a clinical narrative.

Overhead 1.27

1.3 ASI Now More Clinically Useful!

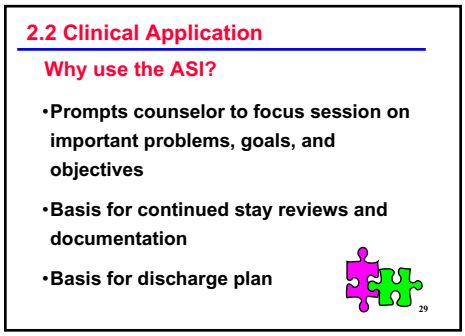
- The DENS now includes treatment planning software (developed for the state of Wyoming and first introduced in January of 2005).
- The purpose in using the software is to prompt and guide clinicians in developing and writing an actual individualized treatment plan!
- The software has a documentation function:
  - It tracks goals and objectives completed.
  - It allows addition of new problems, goals, objectives, and interventions.



Overhead 1.28

2.1 Clinical Application

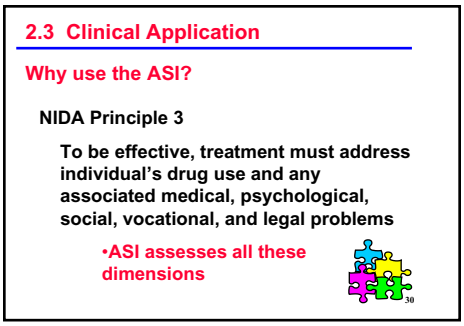
- The semi-structured interview format allows the counselor to gather required information.
- The ASI has been proven reliable and valid (Kosten et al., 1987; McLellan et al., 1980; 1985; 1992).
  - Reliable is how well the questions consistently give you accurate information.
  - Valid means that the questions assess what you intended to assess.
- How the clinician asks questions makes a difference.
  - Example of a vague clinical question: "Are you depressed?"
  - Example of a more specific clinical question: "Do you feel hopeless, have less energy, or have difficulty concentrating?"



Overhead 1.29

2.2 Clinical Application

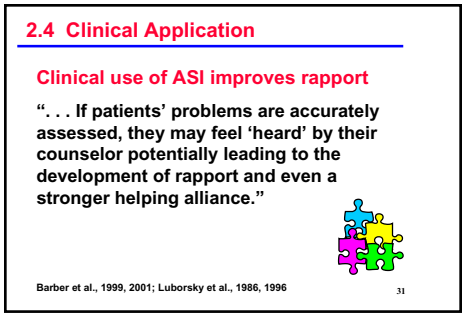
- Helps the client and counselor identify problems and agree on goals, objectives, and interventions.
- Useful in justifying need for services.
  - Example: service authorization/approval for particular level of care
- Provides information useful in justifying need for continued services.
- Gives basis for documentation and discharge planning.



Overhead 1.30

2.3 Clinical Application

- The National Institute on Drug Abuse (NIDA) has outlined a variety of scientifically based approaches to drug addiction treatment in *Principles of Drug Addiction Treatment: A Research-Based Guide*.
- The third principle states, "to be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems" (NIDA, 1999, p. 1).
- The ASI assesses all these dimensions.

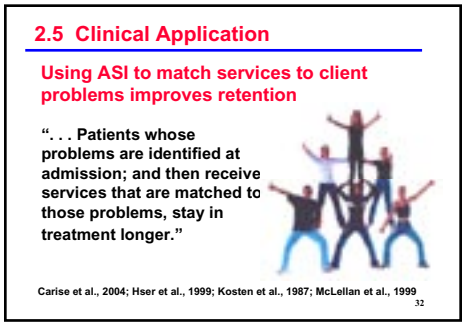


Overhead 1.31

2.4 Clinical Application

Research Shows Clinical Use Improves Rapport

Studies have indicated client retention improves when a client's problem is accurately assessed and when the client feels "heard" by the counselor (Barber et al., 1999, 2001; Luborsky et al., 1986, 1996).



Overhead 1.32

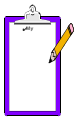
2.5 Clinical Application

Research Supports Treatment Planning

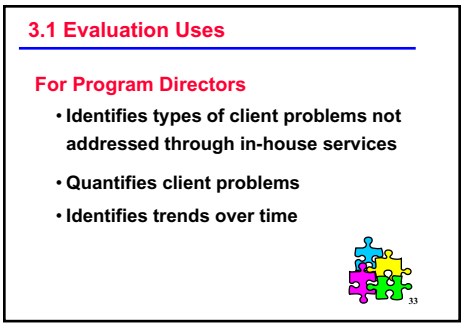
- Retention in treatment improves when services are matched to a client's problems.
- Clients "whose problems are identified at admission and then receive services that are matched to those problems, stay in treatment longer."

(Carise et al., 2004; Hser, Polinsky, Maglione, & Anglin, 1999; Kosten et al., 1987; McLellan et al., 1999)

Trainer Note:



✓ Remember, the treatment plan is an active document that:
- Guides the delivery of services.
- Is continually updated and revised throughout treatment.
- Gives the counselor and client a way to see if progress is made.

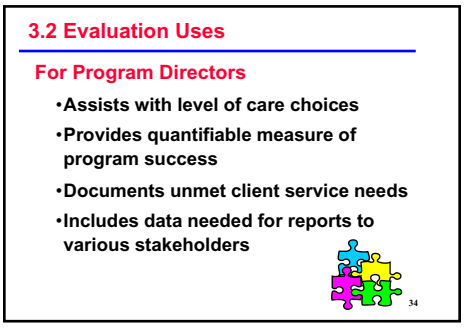


Overhead 1.33

3.1 ASI Evaluation Uses for Program Directors

- Identifies types of client problems not addressed by in-house services
- Quantifies the severity of client problems
  - Example: 80% of clients in the residential program rated their need for treatment as considerable.
- Identifies trends in client problems or needs over time
  - Example: A director might ask, "Do I need to add a parenting class or a Hepatitis C educational group to this treatment program?" The ASI data can help answer that question.

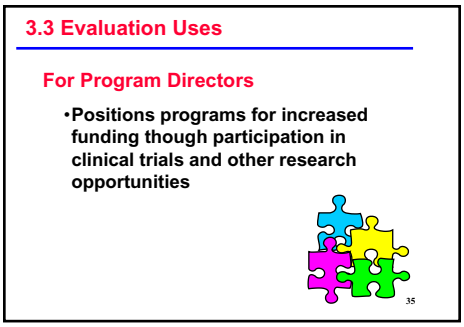
Clinical Example:
Most counselors cannot answer the question "what is your program success rate?" Typically, this is more important to program administrators. Frontline staff, however, are the individuals who usually collect the data to answer that question. Frontline staff are also concerned that their clients get the best care. ASI information can be used to answer these questions (i.e., success rate and client care). Being able to answer these questions helps to establish the profession as more credible and promotes job security.



Overhead 1.34

3.2 Evaluation Uses for Program Directors

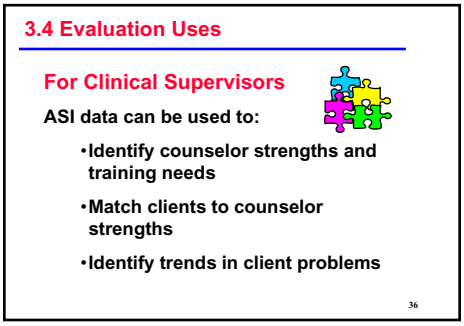
- Assists with level of care choices
- Provides quantifiable measure of program success
  - Example: A program director may look at the severity of client problems at the time of admission and then compare problem severity levels at time of discharge.
  - Example: A program director may also look at the number of days clients were troubled or bothered by psychiatric problems.
- Documents unmet client service needs
  - Example: A program director may want to establish a medication fund for clients with co-occurring mental health needs.
- Includes data needed for reports for TEDS, CARF, JCAHO, grants management, managed care, and other stakeholders



Overhead 1.35

3.3 Evaluation Uses for Program Directors

- By providing standardized accepted baseline data, the ASI can help programs to be in a position for various research opportunities.
- Using the ASI also positions programs for increased funding through participation in clinical trials and research opportunities.



Overhead 1.36

3.4 Evaluation Uses for Clinical Supervisors

- If automated, the ASI data can be used to:
  - Identify counselor strengths and training needs.
  - Assist in matching client to counselor strengths.
  - Identify trends in client problems.

TRAINER FOCUS Module 2

EMPHASIS AREAS:

FOCUS

- Program-Driven vs. Individualized Treatment Plans
- Old Methods and New Methods of Treatment Planning
- Biopsychosocial Model
- Treatment Plan Components

KEY CONCEPTS

- Distinction Between Program-Driven vs. Individualized Treatment Plans
- Old Methods and New Methods of Treatment Planning

Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful

MODULE 2

Recap of Module 1

- Introduction to the treatment planning process, the Addiction Severity Index (ASI), and the ASI/DENS Software
- ASI applications in treatment planning

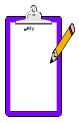
Module 2 will focus on introducing and (for some) reviewing:

- History of treatment planning
- Differences between program-driven and individualized treatment plans
- Biopsychosocial model of addiction
- Treatment plan components

Participants will practice writing non-judgmental and jargon-free problem statements.

Trainer Note:

✓ Module 1 introduced the importance of "marrying" two ingredients of client care: assessment and treatment planning. Treatment planning begins during the assessment process, and the "union" of treatment planning and assessment is a natural process.



Module 2 Handouts

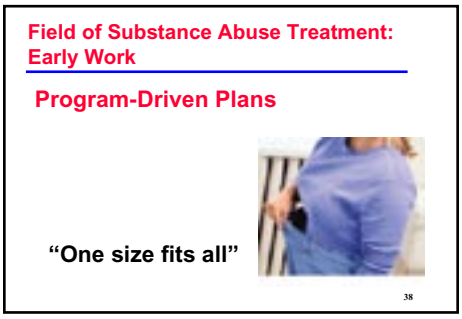
1. ASI Narrative Report – John Smith
2. ASI Master Problem List – John Smith
3. ASI Treatment Plan Template – Drug & Alcohol Plan
4. ASI Treatment Plan Template – Medical Plan
5. ASI Treatment Plan Template – Family Issues Plan
6. Sample: Program-Driven Treatment Plan

Overhead 2.37

Other Organizational Considerations

For clinical paperwork to become more useful in treatment planning other factors at an agency and/or program level may be considered:

- What are the ***information requirements*** needed to satisfy funding/managed care entities?
- Clinical record processes are often subjected to ***incremental changes*** when funding or program credentialing entities introduce new information requirements.
- Taking a ***"bird's eye view"*** of clinical record-keeping processes often reveals duplication of information.
- Use of ***computer technology*** in creating and maintaining clinical documentation could streamline the process.
- The ***ASI DENS Treatment Planning Software*** prompts and guides the counselor in developing a treatment plan.

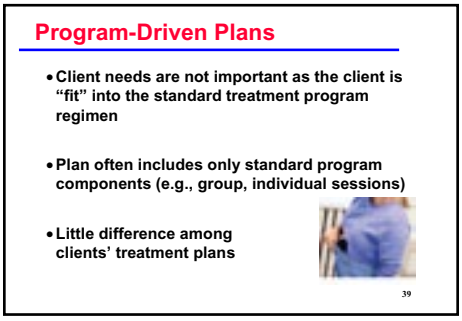


Overhead 2.38

Field of Substance Abuse Treatment: Early Work – "One Size Fits All"

Historically, the field of substance abuse treatment operated from a "one size fits all" treatment philosophy.

- The focus was on a limited number of tools and strategies that had worked with some consistency.
- Programs used the same tools, in the same way, with everyone regardless of their specific problems.
- Unique aspects of client problems and treatment needs were not reflected in treatment planning.
- Most of the time, treatment plans were developed without client involvement and "put in the chart" for the duration of treatment.



Overhead 2.39

What is a Program-Driven Plan?

- The client must fit into the program's regimen.
- A *Program-Driven Treatment Plan* reflects the components and/or standard activities and services available within the treatment program.
- There is little difference among clients' treatment plans.
- *This type of plan will be referred to as the **old method** of treatment planning.*

Trainer Notes:

- ✓ Often, programs are <u>required</u> to offer specific services to all clients. These required services are considered *program-driven components* which are different than a *program-driven treatment plan.*
- ✓ Example: All clients in the outpatient program participate in a weekly relapse prevention group. Many issues are addressed in the relapse prevention group. Certain topic areas may be more specific to the client's situation; these topics can be reflected in the treatment plan.

Overhead 2.40

Program-Driven Plans

Most counselors have either written or have read similar statements in treatment plans (i.e., old method).

Overhead 2.41

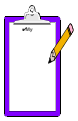
Program-Driven Plans – Other Common Problems "Only baggy jeans?"

Program-Driven Plans . . .

- Identify only those services or program elements immediately available and readily delivered in the agency.
- Based on the client's assessment, additional services may be necessary. Program-driven plans often do not reflect referrals to community service providers such as psychiatric clinics, training programs, or HIV testing clinics.

Trainer Note:

✓ Refer participants to Sample: Program-Driven Treatment Plan (Module 2, Handout 6).



Overhead 2.42

Paradigm Shift to Individualized Treatment Plans

What caused the shift?

Clinicians and researchers wanted to:

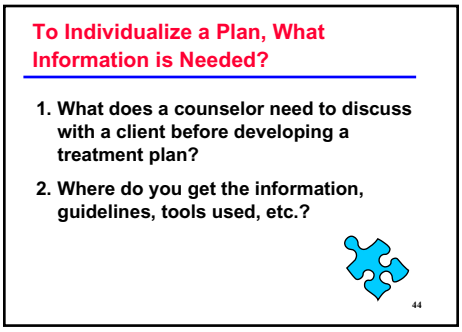
- Improve treatment outcomes.
- Effectively target clients' needs.
- Reflect the variety of techniques and medications used in treatment today.

In addition, payers wanted to contain costs of care by using the lower (less expensive) levels of care when justifiable (Kadden & Skerker, 1999).

Overhead 2.43

Individualized Treatment Plan is "Sized" to Match Client Problems and Needs

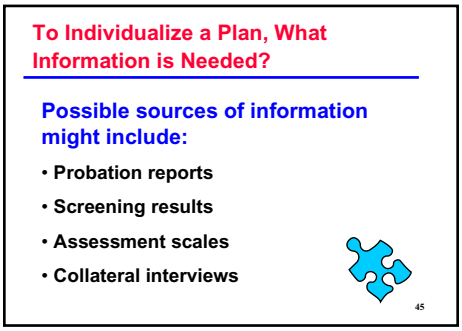
- Not all clients have the same needs or are in the same situation.
- The individualized treatment plan is made to "fit" the client based on her/his unique:
  - ✓ Abilities
  - ✓ Goals
  - ✓ Lifestyle
  - ✓ Socioeconomic realities
  - ✓ Work history
  - ✓ Educational background
  - ✓ Culture
- When treatment programs do not offer services that address specific client needs, referrals to outside services are necessary.



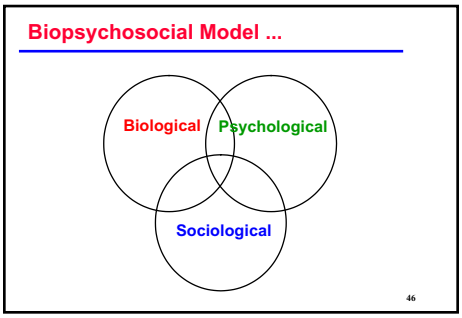
Overhead 2.44

Group Discussion

- What does a counselor need to discuss with a client before developing a treatment plan?
- Where does a counselor get the information to identify client problems? Possible sources of information might include:
  - probation reports
  - screening results
  - assessment scales
  - collateral interviews



Overhead 2.45



Overhead 2.46

Introduce Biopsychosocial Model

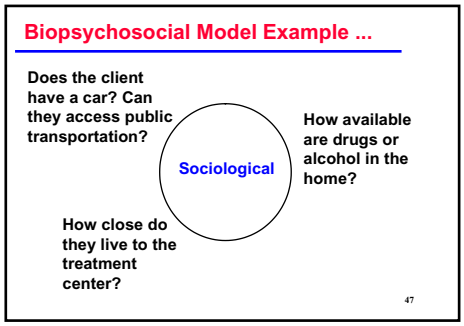
The Biopsychosocial Model of medicine, coined in 1977 by a psychiatrist named George Engel, is widely used as a backdrop in explaining substance abuse and mental health disorders. By most standards, the model is comprehensive and supports several different theories and practices.

Engel viewed a disease as having numerous causal factors that are interconnected. For example, an individual with the disease or condition of obesity may:

- Be predisposed to developing the condition due to a family history of obesity (biological).
- Have an eating or mood disorder which causes overeating (psychological).
- Be living below poverty level and not have the income to buy healthy and nutritious food (social).

The disease or condition of obesity is not treated without focusing on all three perspectives.

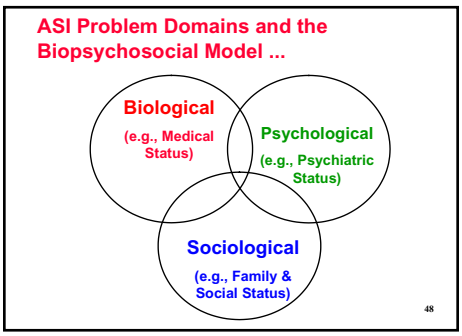
The strength of the biopsychosocial model is that one theory is not necessarily discounted in favor of another theory. The model allows for differing views. Theories can be organized in such a way that they actually complement one another and yet highlight differences in explaining the complexity of treating multiple disorders.



Overhead 2.47

The Biopsychosocial model serves as a reminder to include problems related to biological, psychological, and social aspects of addiction in the treatment plan. For example, a client's environment (social) must be considered when planning their treatment:

- How close does the client live to the clinic?
- Do they have a car or can they access public transportation?
- How available are drugs and alcohol in the client's home?



Overhead 2.48

ASI Problem Domains

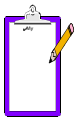
The seven problem domains (Medical Status, Employment and Support, Drug Use, Alcohol Use, Legal Status, Family/ Social, and Psychiatric Status) help support the importance of viewing clients and their problems from a biopsychosocial perspective.

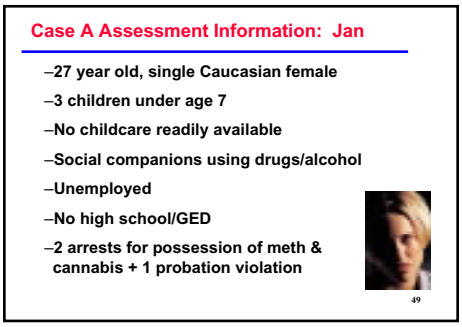
Program-Driven Plan Activity
Instructions:

1. Two case studies will be presented.
2. Sample problem statements, treatment plan goals, objectives, and interventions follow.

Trainer Note:

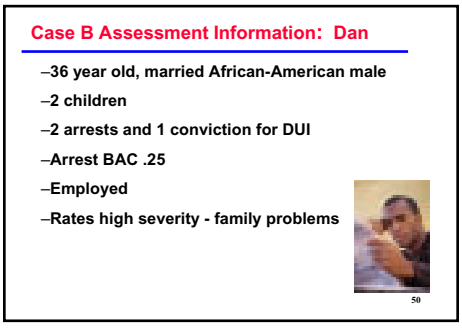
- ✓ Even though the specific steps in the treatment planning process will not be introduced until Module 3, participants will begin to view different styles of problem statements, goals, objectives, and interventions.





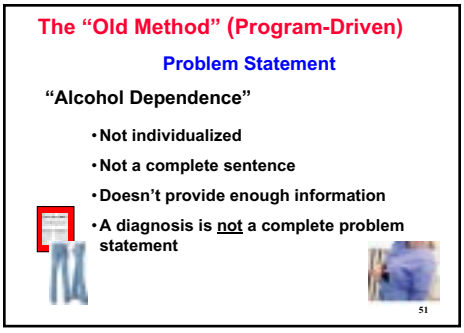
Overhead 2.49

Case A: Jan
Take a minute to read through Jan's assessment information.



Overhead 2.50

Case B: Dan
Take a minute to read through Dan's assessment information.

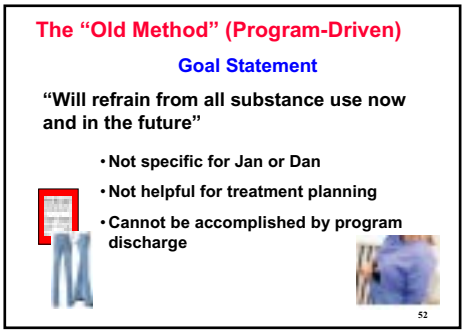


Overhead 2.51

Problem Statement: The "Old Method"

"Alcohol Dependence"

- This is a program-driven problem statement.
- It is not individualized.
- It is not included in a complete sentence structure.
- It does not provide enough information.
- A problem statement is NOT a diagnosis.



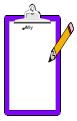
Overhead 2.52

Goal Statement: The "Old Method"

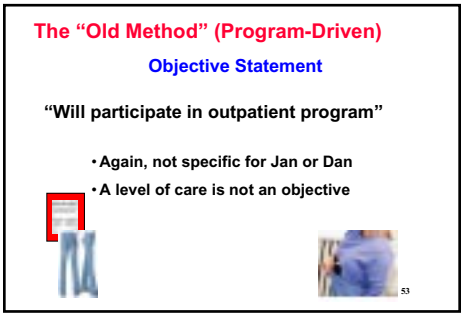
"Will refrain from all substance use now and in the future."

- Goal is not specific for Jan or Dan.
- This could be a goal for either Jan or Dan.
- Goal could not be accomplished by discharge.

Trainer Note:



- ✓ The preceding goal is commonly overused in program-driven treatment plans.
- ✓ Other examples_____

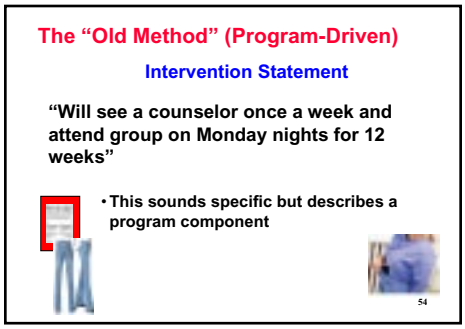


Overhead 2.53

Objective Statement: The "Old Method"

"Will participate in the outpatient program."

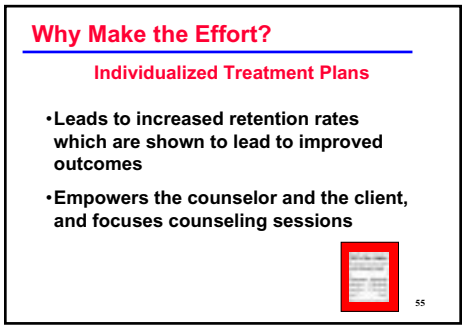
- Objective is not specific for Jan or Dan.
- Statement describes a level of care; a level of care is not an objective.



Overhead 2.54

Intervention Statement: The "Old Method"
"Will see a counselor once a week and attend group on Monday nights for 12 weeks."

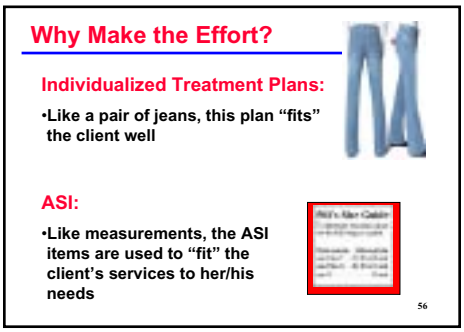
- Intervention is not specific for Jan or Dan.
- This statement sounds specific but describes a program component.



Overhead 2.55

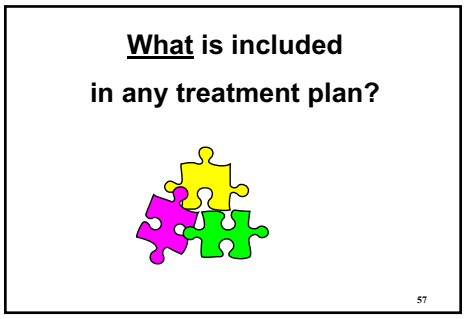
Why Make the Effort?

- Individualized treatment leads to increased client retention, which has been shown to lead to improved outcomes.
- Why is retention important? *Because about 50% of the people that show up for treatment don't return.*
- Empowers the counselor and client, and focuses counseling efforts.



Overhead 2.56

- Treatment plans should pass the "first glance" test. Ideally, you should be able to pick up a client's treatment plan like a pair of jeans and recognize its uniqueness.
  - Example: "This particular plan must belong to a client with children, Hepatitis C, and no high school diploma."
- In keeping with the jeans metaphor, data collected from the ASI can be used as a "measurement" to help "fit" the treatment plan to the client's individual needs.
- The plan is individualized and customized to "fit the client" just as jeans have unique sizes and fits—straight or flared leg, low cut or high-cut waist, or tall, short, or average length.

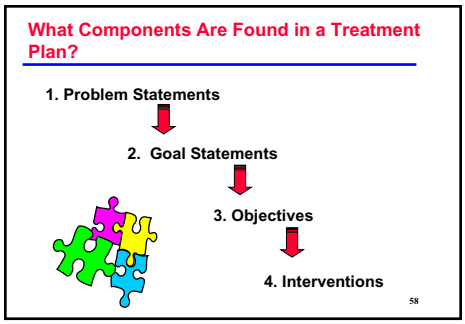


Overhead 2.57

What Is Included in any Treatment Plan?

Questions the counselor and program need to consider:

- What information is essential?
- What does CARF or JCAHO need or require?
- What does your state want?
- What do your payers want?

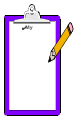


Overhead 2.58

What Components Are Found in a Treatment Plan?

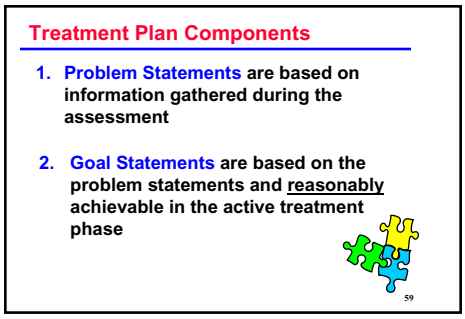
- Problems identified during assessment
- Goals reasonably achievable in the active treatment phase
- The term **objectives** used in this training is defined as *what the client does to meet the goals*.
- The term **intervention** used in this training is defined as *what the staff will do to assist the client*.
- This terminology is consistent with vocabulary used in the DENS ASI Treatment Planning Software.

Trainer Notes:



✓ The terminology used to convey the more specific components of a treatment plan may vary by profession, by program, by agency, and by region.

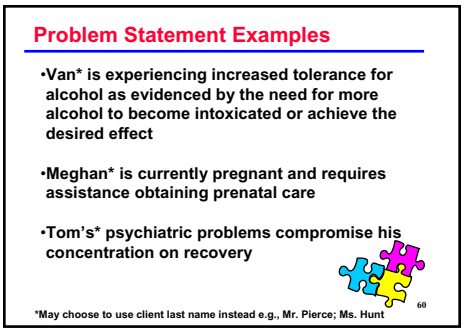
✓ The participants may be familiar with other terms such as action step, task, measurable goal, treatment strategy, benchmark, milestone, solutions, etc.



Overhead 2.59

Treatment Plan Components

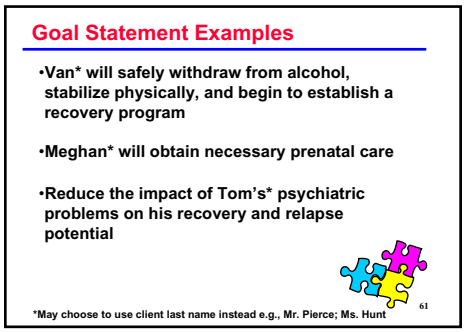
1. **Problem Statements** are based on the information the counselor gathers during the assessment.
2. **Goal Statements** are based on the problem statements. Goals included in the plan should be reasonably achievable in the active treatment phase.



Overhead 2.60

Problem Statement Examples

- Take a minute to look at these problem statement examples.
- Notice how the examples are specific to a client's need.
- You may choose to use the client's last name in place of the first name.



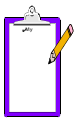
Overhead 2.61

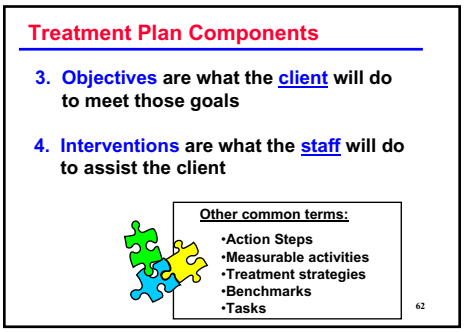
Goal Statement Examples

- Now, take a minute to look at these goal statements.
- Does Van's goal relate to his problem?
- Does Meghan's goal relate to her specific problem?

Trainer Note:

✓ Allow time for the participants to ask questions and seek clarification on terms before proceeding.

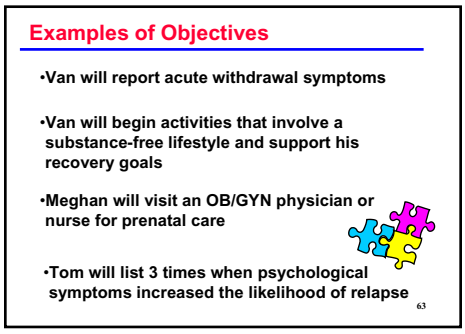




Overhead 2.62

Treatment Plan Components

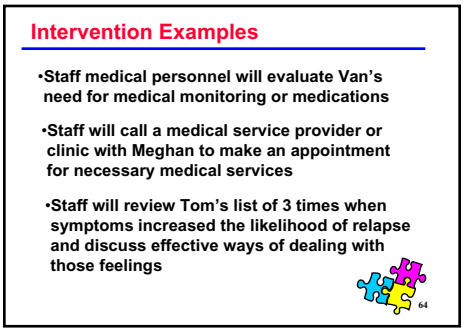
3. Remember **objectives** are defined as *what the client will do to meet those treatment goals.*
4. Remember **interventions** are defined as *what the staff will do to assist the client*.



Overhead 2.63

Examples of Objectives

- Take a minute to look at these examples.
- How do the examples indicate what the client will do?
- You may choose to use the client's last name in place of the first name.



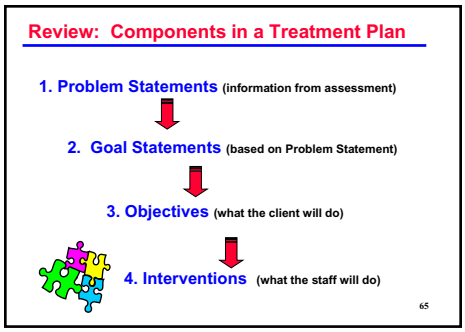
Overhead 2.64

Examples of Interventions

- Take a minute to look at these examples.
- Notice what the staff will do to assist or follow-up with the client.

Trainer Notes:

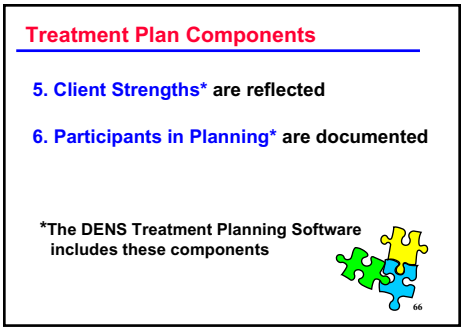
- ✓ Allow time for participants to discuss terminology used in their agencies' treatment plan formats.
- ✓ Remind participants that terms frequently viewed in treatment planning are not standardized nor consistently defined.



Overhead 2.65

Review: Components in a Treatment Plan

1. **Problem Statements** are based on the information the counselor gathers during the assessment.
2. **Goal Statements** are based on the problem statements.
3. **Objectives** are defined as *what the client will do to meet those treatment goals.*
4. **Interventions** are defined as *what the staff will do to assist the client*.

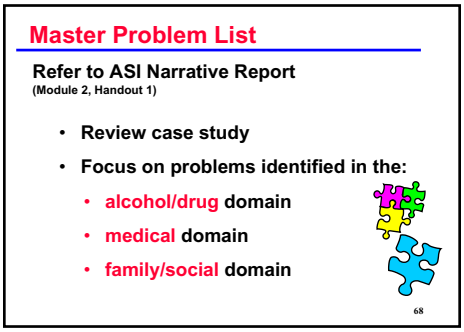


Overhead 2.66

Treatment Plan Components

5. Most clients have strengths that will assist them in their treatment process. Those strengths are often documented and are a required component of treatment plans.
6. Note how family or others participated in the treatment planning activities. Also note whether significant others agreed with the plan.
   - The DENS ASI Treatment Planning Software allows the counselor to document:
     1. Who was invited to participate in the treatment planning process?
     2. If they did not participate, why (unavailable, refused, etc.)?
     3. If the client and other participants agreed with the plan.

Overhead 2.67



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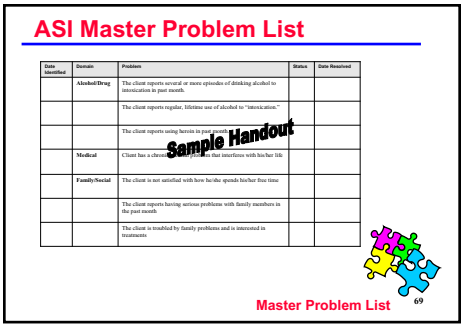


Overhead 2.69

Interactive Activity Instructions: Identify All Problems

The first step in the treatment planning process is to refer to the client's assessment information to develop a Master Problem List.

Refer to Handout John Smith's ASI Narrative Report

Trainer Notes:

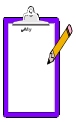
- ✓ The John Smith example report was generated from the *DENS ASI Software*.
- ✓ Allow approximately 15 minutes for participants to read the narrative and identify problems in the alcohol/drug, medical, and family/social domains.

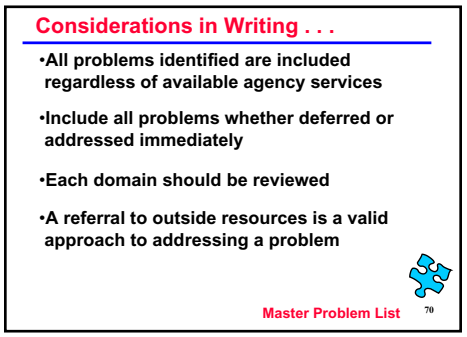
Common Participant Questions/Issues:

- Participants may ask whether "problems" are from the client's or counselor's perspective. Emphasize the collaborative efforts between client and counselor for this process.
- Participants may work ahead, generating goal statements, objectives, and/or interventions for the client. Emphasize that this exercise is for brainstorming a problem list at this point.

Trainer Note:

- ✓ The sequence of the slide presentation below is intentional and recognizes principles for an adult learning style. For example, it is important for participants to be exposed to the correct procedure for writing problem statements rather than being corrected for writing incorrect statements.

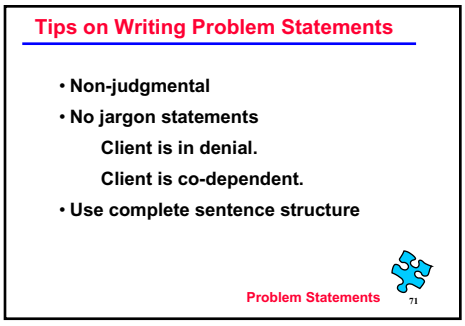




Overhead 2.70

Considerations in Writing Problem Statements

- All problems identified are included regardless of services available at the agency.
- Whether problems are deferred or addressed immediately, all should be included on the Master Problem List.
- There should be a review of each problem domain.
- A referral to outside resources is an appropriate approach to addressing a problem.



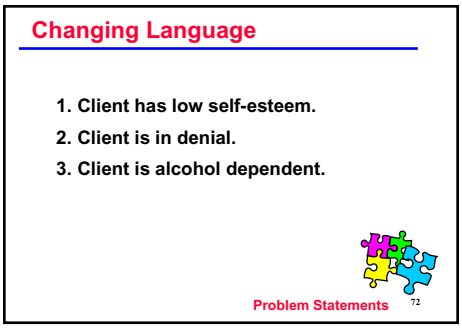
Overhead 2.71

Tips on Writing Problem Statements

Next, use *John Smith's Master Problem List* to begin writing problem statements. First, some tips on writing problem statements.

- Statements are non-judgmental.
- No jargon statements are included (e.g., "client is in denial"; "client is co-dependent").
- Use complete sentence structure when writing Problem Statements.

In general, it is easier to write treatment goals, objectives, and/or interventions if the problem statement reflects specific behaviors. Also, judgmental statements should not be written on the treatment plan as this document is shared with the client.

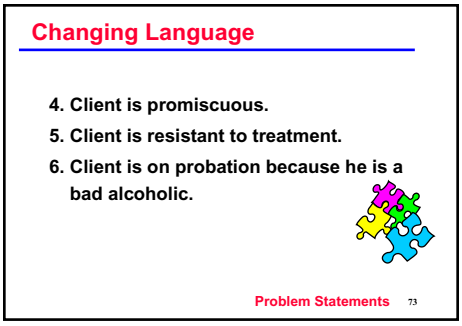


Overhead 2.72

Practice Changing the Language of Problem Statements

Change the language of these common judgmental and jargon-based statements.

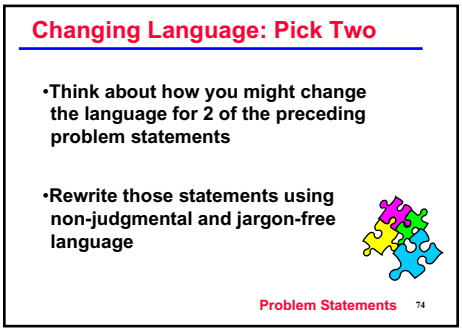
1. "Client has low self-esteem."
2. "Client is in denial."
3. "Client is alcohol dependent."
4. "Client is promiscuous."
5. "Client is resistant to treatment."
6. "Client is on probation because he is a bad alcoholic."



Overhead 2.73

Examine the problem statement, "The client is promiscuous." What does promiscuous mean?

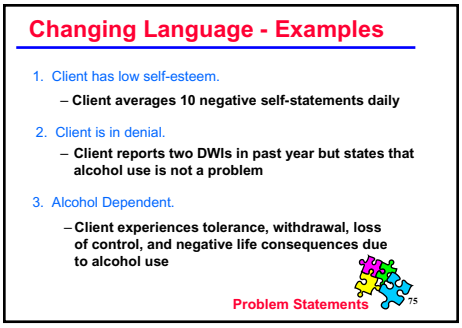
- Does the term refer to the number of sexual partners?
- Does it refer to activities that include high-risk sexual behaviors?
- Does it refer to women or men or both?



Overhead 2.74

Trainer Note:

✓ Have participants select two problem statements and write a non-judgmental and jargon-free statement. Trainers may want to provide incentives at this point for "correct" responses.



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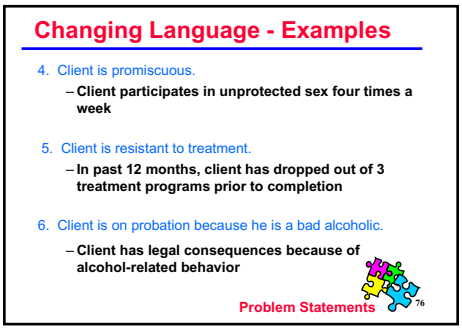
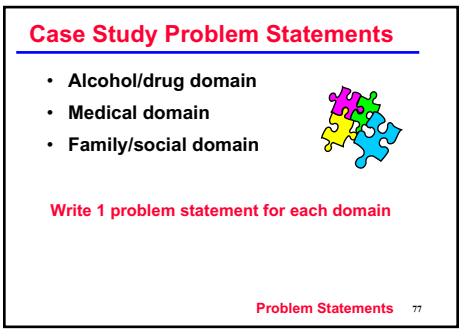


Overhead 2.76

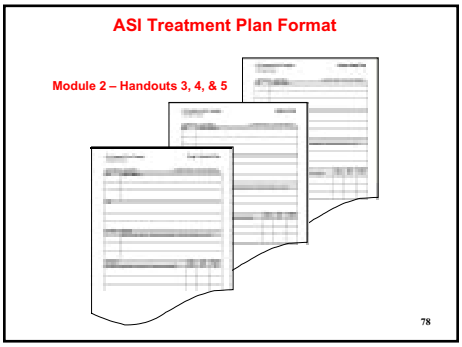
Non-judgmental and Jargon-Free Statements

Introduce examples of responses to each statement:

1. Client averages 10 negative self-statements daily.
2. Client reports two DWIs in the past year but states that alcohol use is not a problem.
3. Client experiences tolerance, withdrawal, loss of control, and negative life consequences due to alcohol use.
4. Client participates in unprotected sex four times a week.
5. In the past 12 months, the client has dropped out of 3 treatment programs prior to completion.
6. Client has legal consequences because of alcohol-related behavior.



Overhead 2.77



Overhead 2.78

Write John Smith's Problem Statements

Individual Activity Instructions:

1. Refer to ASI Treatment Plan Format handouts
   - 3 pages provided (Module 2, Handouts 3, 4, 5)
   - Note where problem statement, goal statement, objectives, and interventions appear.
   - Each practice page has the specific domain noted in the upper right hand corner. In an actual written plan, such separation is not necessary.
     - Alcohol/drug domain (Module 2, Handout 3)
     - Medical domain (Module 2, Handout 4)
     - Family/social domain (Module 2, Handout 5)

2. Write 1 problem statement for these domains.
   - alcohol/drug domain
   - medical domain
   - family/social domain

3. **REVIEW** – Who wants to share a problem statement?

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TRAINER FOCUS Module 3

EMPHASIS AREAS:

FOCUS

- Prioritizing Problems
- Use of Acronym M.A.T.R.S

KEY CONCEPTS

- Treatment Planning M.A.T.R.S.
  - Measurable
  - Attainable
  - Time-limited
  - Realistic
  - Specific

Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful

MODULE 3

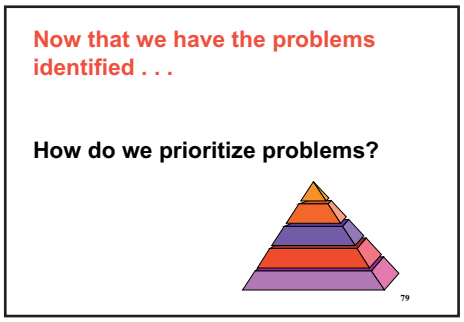
Recap of Modules 1 and 2

- The importance of using a reliable and valid assessment tool like the ASI to identify client problems
- Who, what, when of treatment planning and how to incorporate ASI data in the treatment plan
- The differences between program-driven and individualized treatment plans (old method versus new method)
- Writing non-judgmental and jargon-free problem statements

Module 3 will focus on the mechanics of treatment planning. Participants will discuss prioritizing problem statements and practice writing treatment goals. Emphasize how using the acronym, M.A.T.R.S. is helpful in recalling the features of effective objective and intervention statements.

Module 3 Handouts

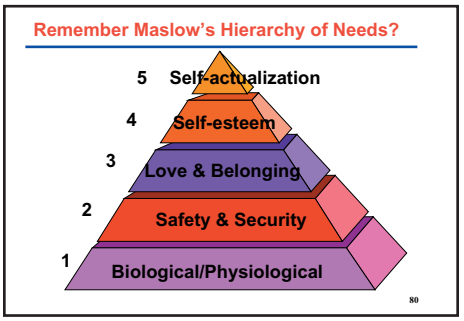
1. Treatment Planning M.A.T.R.S. Checklist
2. The Thesaurus of Treatment Planning
3. The Thesaurus of Client Strengths & Limitations



Overhead 3.79

Prioritizing Problem Statements
A Master Problem List includes all possible problems regardless of services available at the treatment agency. Some problems will be deferred and others addressed immediately.

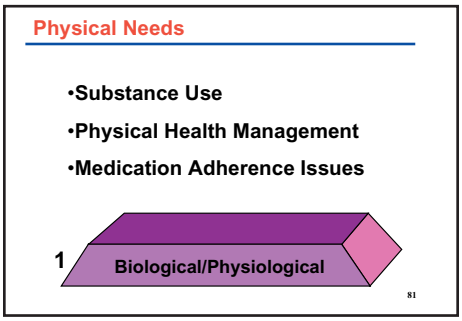
Selecting only those problems requiring immediate attention is the next step in the treatment planning process. The **ASI Severity Ratings** provide information on which problem domains are most critical.



Overhead 3.80

Remember Maslow's Hierarchy of Needs?
A useful model for thinking about prioritizing problems is Maslow's Hierarchy of Needs. This model helps prioritize problem statements that are achievable within the **active treatment phase** or that can be referred to an outside resource.

Maslow's Hierarchy of Needs, developed and published between 1943–1954, is a well-known model of personality development. This theory suggests human beings are motivated by unsatisfied needs. Lower needs must be satisfied before higher needs can be satisfied. Maslow's model begins with the most basic of all human needs—physical survival. To proceed "up the hierarchy," a client must have his or her basic physical needs addressed first (Huitt, 2004).



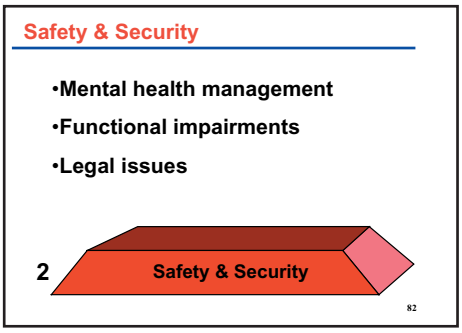
Overhead 3.81

1. **Biological and Physiological Needs** – Air, food, drink, shelter, warmth, sex, and sleep

   - When these needs are not satisfied, human beings may not think about other things or strive to a higher level.

Examples of common client problem areas associated with the first level include:

- Physical changes due to dependence on alcohol and/or drugs
- Health problems often not identified and/or not managed appropriately
- Medication adherence issues—especially for those clients with a co-occurring physical or mental health disorder



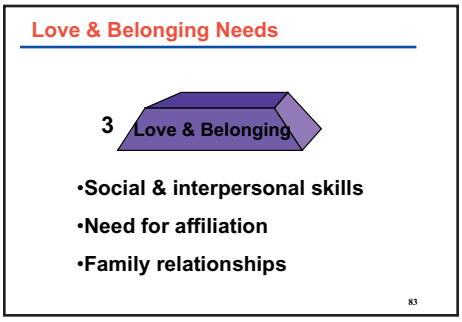
Overhead 3.82

2. **Safety and Security Needs** – Protection from elements, security, order, law, limits, and stability

   - Meeting these needs has to do with establishing consistency in a chaotic world. If these needs are not met, clients cannot move to the next level.

Examples of common client problem areas associated with this level may include:

- Legal issues
- Functional impairments (e.g., inability for self-care)
- Mental health management issues
- Elevated levels of client dangerousness, personal safety
- Issues of public safety



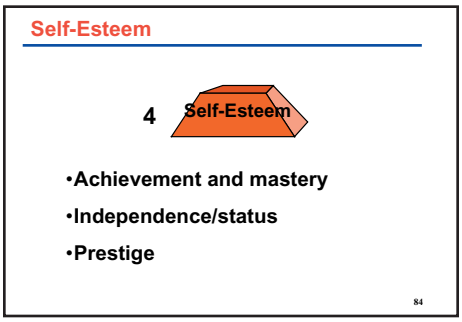
Overhead 3.83

3. **Love and Belonging Needs** – Co-workers, family, affection, and significant relationships

   - Human beings have a basic desire to belong and to feel loved and accepted by others.

Examples of common client problem areas associated with this level include:

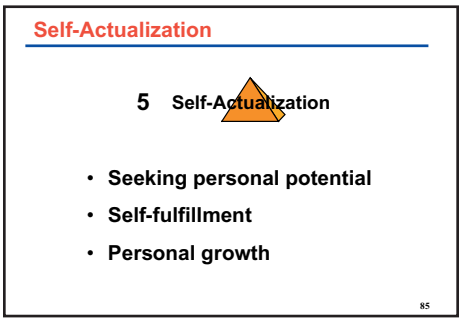
- Social and interpersonal skill deficits
- Need for affiliation
- Family/significant relationship issues



Overhead 3.84

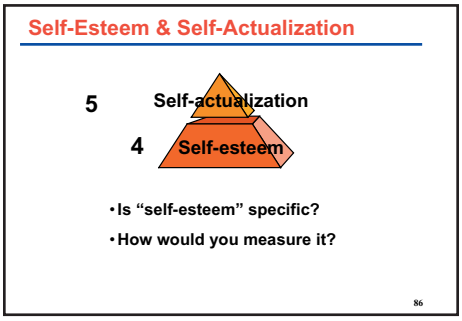
4. **Self-Esteem Needs** – Self-esteem, achievement, mastery, independence, status, dominance, and prestige

   - Self-esteem is a result of feeling one has mastered or is competent to complete a task.
   - Expanding beyond the belonging level, people seek admiration and recognition from others.



Overhead 3.85

5. **Self-Actualization Needs** – Fulfilling personal potential, self-fulfillment, seeking personal growth and peak experiences
   - People who have needs met on the other four levels are capable of maximizing their potential.
   - Seeking knowledge, esthetics, self-fulfillment, and spiritual connections are possible ONLY when other needs are met.



Overhead 3.86

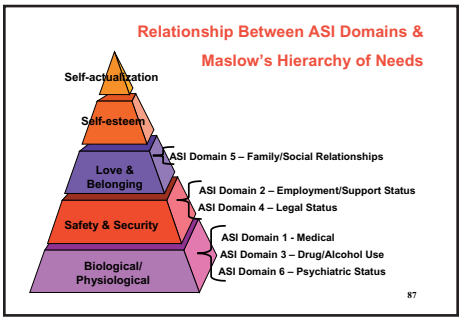
Incorporating "Self-Esteem" in Problem Statements

"Self-esteem" is a term that has been overused and misused when identifying client problems and developing treatment goals and problem statements. Problem statements such as, "Client needs to improve his or her self-esteem," have become "jargonized."

Consider the following when writing problem statements that address self-esteem:

- How will self-esteem be measured?
- Has the client's self-esteem been **directly** linked to other more pressing problems/needs?

Module 3 | **Trainer Guide**

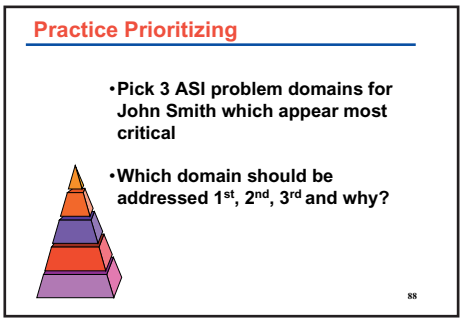


Overhead 3.87

Relationship Between ASI Domains and Maslow's Hierarchy of Needs

This slide illustrates how the ASI Problem Domains relate to Maslow's Hierarchy of Needs.

- Note that all ASI domains are related to the first three levels of Maslow's model.
- Addiction treatment programs are typically designed to address client needs/problems within the 1st, 2nd, and/or 3rd levels of Maslow's Hierarchy.



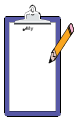
Overhead 3.88

Practice Prioritizing: Using Clinical Judgment to Prioritize John Smith's ASI Problem Domains

Refer to ASI Master Problem List – John Smith

- Have participants select which three ASI domains should be addressed first in John Smith's treatment.
- Discuss how those domains would be prioritized and why.

✓ **Trainer Note:**
According to Maslow's Hierarchy, John Smith's medical problem (asthma) would be a first priority in treatment. However, this would not necessarily be addressed in treatment. ASI problem domains and Maslow's Hierarchy will not always correspond, illustrating the importance of using clinical judgment to prioritize client problems. Client input also needs to be considered when prioritizing problems.



The Master Problem List is a living document. It should be revisited and revised often during treatment. Assessment of newly identified problems and severity of those problems is critical during treatment plan reviews and updates.

Begin Writing Goal Statements

- Use ASI Treatment Plan Handouts
  1. Alcohol/Drug Domain
  2. Medical Domain
  3. Family/Social
- Write at least 1 goal statement for each domain
- Write in complete sentences

89

Overhead 3.89

Writing Goal Statements

Now that participants have identified client problems in the assessment and prioritized those problems, goal statements are written. The counselor takes the problem statement and essentially *reframes* it to target a behavior.

- A treatment goal is what the client wants to achieve during treatment.

Writing Activity

Write at least 1 goal statement for each domain:

- **Alcohol/Drug Domain**
- **Medical Domain**
- **Family/Social Domain**

✓ **Trainer Note:**

- Form small work groups of 4–6 participants each.
- Remind participants to refer to Module 2 handouts.
- Allow approximately 10 minutes for writing activity.

Check-In Discussion

- Will the client understand the goal? (i.e., No clinical jargon?)
- Clearly stated?
- Complete sentences?
- Attainable in active treatment phase?
- Is it agreeable to both client and staff?

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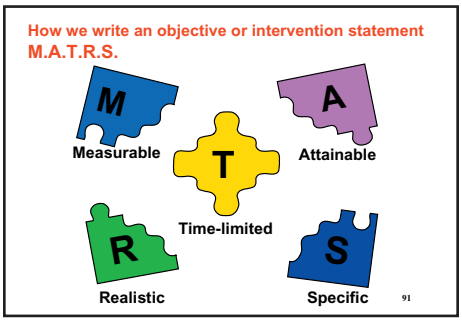
Overhead 3.90

Check-In Discussion

1. Will the client understand the goal statement? Is the statement free of “clinical jargon”?
2. Are your goal statements clearly stated? In complete sentences?
3. Are the goals attainable in the active treatment phase?
4. How confident would you feel in negotiating these goals with a client? Would goals be agreeable to both client and staff?



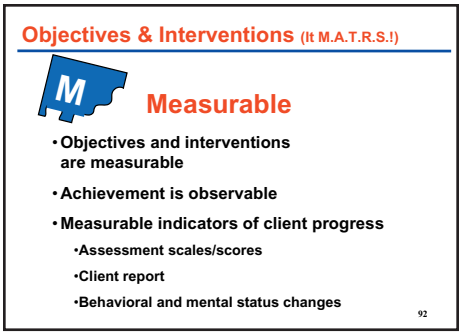
Overhead 3.91

How We Write a Treatment Objective and Intervention Statement M.A.T.R.S.

- **Objectives** are what the client will do to achieve the goal
- **Interventions** are what the staff will do to assist the client in meeting those goals

Trainer Note:

✓ Introduce *Treatment Planning M.A.T.R.S. Checklist*. Suggest participants use checklist to follow along with discussion. Suggest participants duplicate this tool to use in the workplace as a way of checking one's developing skills in writing treatment plans. The tool has also been used in clinical supervision.

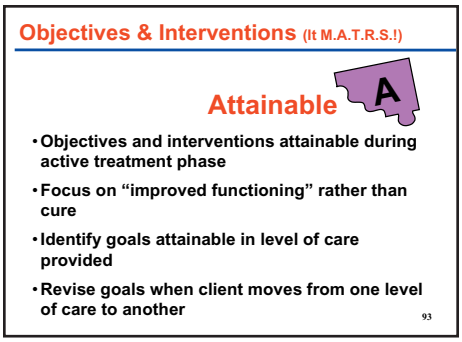


Overhead 3.92

Objective and Intervention Statements (It M.A.T.R.S.)

M=MEASURABLE

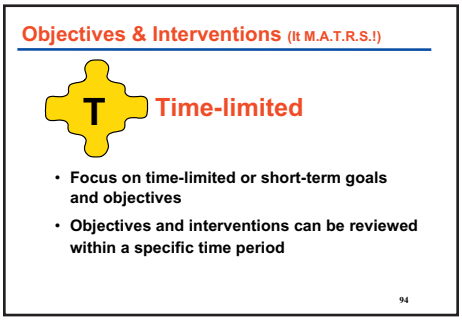
- Objectives are measurable so that the client and counselor can document change.
- Interventions are measurable and hold the counselor and treatment program accountable.
- Dates, occasions of a behavior, and rating scale scores may be included in the objectives.
- Examples of measurable indicators include:
  - ASI Severity Scores, including Interviewer Severity Ratings (e.g., severity rating in the medical domain)
  - Other evaluation scales, test scores, changes in level of risk scales (e.g., Beck's Depression Scale score drops two points)
  - Mental status or behavioral changes (e.g., number of days alcohol free, number of emergency room visits, days of medical problems)
  - Type and frequency of services received (e.g., attended five support sessions)



Overhead 3.93

A=ATTAINABLE

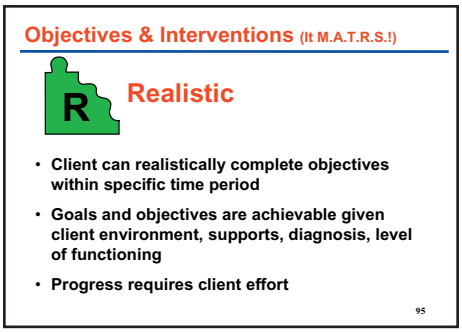
- Goals, objectives, and interventions should be achievable in the active treatment phase.
- Remember to focus on "improved functioning" or improved functional impairment rather than the "end" or "cure" of the problem.
  - Example – *Fill out job application vs. become employed full time*
- Identify those goals that can be attained in the level of care provided.
- Identify those clients that need referrals to outside agencies.
- Objectives and interventions may need to be revised when client moves from one level of care to another.



Overhead 3.94

T=TIME-LIMITED

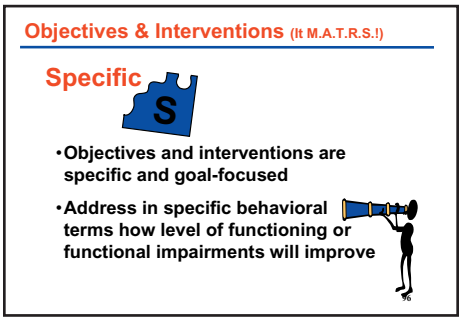
- Specific, time-limited goals and objectives are emphasized.
- Achievement of goals, objectives, and interventions can be reviewed within a specific time period.



Overhead 3.95

R=REALISTIC

- Objectives are realistic.
- It is reasonable to expect that the client can attain the objective in a specific time period.
- Goals and objectives are achievable given client environment, supports, diagnosis, level of functioning or level of functional impairment.
- Have a realistic expectation that a client is able to achieve goals and take steps on her or his own behalf.

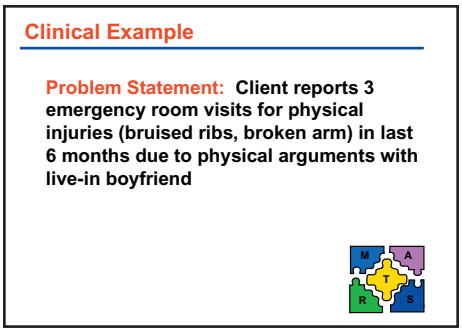


Overhead 3.96

S=SPECIFIC

- Objectives and interventions are specific and goal-focused allowing both client and counselor to note progress (or lack of progress).
- Specific behaviors are targeted which will help clients reduce symptoms and improve level of functioning.

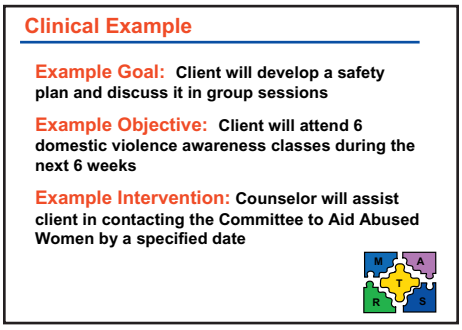
Module 3	Trainer Guide



Overhead 3.97

Clinical Example:
Develop 2 objectives and 2 or more interventions for the following Problem Statement:

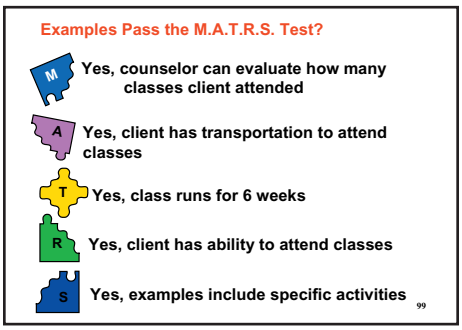
- Client reports three emergency room visits for physical injuries (bruised ribs, broken arm) in the last six months due to physical arguments with live-in boyfriend



Overhead 3.98

Clinical Example

- Example Goal: Client will develop a safety plan and discuss it in group sessions.
- Example Objective: Client will attend six domestic violence awareness classes during the next six weeks.
- Example Intervention: Counselor will assist client in contacting the Committee to Aid Abused Women by a specified date.



Overhead 3.99

Do Example Goals, Objectives, and Interventions Pass the M.A.T.R.S. Test?

- Measurable: Yes, the counselor can evaluate whether the client has attended classes, developed a safety plan, and reported on plan in group sessions.
- Attainable: Yes, in this case, the client has accessible transportation and will be able to attend classes.
- Time-Limited: Yes, the class runs for 6 weeks.
- Realistic: Yes, although the tasks may be emotionally charged, the client has the ability to conduct the activities.
- Specific: Yes, the examples include specific activities.

TRAINER FOCUS Module 4

EMPHASIS AREAS:

FOCUS

- Experiential Exercises
  - Writing a Treatment Plan
  - Writing a Documentation Note
- Other Considerations
  - Stages of Change
  - Legal Issues

KEY CONCEPTS

- It M.A.T.R.S.: Writing Objectives and Interventions
- Considering Client's Readiness to Change
- Documentation Guidelines

Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful

MODULE 4

Recap of Modules 1, 2, and 3

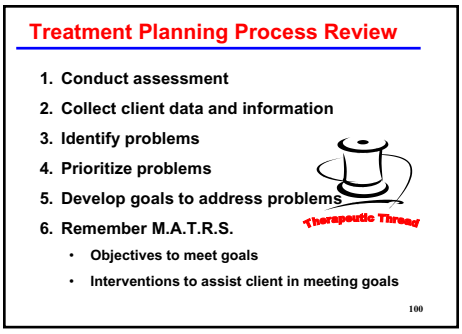
- Components of treatment planning reviewed
- ASI Applications in treatment planning
- Differences between program-driven and individualized treatment plans (old method versus new method)
- Biopsychosocial model of addiction
- The mechanics of treatment planning, including writing and prioritizing problem statements
- Practice writing goal statements
- Introduce M.A.T.R.S. acronym

Module 4 will focus on:

- It M.A.T.R.S.: Writing Objectives and Interventions
- Client Involvement and Readiness to Change
- Writing Documentation Notes

Module 4 Handouts

1. Sample: Individualized Treatment Plan
2. Documenting Client Progress Using S.O.A.P. Method
3. Case Note Scenario
4. Example S.O.A.P. Note
5. S.O.A.P. Progress Note Checklist
6. D.A.P. Progress Note Checklist
7. B.I.R.P. Progress Note Checklist



Overhead 4.100

Treatment Planning Process Review

Problem statements, goals, objectives, and interventions are all part of one continuous therapeutic thread that ties together the delivery of treatment services. Let's review this process:

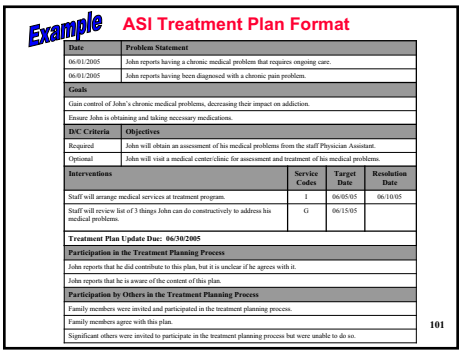
- An assessment is conducted.
- Data and information are collected from the client, collateral sources, and assessment scales.
- Problems are identified.
- Problem statements are prioritized.
- Goals are created that address the problems.
- Objectives to meet the goals are defined
- Interventions are revised or changed based on client response to treatment

In today's training we have:

- Reviewed a sample Master Problem List.
- Developed Problem Statements for three domains:
  - Alcohol/drug domain
  - Medical domain
  - Family/social domain
- Discussed ways to prioritize Problem Statements.
- Wrote goal statements for the three domains.

In this module, we'll focus on writing:

- Objective and intervention statements that meet the M.A.T.R.S. criteria
- Documentation notes reflecting treatment plan progress



Example **ASI Treatment Plan Format**

Date	Problem Statement
06/01/2005	John reports having a chronic medical problem that requires ongoing care.
06/01/2005	John reports having been diagnosed with a chronic pain problem.
Goals	
Gain control of John's chronic medical problems, decreasing their impact on addiction.	
Ensure John is obtaining and taking necessary medications.	
D/C Criteria	**Objectives**
Required	John will obtain an assessment of his medical problems from the staff Physician Assistant.
Optional	John will visit a medical center/clinic for assessment and treatment of his medical problems.

Interventions	Service Codes	Target Date	Resolution Date
Staff will arrange medical services at treatment program.	1	06/05/05	06/10/05
Staff will review list of 3 things John can do constructively to address his medical problems.	G	06/15/05	

Treatment Plan Update Due: 06/30/2005
Participation in the Treatment Planning Process
John reports that he did contribute to this plan, but it is unclear if he agrees with it.
John reports that he is aware of the content of this plan.
Participation by Others in the Treatment Planning Process
Family members were invited and participated in the treatment planning process.
Family members agree with this plan.
Significant others were invited to participate in the treatment planning process but were unable to do so.

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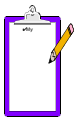
Overhead 4.101

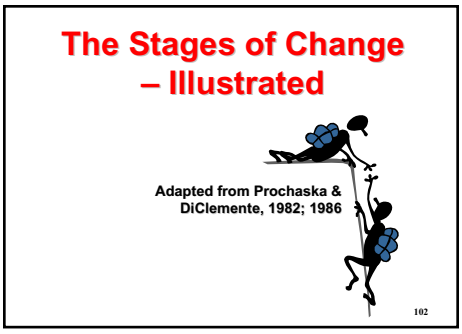
Trainer Note:

- ✓ Refer to Module 4, Handout 1 when reviewing ASI Treatment Plan Format.



Special Features of the ASI Treatment Plan Format

- Service codes are incorporated in the form.
- These codes make the job of writing a plan easier.
- Such short-hand features are less likely to be misinterpreted by clients and other clinicians.
- Each section of the form is labeled to insure all required information is noted.
- Interventions include information about referrals and need to accurately reflect activities occurring during the active treatment phase.
- If it's not reflected in the treatment plan, it didn't happen.

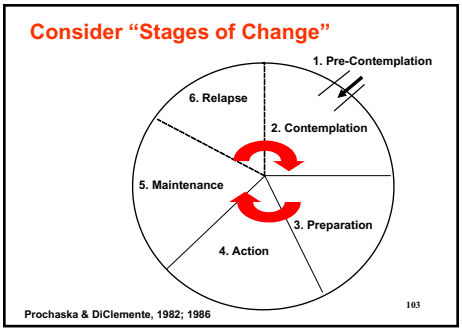


Overhead 4.102

Other Considerations in Treatment Planning

Client Involvement and Readiness to Change

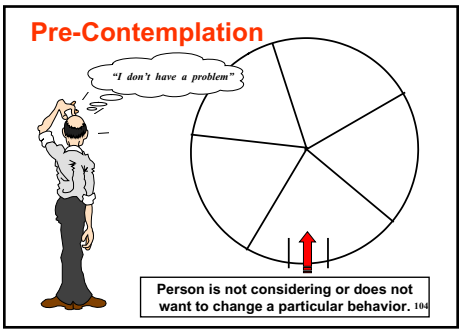
- Since this training is about the process of treatment planning, it might be helpful to look at a theory of how people make changes. We can view clients, ourselves, our agency—even the whole system—through these stages of change. This theory or model is called *Transtheoretical Stages of Change Model*.
- The client's treatment needs, along with her or his readiness to change, should be accurately assessed before treatment recommendations are developed.



Overhead 4.103

Stages of Change

- According to Prochaska and DiClemente (1982; 1986), behavioral change is a multi-step process, rather than a one-time event. Different stages of the change process include:
  - *Precontemplation:* change is not considered
  - *Contemplation:* change is being considered
  - *Preparation:* some action steps toward change have occurred
  - *Action:* active steps toward change are happening
  - *Maintenance:* maintaining behavioral change until it becomes permanent
  - *Relapse:* return to previous pattern of behavior
- Determining a client's stage of change can help the counselor "fit" the treatment plan to the client's readiness and needs. This may help prevent the client from rejecting all or parts of the treatment plan.



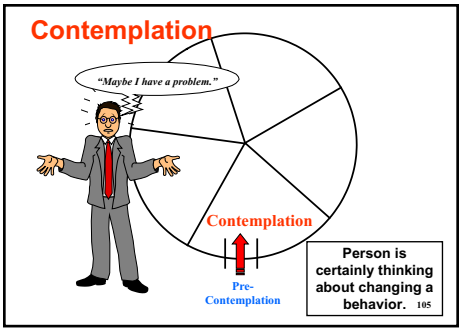
Overhead 4.104

Pre-Contemplation

- The first stage of change is referred to as **Precontemplation.** People in this stage are not thinking about changing. There may be several reasons for this. Perhaps they don't see anything that needs to be changed. Perhaps they have tried and failed to change and no longer have hope. For whatever reason, they are not thinking about changing.

Stages of Change Exercise

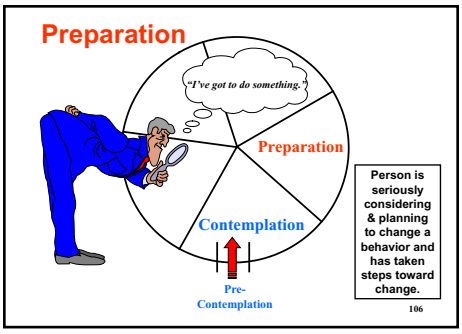
- Have participants think for a moment about a change they are considering or have recently considered making but have not made. Remind them that they will not have to discuss this change with the group unless they want to. This change can be about a job, marriage, smoking, diet, exercise, education, etc.
- Ask participants the following: "How long have you considered making this change?" (e.g., one week, two weeks, one month, three months, six months, or one year?)



Overhead 4.105

Contemplation

- The previous exercise should demonstrate to participants that they are all in the stage called **Contemplation**. People in this stage are at least thinking that a change may need to take place.
  - They may be weighing the pros and cons or the possibilities involved in the change.
  - They experience ambivalence and uncertainty.
  - They have not committed to change at this point.
  - They are just thinking about it, which is the first step in making a change.

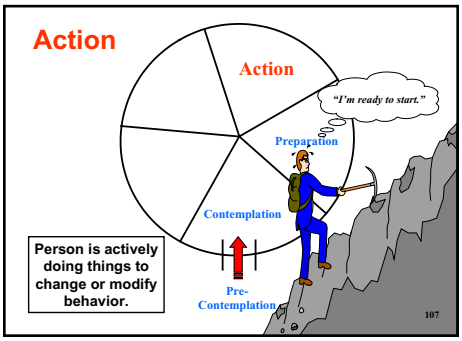


Overhead 4.106

Preparation

- The next stage is **Preparation**. People in this stage are preparing to act. They are committed to and planning to change in the near future. But they are still considering what to do and how to change.

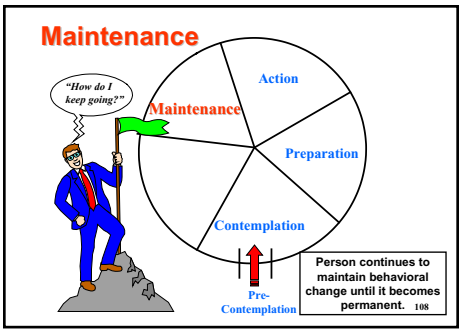
  For example, they may question whether or not they should try to change on their own.
  - Should they seek professional help?
  - Go cold turkey?
  - Try medication?
  - Try self-help?



Overhead 4.107

Action

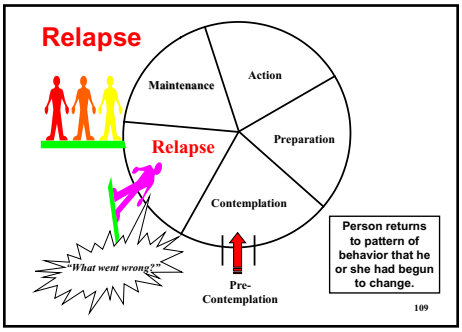
- The **Action** stage is just what it describes. People in this stage are actively taking steps to change but have not reached a point of stability. Treatment programs often focus on interventions that assume the client is in the Action phase.



Overhead 4.108

Maintenance

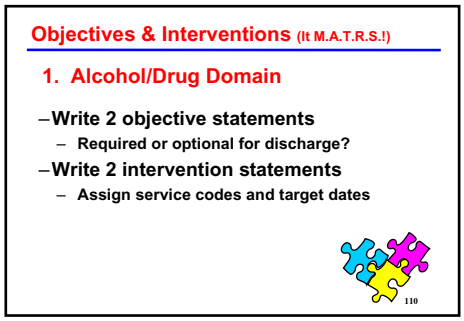
- People in the **Maintenance** stage have achieved their initial goals and are working to maintain gains and continue the change process.



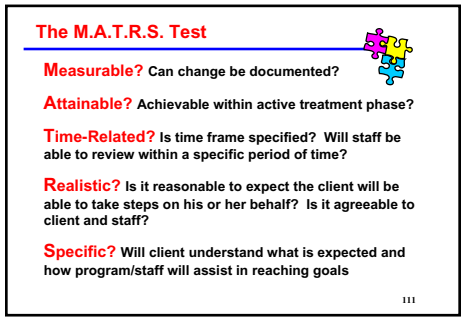
Overhead 4.109

Relapse

- People in the **Relapse** or **Recurrence** stage have experienced a return to the behaviors or symptoms and must now decide what to do next.
- A relapse is a common occurrence in behavioral change.
- It is helpful to define success or progress in smaller increments by moving from one stage to the next.
- Keep in mind these stages of change when writing goals, objectives, and interventions.



Overhead 4.110



Overhead 4.111

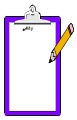
Writing Activity

Write Objectives and Interventions for the Alcohol/Drug Domain:

1. Focus on just the "Alcohol and Drug Domain" for now.
2. Use the ASI Treatment Plan Handout (Module 2, Handout 3). Keep in mind the M.A.T.R.S. acronym when writing 2 objective statements.
3. Now, write 2 intervention statements, keeping in mind the M.A.T.R.S. acronym.
4. Assign service codes and target dates.

✓ **Trainer Note:**

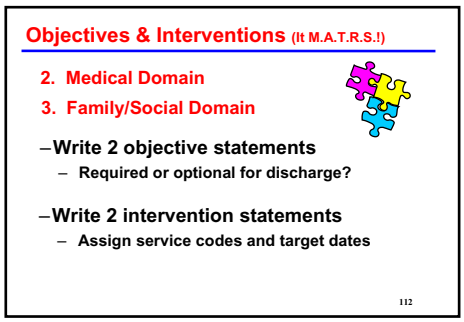
- Allow 15 minutes for writing activity.



Check-In Discussion Questions

Are the objective and intervention statements

- MEASURABLE?
  - Written in such a way that change or progress can be easily documented?
- ATTAINABLE?
  - Achievable within the active treatment phase?
- TIME-RELATED?
  - Is the time frame specified?
  - Will staff be able to review within a specific period of time?
- REALISTIC
  - Is it reasonable the client can take steps on his or her own behalf?
  - Would these statements be agreeable to a typical client and/or staff member?
- SPECIFIC
  - Would a client be able to understand what is expected?



Overhead 4.112

Writing Activity

Write Objectives and Interventions for the Medical and Family/Social Domains

1. Now, move onto the "Medical and Family/Social Domains (Module 2, Handouts 4, 5)."
2. Write 2 objective statements, keeping in mind the acronym M.A.T.R.S.
3. Specify if you think the objectives should be required or optional for client.
4. Write 2 intervention statements with the M.A.T.R.S. acronym in mind.
5. Assign service codes and target dates.

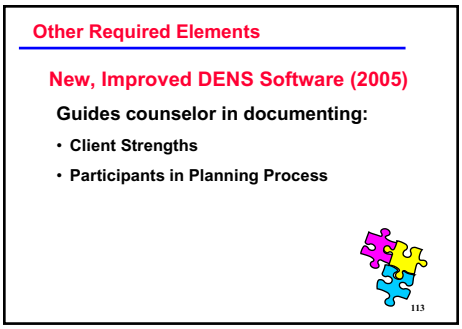
✓ **Trainer Note:**

- Allow 15-20 minutes for writing activity.

Check-In Discussion Questions

Are the objective and intervention statements

- MEASURABLE?
  - Written in such a way that change or progress can be easily documented?
- ATTAINABLE?
  - Achievable within the active treatment phase?
- TIME-RELATED?
  - Is the time frame specified?
  - Will staff be able to review within a specific period of time?
- REALISTIC
  - Is it reasonable the client can take steps on his or her own behalf?
  - Would these statements be agreeable to a typical client and/or staff member?
- SPECIFIC
  - Would a client be able to understand what is expected?



Overhead 4.113

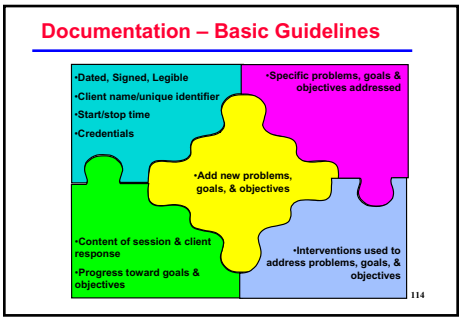
Other Required Elements of a Treatment Plan

✓ **Trainer Note:**

- Acknowledge additional elements typically required in most treatment plans.
- **Client Strengths** should be reflected in the treatment plan.
- **Participation in Treatment Planning Process** is a second element included in most treatment plans and/or documentation notes.
- ***The New and Improved ASI DENS Treatment Planning Software (2005)*** guides the counselor in completing these elements and documents these in the treatment plan report.

Ongoing Documentation (Progress Notes)

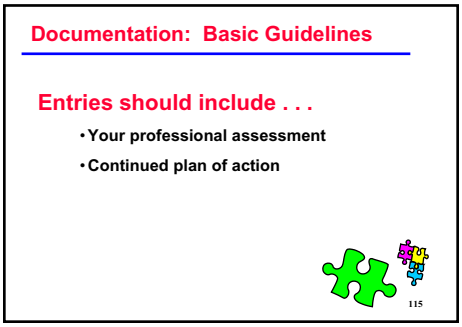
Case notes are the narrative portion of the client's treatment record—the "story" of what has occurred during the beginning, middle, and ending phases of treatment. Case notes also provide a connection to the treatment plan. A counselor not familiar with a client's case should be able to read the case notes section of the treatment record and understand exactly what has occurred in treatment.



Overhead 4.114

Basic Guidelines

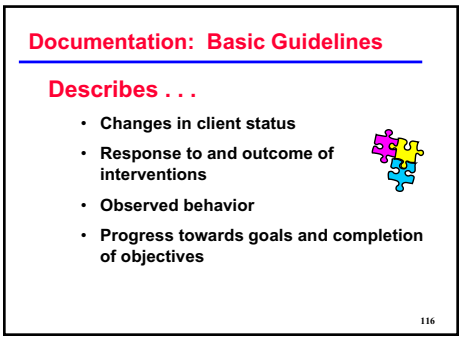
- Notes are dated, signed, and legible.
- Client name and identifier are included on each page of the clinical record.
- Referral information has been documented.
- Sources of information are clearly documented.
- Client strengths and limitations in achieving goals are noted and considered.
- The style of documentation should be consistent and standardized throughout the agency/institution.
- Abbreviations should be standardized and used in consistent context.
- Documentation should reflect changes in client status including response to and outcome of interventions.



Overhead 4.115

Basic Guidelines

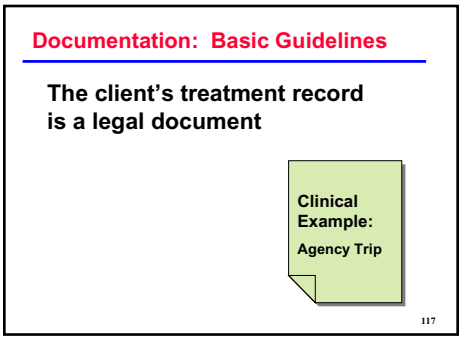
- Entries should include the clinician's professional assessment and continued plan of action.



Overhead 4.116

Basic Guidelines

- Changes in client status should be documented (e.g., change in level of care provided or discharge status).
- Client response to and outcome of interventions should be included.
- Observed behavior should be noted.
- Include documentation of progress towards goals and completion of objectives.



Overhead 4.117

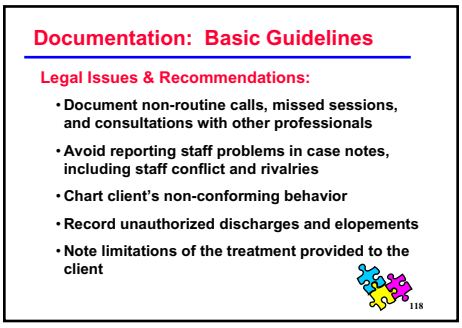
Legal Issues and Documentation:

- The client's treatment record is a legal document.
  - The treatment record can be subpoenaed.
  - The treatment record may be reviewed by managed care utilization review teams or auditors.

Appelbaum and Gutheil (1982) recommend counselors take the perspective that treatment records will have future readers. Entries will be read or scrutinized by others.

Optional Discussion Activity:
Read case scenario to support legal issues and recommendations that follow.

Case Scenario:
A client gets injured while on a wilderness trip sponsored by the treatment provider. The counselor writes a two-sentence case note entry about the incident leaving out important details like the safeguards taken by the provider, the actions taken to remedy the situation, and statements the client made before, during, and after the incident. Two years later the client files a lawsuit against the treatment provider for negligence. The only details relating to the incident are the two sentences documented in the treatment record. Case notes should record the details of the incident in a fair and ethical manner.



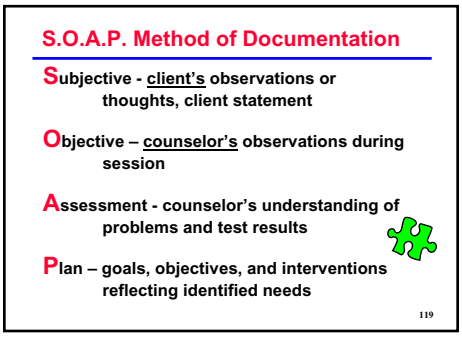
Overhead 4.118

Legal Issues and Recommendations

- Document non-routine calls, missed sessions, and consultations with other professionals.
- Avoid reporting staff problems in the case notes, including staff conflict and rivalries.
- Chart client's non-conforming behavior.
- Record unauthorized discharges and elopements.
- Note limitations of the treatment being provided to the client.

Problem Oriented S.O.A.P. Notes

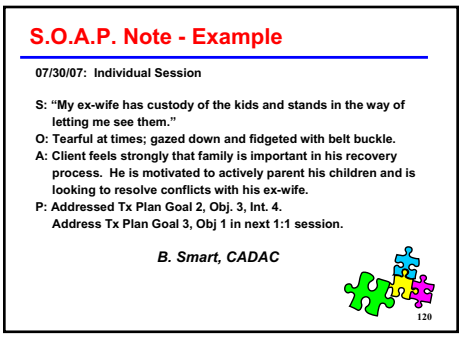
- In 1968, Lawrence Weed published his proposal of the S.O.A.P. note. This style is one of the most widely used methods of reporting ongoing progress.
- S.O.A.P. was designed to standardize and improve the structure of the medical record.
- It encouraged a logical thought process and approach to record keeping with an aim to produce less unstandardized, narrative note-taking.
- Information was more concise and communicated client activities clearly to other clinicians.



Overhead 4.119

Progress Notes (S.O.A.P.)

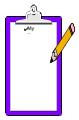
- **S**ubjective – the client's observations or thoughts; a client's direct statement
- **O**bjective – the clinician's observations during the session
- **A**ssessment – the clinician's understanding of the problem and test results
- **P**lans – goals, objectives, and interventions reflective of problems/needs identified during assessment or ongoing assessment



Overhead 4.120

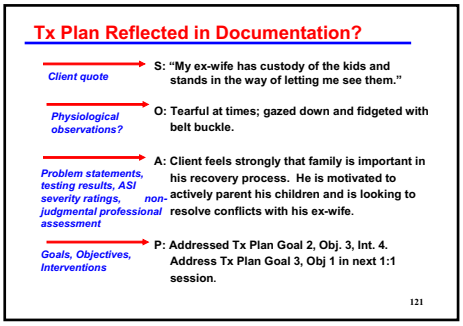
S.O.A.P. Note Example

Trainer Note:



- ✓ Introduce *S.O.A.P. Progress Note Checklist*
- ✓ Introduce the *B.I.R.P. Progress Note Checklist*
- ✓ Introduce *D.A.P. Progress Note Checklist*

Remind participants that tools may be duplicated and used as references in a clinical setting.



Overhead 4.121

Is the Treatment Plan Reflected in Documentation?

- Notice the connection between treatment plan components and the documentation note.

Other Recognized Documentation Formats

D.A.P.

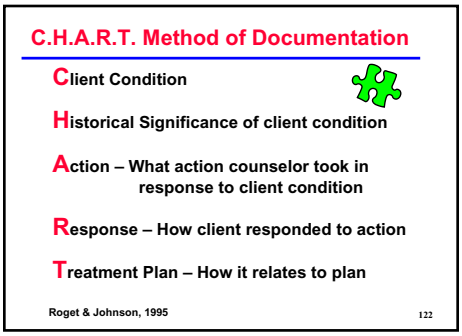
- **D** = Describe (or Data)
- **A** = Assess
- **P** = Plan

B.I.R.P.

- **B** = Behavior
- **I** = Intervention
- **R** = Response
- **P** = Plan

C.A.R.T. (Roget & Johnson, 1995)

- **C** = Client **condition**
- **A** = What **action** did the counselor do in response to client condition?
- **R** = Client **response** to treatment plan
- **T** = How response relates to **treatment plan**



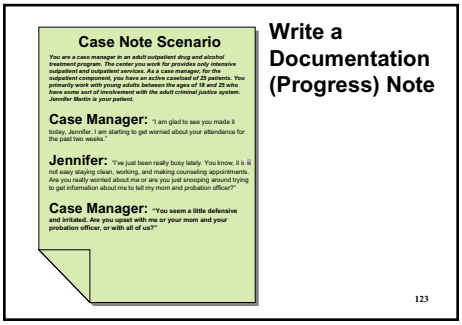
Overhead 4.122

C.H.A.R.T. (Roget & Johnson, 1995)

- **C** = Client **condition**
- **H** = **Historical** significance of client condition
- **A** = What **action** did the counselor do in response to client condition?
- **R** = Client **response** to treatment plan
- **T** = How response relates to **treatment plan**

General Discussion: What Other Formats Are Used?

- What other styles are used in your state/agency?
- Identify and/or review state-specific documentation requirements.



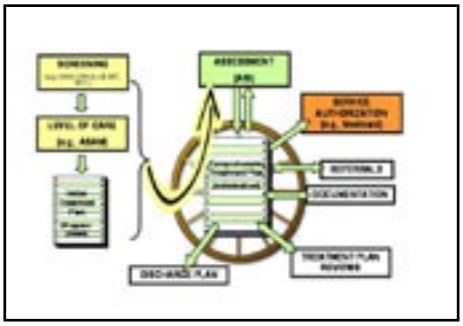
Overhead 4.123

Optional Writing Activity:
Write a Documentation (Progress) Note

- Refer to Case Note Scenario Handout (Module 4, Handout 4).
- Ask participants to read and discuss in small groups.
- In groups of 2 to 3, practice writing a sample documentation note.
- Participants may choose to use any documentation style presented.

Overhead 4.124

The Treatment Plan is the pivotal point in which all other documentation activities revolve. The plan is like the hub of a wheel—without the hub, the spokes have no way to connect.

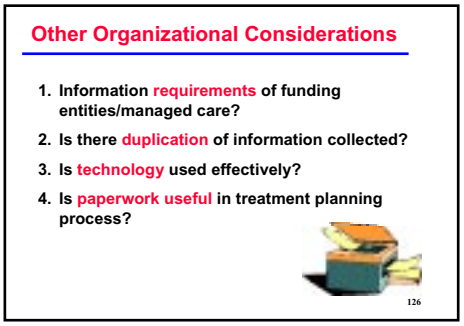


Overhead 4.125

The Role of the Treatment Plan in Clinical Records

- **Screening** instruments (e.g., URICA, SASSI-3, MAST) are administered to gather and sort information to determine the most appropriate initial course of action and determine if a comprehensive assessment is appropriate.
- **Patient Placement Criteria** is a guideline used to match client needs to a broad level of service and/or a level of care. A widely used national guideline, such as the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM PPC-2R), may be used as a tool in treatment planning.
- An **initial treatment plan** focuses on the client's short-term or preliminary goals and objectives and guides the initial course of treatment. Elements of an Initial Plan include reason(s) treatment is indicated, a preliminary diagnosis, client's presenting problems/ symptoms, and initial methods/services that will be used to address problems. *These preliminary plans often resemble the "program-driven" style of treatment plan.*
- The **assessment** is an ongoing process and is the next step in formulating an individualized treatment plan. Validated assessment instruments, such as the ASI, are interpreted and results are used to identify client strengths and needs. (If the ASI is administered, problem areas are identified leading to a Master Problem List).
- An **individualized treatment plan** is a written document that identifies important treatment goals, describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between the counselor and client.
- **Service authorization** is frequently determined through review of the treatment plan.
- **Referrals** to outside resources are reflected in the treatment plan.
- **Ongoing documentation** (i.e., progress notes) is recorded in the client record after each encounter. Notes should reflect treatment plan progress.

- **Treatment plan reviews/continued stay reviews** reflect client progress in relation to the problems/ goals identified in the most current treatment plan and may also adjust the level of care.
- Most program certification/licensing practice guidelines require a **discharge plan** be developed soon after admission to a treatment program. Discharge criteria are determined by the problem and goals addressed in the treatment plan.
  - NOTE: Discharge criteria may be specified as "required for discharge" OR "optional for discharge" in the ASI Treatment Plan format.



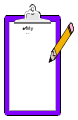
Overhead 4.126

Other Organizational Considerations

For clinical paperwork to become more useful in treatment planning, other factors at an agency and/or program may be considered:

- Clinical record processes are often subjected to incremental changes when funding or program credentialing entities introduce new information requirements.
- Taking a "bird's eye view" of clinical record-keeping processes often reveals duplication of information.
- Use of computer technology in creating and maintaining clinical documentation could streamline the process.
- Look for ASI DENS Software that will prompt and guide the clinician in developing a treatment plan and ongoing documentation.

✓ **Trainer Note:**
- The above organizational considerations were previously covered; see Module 2.



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