Skill-Building in Treatment Plans that Make Sense to Clients

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A. Person-Centered Service and Treatment Planning

Consider the following:

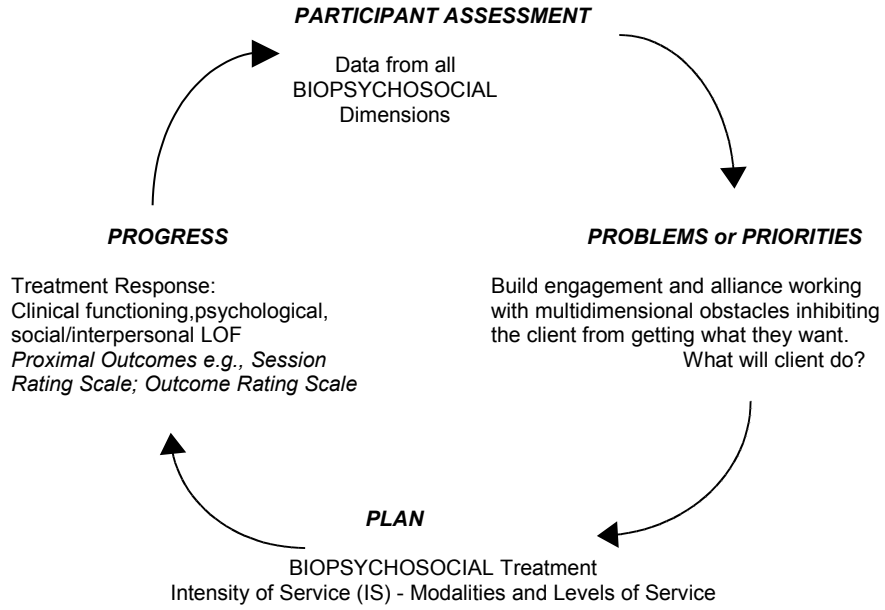
1) What is a treatment plan, and why use one?
   a) NOT just a written plan on paper
   b) Most important with the most complex clients
   c) Should represent a shared vision

2) Teamwork
   a) The client is the most important team member
   b) The client is the person who should know the treatment plan the best
   c) Includes productive work with each other, especially across agencies

3) Engagement
   a) Do we view the world through the client's eyes?
   b) What does the client want most that drives the treatment plan?
   c) How can we help the client to be utilizing his/her strengths?
   d) How do WE feel if the focus is only on the negative—desires, hopes and goals are critical

1. Individualized Treatment

A diagnosis is a necessary, but not sufficient determinant of treatment. A patient is matched to services based on clinical severity, not placed in a set program based only on having met diagnostic criteria.



2. Multidimensional Assessment

Because mental and substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of the six assessment dimensions of the ASAM Patient Placement Criteria can be used to determine multidimensional assessment of severity and level of function of addiction disorders.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

OR

The six LOCUS dimensions are used to determine clinical severity to identify needs and services.

I. Risk of Harm
II. Functional Status
III. Medical, Addictive and Psychiatric Co-Morbidity
IV. Recovery Environment – A. Level of Stress
B. Level of Support
V. Treatment and Recovery History
VI. Engagement

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

3. Correlation Between ASAM PPC-2R and the LOCUS

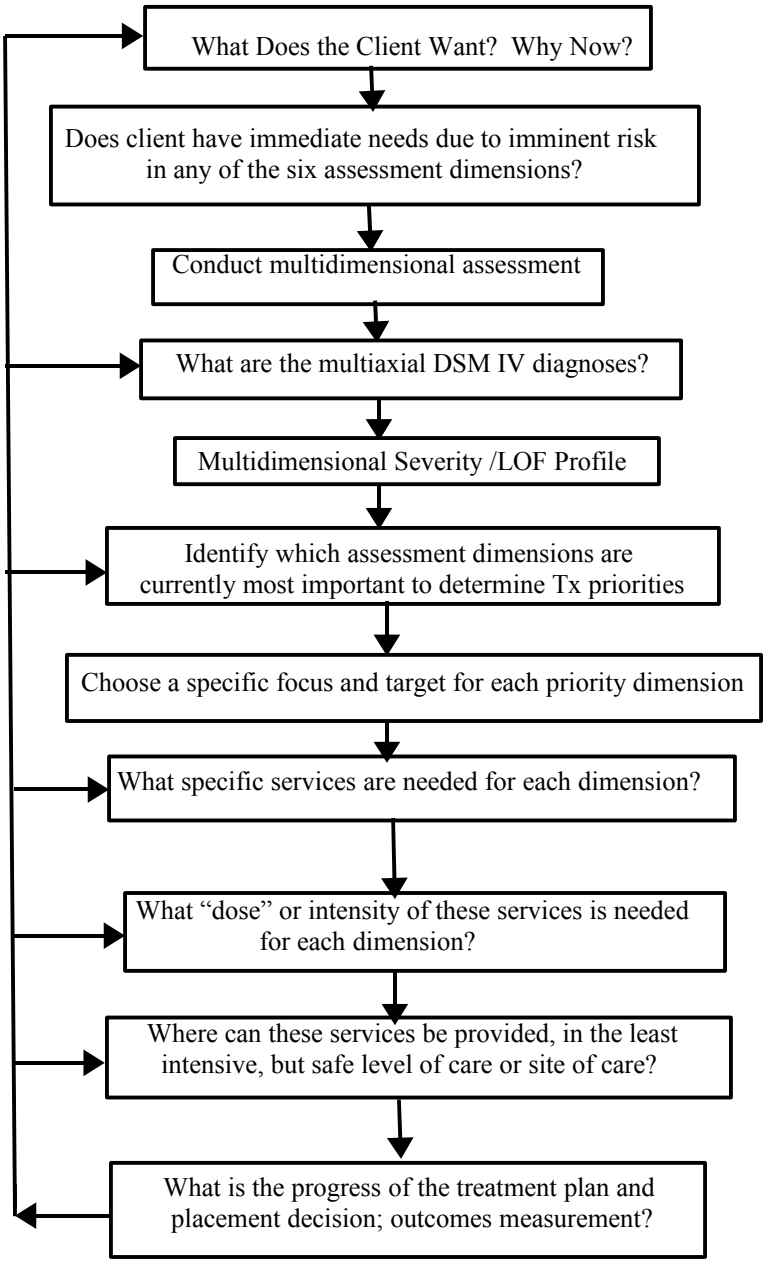
ASAM Dimensions	LOCUS Evaluation Parameters
1. Acute Intoxication and/or Withdrawal Potential	I. Risk of Harm III. Medical, Addictive Co-Morbidity
2. Biomedical Conditions and Complications	III. Medical, Addictive Co-Morbidity
3. Emotional/Behavioral/Cognitive Conditions and Complications	I. Risk of Harm III. Psychiatric Co-Morbidity
4. Readiness to Change	VI. Engagement
5. Relapse/Continued Use/Continued Problem Potential	V. Treatment and Recovery History
6. Recovery Environment	IV A. Level of Stress IV B. Level of Support

4. Biopsychosocial Treatment - Overview: 5 M's
   * Motivate - Dimension 4 issues; engagement and alliance building
   * Manage - the family, significant others, work/school, legal
   * Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
   * Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
   * Monitor - continuity of care; relapse prevention; family and significant others

5. Treatment Levels of Service

   I Outpatient Services II Intensive Outpatient/Partial Hospitalization Services
   III Residential/Inpatient Services IV Medically-Managed Intensive Inpatient Services

6. How to Target and Focus Treatment Priorities



B. **Client-Directed, Outcome Informed Approach - Common Curative Elements Central to All Forms of Therapy (Despite theoretical orientation, mode, or dosage)**

Miller, Duncan, and Hubble have attempted to describe a transtheoretical perspective of what accounts for how clients change, and once knowing this, what therapists can do to enhance the change process. (Miller, Scott D, Duncan, Barry L, Hubble, Mark A (1997): "Escape from Babel – Toward Unifying Language for Psychotherapy Practice" WW Norton & Company)

Hubble MA, Duncan BL, Miller SD (Eds) (1999): "The Heart and Soul of Change: What Works in Therapy" American Psychological Association. Washington, DC.

Duncan BL, Miller SD (2000): "The Heroic Client: Doing Client-Directed, Outcome-Informed Therapy" Jossey-Bass Inc. San Francisco.

1. **Client and Extratherapeutic factors**: accounts for 40% of the change in therapy.

Listen for and validate client change wherever and for whatever reason it initially occurs during treatment process.

- Pretreatment change: (change that occurs between first call to schedule and first appointment)
  - 60% of clients report pretreatment change
- Between session change: Improvement between sessions is the rule rather than the exception.
  - 70% report complaint related improvement between sessions.
  - The largest percentage of change occurs early in therapy (within the first 1-7 sessions).
- Potentiating change for the future:
  - Clients need to see change is a consequence of their own efforts ("positive blame")

2. **Therapeutic Relationship Factors**: accounts for 30% of the change in therapy.

The role of accurate empathy, respect or warmth and therapeutic genuineness

- Build a strong therapeutic relationship, which emphasizes partnership or collaboration in achieving goals
- Treatment should accommodate the client's motivational level or state of readiness for change
- Treatment should accommodate the client's goals for therapy

Treatment should accommodate the client's view of the therapeutic relationship - The client's definition and rating of warmth, empathy, respect, genuineness and validation yields stronger predictions of positive outcome than the therapist's ratings

3. **Expectancy, Hope and Placebo Factors**: accounts for 15% of the change in therapy.

Therapists are more likely to facilitate hope and expectation in their clients when they stop trying to figure out what is wrong with them and how to fix it, and focus instead on what is possible and how their clients can obtain it.

Ways to become Possibility focused:

- Treatment should be oriented toward the future. Clients, research shows, come to therapy not because they have problems but because they have become demoralized about their chances of resolving them.
- Treatment should enhance or highlight the client's feeling of personal choice.
- Treatment should "de-personalize" the client's problems, difficulties, or shortcomings. Therapist should talk about problems in a way that says in essence, "Yes, you have a problem, but you are not the problem"

4. **Model and Technique Factors**: accounts for 15% of the change in therapy. The importance of models and techniques has been inflated in psychotherapy.

- Research literature indicates that focus and structure are essential elements of effective psychotherapy. One of the best predictors of negative outcome in psychotherapy is a lack of focus and structure
- Different schools of therapy may be most helpful when they provide therapists with novel ways of looking at old situations; when they empower therapists to change rather than make up their minds about clients
- Research confirms clients are more likely to benefit from and be satisfied with treatment when therapists are flexible in orientation and do not try to convince them of the utility or rightness of any single approach
- The data indicate that therapists should consider doing something different when they fail to hear or elicit reports of progress from clients within several hours of, rather than several months of therapy. 50 - 60% of clients experience significant symptomatic relief within 1-7 visits

5. **Evidence-based practices**: give you a wide range of guidelines and techniques to draw from when engaging and treating clients. But if you focus only on the particular model as if strict adherence to the model will automatically produce positive outcomes, expect to be disappointed.

   Even if you do not use formal measures of outcome and the therapeutic alliance, you can still be curious about these and check them out clinically:

- Is your client missing appointments? Is she inconsistent in her attendance at sessions? Clients may be voting with their feet that treatment is not helping. You best listen to them to discover what is in your services that's not working for them.
- Is the client passively sitting in individual or group sessions? Do you feel like you are doing all the work? When a client is "doing time" not "doing treatment", the clinical work may be focused on something clearly not of interest to them. They are not pursuing changing in that area of focus. For example, if you're zeroing in on abstinence when your client just wants to cut back their use, don't be surprised if there is poor participation. Perhaps you are working on medication compliance for someone who thinks they are being poisoned; you will usually experience resistance and passivity.
- Is the client relapsing with substance use or mental health signs and symptoms? The focus should not be on discharge or sanctions, but to revisit assessment. Recurrence of substance and mental health problems may be a a crisis, and can worsen. A client might not even agree there is an addiction or mental health problem to work on, therefore the strategies you've put in a treatment plan mean nothing to them. Engagement and motivational enhancement then becomes the clinical focus of attention. There's many possible explanations for relapse. Maybe the person wants help, however what you worked out with them to do is too hard; maybe new obstacles have arisen; or they are demoralized and defeated that anything will work. Providing hope and collaboration on a realistic plan is then the next step.
- How long since you revamped the service plan with the client- weeks, months? Does your client even know what their treatment plan says, what they want to do in group treatment or an individual session to advance their treatment plan? The treatment plan may either be so generic that it has no meaning as a "living document." It might be out-of-date so neither you nor the client can remember it.
- What is the quality of the therapeutic alliance you have with your client? Remember that a therapeutic alliance is not some nebulous, touchy-feely relationship. It is agreement on goals and strategies in the context of an emotional bond. This has the best chance of producing a positive outcome. If you work on things the client is not interested in; if you use methods and interventions that don't make sense to them and their family members; if you raise issues in an atmosphere coercive of change rather than conducive of change, don't be surprised if the outcomes are poor. And don't blame the client for being non-compliant, resistant and unmotivated.

- What variety of methods and models have you been drawing from to create a mix of clinical strategies? Ask this question especially if the client has been unengaged and passive with poor adherence. If something is not working, it's time to quickly shift to a different method/model in collaboration with the client. Figure out what might work better to help the client get what they want. And they do want something from you or they wouldn't be there. It's just that what you want for them, and think they should do, might not be what they want and think should be done. But that is your problem, not their problem! That's where evidence-based practices come in to play - to have enough tools in your clinical tool-kit to shift quickly when the outcomes are not going well.

C. **Skill-Building in Developing and Communicating the Treatment Plan**

1. Engaging the Client as a Participant in Treatment

	CLIENT	CLINICAL ASSESSMENT	TREATMENT PLAN
WHAT?	What does client want?	What does client need?	What is the treatment contract?
WHY?	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what the client wants?
HOW?	How will s/he get there? How quickly?	How will you get him/her to accept the plan?	Does the client buy into the link?
WHERE?	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by placement criteria?	Referral to level of care
WHEN?	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

(David Mee-Lee, MD, 1996)

2. Guidelines for Defining and Writing Problems

* counterproductive attitudes - 3 I's: irrelevant; irritating; insurance-driven
* productive attitudes - 3 C's: concentrate treatment; communicate; cont.-of-care

* problem identification - "2x4":

A – Appropriate to diagnosis (addiction and/or mental health);
A - Achievable: time, place, person
B - Brief; **B** - Behavioral
C - Care: level of care e.g. acute-care oriented, time, place, person;
C - Caring: expressed in accepting, non judgmental words
D - Different: for each patient; what different strategy; time, place, person;
D - Dimension: which of the multidimensional assessment areas does this problem address e.g. Dimension 1

* ***What Made Me Say That?***

(a) **Principles**

1. Problems identified should arise from a biopsychosocial assessment and level-of-functioning (LOF) or severity-of-illness (SI) profile.

2. Problems should be short-term in an acute-care treatment plan; may be longer-term in a program with a longer length of stay (LOS).

3. Treatment planning is a continuous, ongoing process of assessment, problem identification and matched treatment strategies. Thus problems, whether in acute care or longer LOS program, should be specific and treatable within the current level of care (LOC); not fixed for the whole LOS; and should be updated and/or resolved and replaced with new problems identified from ongoing assessment.

4. A problem identified at any time may be listed on the Master Problems Index and coded to indicate whether treatment is to be addressed in the current LOC or later in the recovery or treatment process.

(b) **Steps to Writing Problems**

1. Review the multidimensional Level of Functioning/ Severity Profile and identify which dimensions are of most concern.

2. Look especially at each high and medium severity dimension and ask yourself what concerns you most within that assessment dimension.

3. Review the specific information related to the dimension in the biopsychosocial assessment for help in defining a problem for each dimension of concern.

4. In general, write only one problem for each dimension of concern to keep the treatment plan focused, specific, fluid and achievable. If there is an additional acute problem needing treatment, then a second problem for that dimension may be necessary.

5. Define the problem using the "2x4" guidelines.

6. Check the problem you have decided to document for specificity and individualization by asking yourself, "What made me say that?". If you can answer with a more specific behavior or observation, then that should be the problem, not the more abstract problem originally chosen.

(c) **Clinical Problem:**

1. A situation or issue in need of improvement; and
2. Related to the clinical assessment of the client.

(d) **Short Term Goal:**

1. An expected result or condition which takes a short time to achieve
2. Related to the identified clinical problem
3. Stated in measurable terms
4. Use action verb to illustrate direction of change
5. One goal per statement
6. Provides a guideline for the direction of care.

(e) **Plan of Treatment:**

1. Describes the service(s) or action to meet the stated goal
2. Specifies frequency of treatment procedures
3. Has a time for achievement
4. Identifies if client and/or staff member(s) responsible for action or strategy in the treatment plan e.g., John is to try the “I have strong willpower, no NA meeting” treatment strategy; and counselor to arrange random urine drug screens.

Case Presentation Format

Before presenting the case, please state why you chose the case and what you want to get from the discussion

I. Identifying Client Background Data

Name
Age
Ethnicity and Gender
Marital Status
Employment Status
Referral Source
Date Entered Treatment
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
Current Level of Service (if this case presentation is a treatment plan review)
DSM Diagnoses
Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating (See Dimensions below 1 - 6)

1.

2.

3.

4.

5.

6.

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

This last section we will talk about together:

III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

Specificity of the problem

Specificity of the strategies/interventions

Efficiency of the intervention (Least intensive, but safe, level of service)

D. **Documentation in Individual and Group Treatment**

1. How to Focus the Treatment Contract in Individual or Group

WHAT DO I WANT?

a. What do you want that made you decide to come here? **(Say what you want, not what others have said they think you need or should do)**

b. Why do you want that? How really important to you is that, anyway? **(Think what it would be like if you didn't get your way with what you want)**

c. Do you know how to get it? What are your ideas about what should be done? **(Be honest and open about your ideas, not what you think others think you should do)**

d. Where and When do you want to do this plan? **(Think whether or not you want to do this here at this site or program, or whether you had somewhere else in mind)**

2. Stages of Change and Therapist Tasks

Stage of Change	Catalyst, Process of Change	Goal	Strategies and Interventions
Precontemplation	Consciousness Raising Social Liberation	Raise doubt	• Establish a relationship and identify the treatment contract • Develop discrepancy between client's goals and current behavior • Use leverage to create incentives to change
Contemplation	Consciousness Raising Social Liberation Emotional Arousal Self-Reevaluation	Tip the balance	• Allow and explore ambivalence • Decisional Balance – pros and cons; costs and benefits • Elicit self motivational statements
Preparation	Social Liberation Emotional Arousal Self-Reevaluation Commitment	Determine best course	• Clarify and reinforce client's goals and strategies • Identify obstacles to following through • Declare plans to change to others
Action	Social Liberation Commitment Reward Countering Environment Control Helping Relationships	Take steps to change	• Strategize on how to reach client's goals and start actual behaviors and changes in thinking • Identify what has worked and what is working and do more of that – Solution-focused • Establish support network and coping skills
Maintenance	Commitment Countering Environment Control Helping Relationships	Prevent relapse	• Strengthen and support lifestyle changes • Celebrate successes and rewards of change • Identify relapse situations, triggers and develop a plan to avoid or deal with relapse
Relapse/Recycling	Depends on which stage relapse returned to	Renew processes of change	• Positively reinforce client's honesty to admit relapse and their return for help • Identify to which stage client returned • Examine where client got "off track" and how what needs to change to resume recovery

3. The Coerced Client and Working with Referral Sources

The mandated client can often present as hostile and resistant because they are at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C's are important:

3 C's

- **Consequences –** It is within criminal justice's mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- **Compliance –** The offender is required to act in accordance with the court's orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- **Control –**The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care now at this point in time. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create incentives for change and provide supports to allow change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

E. **Making Treatment Plans a "Living" Document**

1. Getting There from Here

a) Initial Multidimensional Assessment
b) Development of Treatment Contract (Individual Focus of Treatment) and placement in Appropriate Level and Intensity of Service
c) Recovery Planning: Clinical Interventions based upon the Treatment Contract and multidimensional assessment
d) Multidimensional reassessment of the consumer's service needs
e) Adjustment of the Treatment Contract, Treatment Plan and Level and Intensity of services.

The goals of the Initial Multidimensional Assessment is to balance the clinician's objective assessment of patient data with the patient's concerns and goals and then engage the patient in treatment. The patient's treatment contract (focus of treatment) drives the Treatment Plan (service agreement) between therapist and the patient. Since the patient's treatment contract is highly individualized, it is part of the primary information that is transferred interagency. In quality case reviews supervisors are trained to review three critical chart elements:

1. The Treatment Contract from the Initial Assessment
2. Treatment Plan
3. Chart Progress Notes

These all should form a congruent description of the client's community treatment. These three elements provide a matrix by which the effectiveness of a patient's treatment can be measured in real time.

2. Developing an Individualized Service Delivery Plan

- The individualized service delivery plan is basically a written summary—a snapshot so to speak—of the alliance between a particular client and therapist at a given point in time. While definitions vary from researcher to researcher, most agree that an effective alliance contains three essential ingredients: (1) shared goals; (2) consensus on means, methods, or tasks of treatment; and (3) an emotional bond (Bachelor & Horvath, 1999; Bordin, 1979; Horvath & Bedi, 2002). To these three, we have added a fourth; namely, the client's frame of reference regarding the presenting problem, its causes, and potential remedies—what has been termed, the client's theory of change (Duncan, Hubble, & Miller, 1997).

- When the individualized service plan is considered a written reflection of the alliance between a client and therapist rather than *the* game plan for expert intervention, both the document and the process leading to its creation are entirely different than in traditional care. Instead of being a fixed statement of how treatment will proceed given the client's diagnosis, severity of illness, level of functioning, and programming available, the plan becomes a living, dynamic document—a collaboratively-developed synopsis of the goals, type, and level of interaction the client wants from the counselor or system of care.

3. Quality Audits – Focus on Outcomes not Process

- Paperwork demands that often are more compliance-driven than clinically or outcomes-driven
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(See TIPS and TOPICS September 2007 - www.davidmeelee.com)

- *ASK THE EXPERT*

We've found that including client feedback in our quality assurance process is essential. In the past few years we have conducted in-depth face-to-face interviews with hundreds of individuals receiving services. Clients appreciate the interest we take in their concerns as customers and they welcome the opportunity to improve a system in which they are invested, and, quite frankly, hold expert status.

A client satisfaction interview and a clinical interview require the same skills: promoting trust, assuring confidentiality, and creating an atmosphere where the client is comfortable expressing his/her opinions and offering suggestions.

We developed - and are continuing to improve - a standardized interview format. The interview includes a number of close-ended questions such as "how many, how much, how often" that make calculating data for our stakeholders possible. We also ask open- ended question that allow a conversation with the client to develop. Questions like "What brought you here?" "What would you suggest that might improve our services?" "What would you like to get out of treatment?" And, "Is that on your treatment plan?"

- *WHAT TREATMENT PLAN?*

It became apparent from reading treatment plans across a large system as well as from client interviews that treatment planning, treatment plans, treatment plan reviews are the most obscure feature on the clinical landscape. Often repetitive, prescriptive, and based on the program's offerings, they seldom reflect the living process that the client and the clinician are attempting to make. It's not unusual to find goals and objectives such as "Accept the need for recovery and establish abstinence; attend AA meetings and find a sponsor; complete all assignments; graduate from the program" repeated for all clients. Nor is it unusual for these objectives to remain the same at review. Interventions or methods are often a list of standard clinical services such as group, individual therapy, and case management.

Treatment plans by mandate have strangled our clinical process. Fixed time lines, standardized formats, and drop-down elements in most electronic records have further cluttered the scenery and encouraged clients and therapists to think in program- driven terms as typified by "attend 36 groups; 10 aftercare groups; 4 University lectures; and pass 26 UA's."
In interviewing clients, we found them aware and/or supportive of their treatment plan 51% of the time - meaning that 49% of our clients either do not agree with or do not have a treatment plan.

- *I'VE GOT A PLAN!*

However, the amazing discovery was that 100% of clients have a plan! In interview, they tell us about their personal expectations for treatment and recovery. And what they tell us appears reasonable and would provide a great beginning to a dynamic, individualized treatment plan.
–> "I don't have a treatment plan. What I want is to stay clean and sober. I'm hoping that after the year is up I won't have cravings anymore."
–>"No, not through here. My workforce services counselor has helped me though."
–>"I can't remember what's on the treatment plan. I think I saw it when I was moving to the 2nd level. My goal is to graduate, to maintain sobriety and healthy living and live day by day without using."

–>"I haven't got a treatment plan. I have a plan I made for myself at home. I want to stay sober and not do drugs. I want to be a responsible mom, get a job and go to school."
–>"Five years ago I would have sold everything to keep using. I don't want to lose everything that's going on now - I'm raising my grandson and that's my most important thing. No, that's not on my treatment plan."
–>"To complete the program and get a job. I want to get as much out of this as I can. I have a treatment plan, but I don't know how to read it."
–>"I think we did a treatment plan and that it was faxed to my PO but it's been so long ago I can't remember for sure."
–>"They don't agree, but I want to use for pain management only."
–>"Not go through treatment centers no more."
–>"After they have their meeting they will inform me."
–>"My goals were established through writing an autobiography and sharing it with the group and then the group decided what I will work on."
–>"I just got back into treatment. I left last week with my friend so we could go use, but she died of an overdose. When people come in now they start writing plans. I just can't plan ahead right now. I'm just going day-by-day, hour-by-hour. That's how the world's going for me right now."
–>"Initially I got to help create my treatment plan and then my therapist changed last week. My new therapist added another goal, but I had already chosen my goals and I don't want to do both. My new therapist said she would review it with her team and get back to me with what they decide."
–> "I don't have a treatment plan. I just want to hurry and complete the program. I don't want to have to involve my kids. My drug problem is my problem, not theirs."
–>"My plan is to lay low in here because if they knew what I'm thinking they would make me start over."
–>A parolee shared his 6 point plan created while he was incarcerated. It included completing all the substance abuse courses offered by the prison and earning his high school diploma before his release. In his transition to parole he was assisted in making contact with his family and repairing those relationships. Since his parole he finished a vocational program and earned certification allowing him to hold a good job. Now he had that job and was working. Coming to treatment however was interfering with his work because his boss was not happy about letting him off early to attend treatment and treatment was not willing to compromise their program to support his goals.

- *ARE THERE ANY QUESTIONS?*

Reviewing client comments raised questions. We questioned if and how clients found treatment sensitive to their needs, or if some clients just 'endure' treatment while working to meet goals on their own - in spite of our 'interventions.' As one client told us, "I just want to complete treatment and endure the longevity of sobriety."

We questioned the mandatory nature of a treatment plan that imposes timelines and formats that are burdensome to clinicians, that don't follow clinical logic and further encourage program-driven treatment.

- *ARE THERE ANY ANSWERS?*

We've responded to our findings with a number of changes to our audit process beginning with a redesign of our treatment plan/treatment plan reviews. Our new ASAM guided treatment plan will be connected directly to the progress notes, because, as our client record auditing has shown, the progress note most closely follows the clinical flow and represents the 'here and now' of treatment. We will ask our programs to think "dimensionally" as they partner with their client in establishing a meaningful goal (there will be no drop down or pre-cooked goals). A progress note that incorporates the treatment plan and ASAM PPC-2R to evaluate and track the client's needs in each dimension and identify objectives and interventions in the present rather than waiting to meet an arbitrary timeline. It is our hope that this change will promote the treatment plan/review as a living document and the relationship between clinician and the client as a dynamic, problem-solving partnership.

Again, documentation alone is not an adequate measure of the quality of service. However, as a tool, documentation will continue to serve us in all the usual ways while provoking us with the questions it poses. So, no, eliminating documentation is not the answer. But we can set expectations that allow documentation to become more meaningful to clinicians, payers, auditors and clients, more supportive of the therapeutic alliance and more encouraging of client-driven, individualized treatment across a continuum of care.

4. Salt Lake County Audit Survey

- Current version of the survey Salt Lake County is using to assess client involvement, and to consult with programs to improve quality of care and outcomes.

Salt Lake County Division of Substance Abuse
CQI/UR Client Interview

Client ID:
Treatment Provider/Program:
Date entered Tx:
ASAM Level: (How long at this level)

Date:
Interviewer:

1. What's the single most important thing that brought you to treatment?

Why Now?

What would happen if you hadn't come here?

Court ordered: _____ Self-referred: _____ Other: _____

2. Have you been in treatment before?
Yes: _____ No: _____
(If yes, how many times?) 1-2:___ 3-4:__ 4- 6:___ 7+:____

3. What are you hoping to get out of treatment? (What will make your time here worthwhile, etc.?)

4. What will you need to make this happen?

5. Using this scale, how well do you think treatment is helping you make this happen?
Not at all _____ Very Well

6. Are these things on your treatment plan?
Yes_____ No_____

7. Are you linked to other services?
Yes: ____ No: ____
If yes: list services/agencies

Did treatment connect you with services? Yes: ____ No: ____

8. What have been barriers to your treatment? (What's made it hard for you to be here? Probes: how long did it take to get into treatment, fees, transportation, hours, conflict with employment, child care, etc.)

9. What is your drug of choice?

10. Since you have been in treatment, have you been abstinent? (Date of last use? Probe how the client reduced use; what worked or didn't work)
Yes: ____ No: ____

If no: have you reduced your use? (What's the program's reaction to use?) Yes:____ No:____

11. Since you have been in treatment, have you had fewer problems with the police and/or courts?
N/A____ Yes: ____ No: ____

12. Do you have children?
Yes: ____ No: ____
If yes, how many_____

13. Since you've been in treatment have you had fewer family problems?
N/A____ Yes: ____ No: ____

14. How do you know when you have completed this phase of your treatment?

15. How will you know when you're ready to complete treatment? (Probes: is it time driven [court or program driven] or when treatment individual goals are met [client driven?] Does client have a sense of the treatment continuum of care or do they think they "graduate"?)

16. What are the strengths of this program? (Probes: what have you learned; what do you like; what has helped?)

17. Using this scale, how would you rate this program?
Not Helpful _____ Very Helpful

18. What would you suggest to make your treatment even more helpful? (Ask client to suggest something we can do to bring the mark up just a little)

19. How likely is it that you would recommend this program to others?
Definitely Would Not_____ Definitely Would

What would make you more likely to recommend this program to others?

F. **Changes Necessary to "re-tool" Treatment Planning and Services**

* Personnel; Programs; Payment; Public/Private Sectors:

1. Personnel

* Better training in biopsychosocial theories, modalities of treatment, assessment and documentation skills
* Increased interdisciplinary functioning and team work
* Increased individualized treatment and thorough case management
* Increase curiosity and research

2. Programs

* Flexible lengths-of-service in all levels of service
* Overlapping levels of care - better continuity and efficiency
* Expanded intensities of service
* More modalities of treatment - biopsychosocial
* Innovative program structure - milieu; individualized treatment

3. Payment

* Reimburse or fund all levels of service
* Increase incentives for less costly care
* Fund thorough case management

4. Public/Private Sectors

* One quality and system of care
* One common set of criteria - clinically-based not program-based
* Increase interdependence - improve incentives and equalize over/under capacities

Carl

Carl is a 15 y.o. young man who you suspect meets DSM criteria for Alcohol Abuse and Marijuana Abuse, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl claims he is holding for a friend.

LEVEL OF CARE ASSESSMENT FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

Discussion Case

(Kenneth Minkoff, MD
Kminkov@aol.com)

Please review the following case carefully, and try to determine what level of care you would consider to be most appropriate and cost-effective. Utilize whatever level of care assessment tool(s) you prefer to assist you in this process (e.g., ASAM PPC-2R, LOCUS, CHOICE-Dual). For the sake of this discussion, assume that the system has available any of the following services: medical hospitalization for detox; Dual Diagnosis Enhanced (DDE) psychiatric inpatient; Dual Diagnosis Capable (DDC) psychiatric inpatient; DDE Level 3.7 medically-monitored detox; DDC level 3.7 detox; DDE level 3.5 addiction residential treatment; DDC level 3.5 addiction residential treatment DDC psychiatric crisis stabilization bed; DDE psychiatric partial hospitalization with dual track; DDC addiction day treatment; DDC addiction IOP; outpatient addiction groups; individual outpatient counseling. You can recommend more than one service.

Ms. A presents to the crisis service intoxicated and expressing suicidal ideation. Her history is as follows. She is a 37 year-old divorced woman with a long history of treatment for PTSD and Dissociative Identity Disorder (related to childhood sexual abuse) and alcohol dependence. She lives alone and is supported by SSI. She has a primary therapist, whom she sees weekly, and a psychopharmacologist, whom she sees monthly, receiving an SSRI, an atypical neuroleptic, and clonidine. She also attends a psychiatric clubhouse several times per week. She is obese, has a history of seizures (which may be dissociative), and suffers from hypertension.

Approximately 15 months ago, Ms. A had an episode of residential addiction treatment, followed by day treatment, and has been consistently sober since, attending AA meetings 2-3 times per week, and DRA once per week. She also attended a women's early recovery group regularly for one year, and then discontinued the group 3 months ago. While sober, she has not been hospitalized, but frequently has experienced flashbacks and dissociative episodes associated with impulses to harm herself. These were managed with outpatient crisis support, and occasionally an overnight stay in a crisis bed. One week ago, she had contact with her abusive father for the first time in a year. This precipitated severe flashbacks, which in turn led her to relapse on alcohol. She felt ashamed of this relapse, and has since avoided AA and her sober contacts, including her sponsor. She continued to drink all week, not taking medicine, and missing her therapy appointment. She has felt progressively depressed, and today experienced strong impulses to hurt herself, to the point that she scratched her wrists superficially with a knife, and reports strong impulses to take all her pills. Her blood alcohol level on admission to the crisis service is 0.18. She denies history of DTs or withdrawal seizures. She does not wish to be hospitalized, and reports she feels safer now that she is in the crisis service. She agrees for her therapist to be contacted; her therapist expresses concern about her safety, but also says she is usually reliable when contracting.

After an hour, her blood alcohol level is 0.1. She is calmer, but still expressing some suicidal thoughts. She states that she knows she needs to get back to sobriety, though she isn't clear how she will manage the difficult feelings stirred up by seeing her father. She states that she would like to go home, and that she will see her therapist the next day, and begin attending AA again, but will agree to whatever suggestions we make in concert with her therapist, other than agreeing to hospitalization.
What would you recommend?

After you have considered your answer, think about whether any of the following considerations would affect your decision, and if so, in what way:

1. Presents with a deep wrist cut requiring sutures.
2. Lives with a sober, concerned boy friend
3. Presents to the crisis service with her AA sponsor who promises to get her to a meeting tomorrow
4. Has been drinking steadily for one month.
5. Has insulin dependent diabetes and/or a history of withdrawal seizures
6. Tells us that only one of her alters drinks, and she is not sure how to stop her.
7. Her therapist states she is unreliable when drinking
8. Has never had addiction residential or day treatment.
9. Is currently followed by an integrated ACT Team with 24 hour crisis capability.
10. Requests hospitalization, and refuses to agree to a lower level of care.

Tracy

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment.

The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and nurse from the psychiatric unit who came from the unit to evaluate the teen, both feel she needs to be in hospital given the animosity at home, the violent behavior and the question of intoxication.

Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

Dimension 1, Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.

Dimension 2, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints

Dimension 3, Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.

Dimension 4, Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to treatment, but doesn't want to be at home at least for tonight.

Dimension 5, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be a reoccurrence of the fighting and possibly violence again, at least with father.

Dimension 6, Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting.

Severity Profile: (High, Medium, Low)	Dimension: Severity:	1	2	3	4	5	6

Services Needed:

Site of Care:

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY **Page 1 of 2**

Name:_____ **Date:**_____

Immediate Need Profile: **Assessor considers each dimension and with just sufficient data to assess immediate needs, checks "yes" or "no" in the following table:**

Dimension	Questions	Yes	No
1. Acute Intoxication and/or Withdrawal Potential	1(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal?		
1. as above	1(b) Currently having similar withdrawal symptoms?		
2. Biomedical Conditions/Complications	2 Any current severe physical health problems?		
3. Emotional/Behavioral/Cognitive Conditions/Complications	3(a) Imminent danger of harming self or someone else?		
3. as above	3(b) Unable to function and safely care self?		

. Yes to questions 1a, 1b, 2 and/or 3a, 3b requires that the caller/client immediately be referred for medical and/or mental health evaluation, depending on which dimension(s) involved.

4. Readiness to Change	4(a) Does client appear to need alcohol or other drug treatment/ recovery, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK		
4. as above	4(b) Client been coerced, mandated or required to have assessment and/or treatment		

. Yes to questions 4a and/or to 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client's stage of readiness to change.

5. Relapse/Continued Use Potential	5(a) Is client currently under the influence or intoxicated?		
5. as above	5(b) Is client likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner?		

. Yes to question 5a requires caller/client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24-hour structure or care.

6. Recovery Environment	6. Are there any dangerous family, sig. others, living/work/school situations threatening client's safety, immediate well-being, and/or sobriety?		

. Yes to Dimension 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be assessed for the need of a safe or supervised environment.

LEVEL OF FUNCTIONING/SEVERITY: Using assessment protocols that address all six dimensions, assign a severity rating of **High, Medium or Low** for each dimension that best reflects the client's functioning and severity. Place a check mark in the appropriate box for each dimension.

Level of Functioning/Severity	Intensity of Service Need	1. Intox With	2. Bio-med	3. Emot/ Beha	4. Read i-ness	5. Rel-apse	6. Rec. Envir
Low Severity – Minimal, current difficulty or impairment. Absent, minimal, or mild signs and symptoms. Acute or chronic problem mostly stabilized; or soon able to be stabilized and functioning restored with minimal difficulty	**L** No immediate services or low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings						
Medium Severity - Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance	**M** Moderate intensity of services, skills training, or supports needed for this Dimension. Treatment strategies may require intensive levels of outpatient care						
High Severity - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate & cope with problems.	**H** High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily						

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY (cont.)

Page 2 of 2

Name:_____ **Date:**_____

PLACEMENT DECISIONS: Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs

ASAM PPC-2R Level of Detoxification Service	Level	Dimen. 1 Intoxic/ Withdr.
Ambul. Detox without Extended On-Site Monitor.	I-D	
Ambul. Detox with Extended On-Site Monitoring	II-D	
Clinically-Managed Residential Detoxification	III.2-D	
Medically-Monitored CD Inpatient Detoxification	III.7-D	
Medically-Managed Intensive Inpatient Detox.	IV-D	

ASAM PPC-2R Level of Care for Other Treatment and Recovery Services *	Level *		Dimen. 2 Biomed.	Dimen. 3 Emot/ Behav.	Dimen. 4 Readi-ness	Dimen. 5 Relapse/ Cont Use	Dimen. 6 Recov. Environ.
Early Intervention / Prevention	0.5						
Outpatient Services / Individual	I						
Intensive Outpatient Treatment (IOP)	II.1						
Partial Hospitalization (Partial)	II.5						
Apartments /Clinically-Managed Low-Int. Res. Svcs.	III.1						
Clinically-Managed Med-Intens. Residential Svcs.	III.3						
Clinically-Managed High-Intens. Residential Svcs	III.5						
Medically-Monitored Intens. Inpatient Treatment	III.7						
Medically-Managed Intensive Inpatient Services	IV						
Opioid Maintenance Therapy	OMT						

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity.	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level is not utilized, insert the most appropriate placement available and circle the Reason for Difference between Indicated and Received Level	
Reason for Difference - Circle only one number -- **1**. Service not available; **2**. Provider judgment; **3**. Client preference; **4**. Client is on waiting list for appropriate level; **5**. Service available, but no payment source; **6**. Geographic accessibility; **7**. Family responsibility; **8**. Language; **9**. Not applicable; **10**. Not listed.	

COMMENTS:

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