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## **Skill Building in Recovery: Treatment Plans that Make Sense to Clients**

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July 27, 2010

Newark, DE

### **Pre-Test Questions**

Select the Best Answer:

1. Prochaska's Transtheoretical Model of Change:
  - (a) Can apply to addictive disorders as well as to mental health disorders, including gambling.
  - (b) Requires extensive training to understand.
  - (c) Provides a linear model of stages that are fixed and static.
  - (d) Recommends that only motivated people should receive treatment.
  
2. Assessment of resistance and denial is important to:
  - (a) Match treatment to the client's readiness to change.
  - (b) Ensure residential care is not wastefully utilized.
  - (c) Avoid confrontational approaches that alienate the client.
  - (d) Individualize the referral and treatment plan.
  - (e) All of the above.
  
3. To ask a consumer what s/he really wants:
  - (a) Is unnecessary as their judgment is so poor.
  - (b) Is as important as assessing what the consumer needs.
  - (c) Gives a false impression that they should have choice about treatments
  - (d) Leads to disrespect of the clinician's authority and expertise.
  - (e) Usually reveals unrealistic goals that should be ignored.
  
4. Treatment plans should be:
  - (a) Vague to protect confidentiality.
  - (b) General to allow flexibility in lengths-of-stay.
  - (c) Preprinted to improve consistency.
  - (d) Highly technical to demonstrate professionalism
  - (e) Assessment-based to improve individualization.
  
5. Problem statements in treatment plans should be:
  - (a) Standardized and generic to allow speedy documentation.
  - (b) Comprehensive and wordy enough to show professionalism.
  - (c) Exclusively patient quotes so as to demonstrate individualization.
  - (d) Brief and behavioral to allow measurable outcome.

Identify what stage of motivational readiness to change corresponds with each of the following client statements:

6. Client: “I guess this is making my life difficult, but it’s just too hard to change.”  
Stage of Change:

7. Client: “I’ve stopped gambling now for eight months and doing well with urges to gamble.”  
Stage of Change:

8. Client: “I don’t have a problem with anger, it’s just because I’m depressed.”  
Stage of Change:

Indicate True or False:

T F

- 9. It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms. ( ) ( )
- 10. If a person is ambivalent, it is best to talk persuasively about the healthy choices. ( ) ( )
- 11. The counselor’s role is to facilitate the client’s natural self-change process. ( ) ( )
- 12. If a client disagrees with your assessment or recommendations, it is best to gently remind him or her that you are the professional and they are the client. ( ) ( )
- 13. Progress Notes too often just document attendance at a session or compliance with treatment expectations, instead of specific information on response to treatment. ( ) ( )
- 14. Goals should be written for the client as we know what is best for their recovery. ( ) ( )
- 15. Clients should be encouraged to express their concerns with the treatment plan. ( ) ( )
- 16. Clients in early stages of change need relapse prevention strategies. ( ) ( )

**A. Recovery – Definitions and Attitudes**

1. What do you mean by recovery?

2. How do you know if a person is in recovery? Describe a person in good recovery:

3. List five questions you would explore with a client to promote a strength-based, positive recovery perspective rather than a pathology deficit-based perspective.

4. List five questions you would explore with a client that perpetuates a pathology-oriented, deficit-based perspective.

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### **Recovery in Addiction**

“Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse or substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.”

(White, W. & Kurtz, E. (2005). “The Varieties of Recovery Experience”. Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at <http://www.glattc.org>)

### **Recovery in Mental Health**

“Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness”

(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

A 2001 paper in *Psychiatric Services* summarized a conceptual model on recovery and referred to both internal conditions (“the attitudes, experiences and processes of change of individuals who are recovering”) and external conditions (“the circumstances, events, policies and practices that may facilitate recovery”).

### **Recovery – A Conceptual Model**

#### ***Internal Conditions***

- Hope – belief that recovery is possible; it lays the groundwork for healing to begin
- Healing – recovery is not synonymous with cure; active participation in self-help activities; locus of control is with consumer
- Empowerment – corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices
- Connection – recovery is a social process; a way of being in the company of others; to find a role to play in the world

### **Recovery – A Conceptual Model**

#### ***External Conditions***

- Human rights – reducing and eliminating stigma, discrimination against psychiatric disabilities; equal opportunities in education, employment, housing; access to needed resources
- Positive Culture of Healing – a culture of inclusion, caring, cooperation, dreaming, humility, empowerment, hope
- Recovery-oriented services – best practices of clinical care, peer and family support, work, community involvement to be implemented by consumers, clinicians, and community; services that facilitate individual recovery and personal outcomes; collaborative services; consumers for consumers

### **References:**

Jacobson N, Greenley D (2001): “What Is Recovery? A Conceptual Model and Explication” *Psychiatric Services*. April 2001, Volume 52; No. 4:482-485. You can go to Google, type in *Psychiatric Services* journal and get to the April 2001 edition and download the paper.

Also, check out a commentary on that paper: Peyser H (2001): “What Is Recovery? A Commentary” *Psychiatric Services*. April 2001, Volume 52; No. 4:486-487.

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## **B. Role of Illness Management in Recovery**

**1. Era of Consumerism** (Kizer, KW (2001): “Establishing Health Care Performance Standards in an Era of Consumerism” JAMA 286:1213-1217)

- US Health care system reengineering itself to address the need for quality improvement
- It is being actively reshaped by the expectations of consumers
- All stakeholders demand active collaboration with health care system

**2. Self-Management of Chronic Disease** (Bodenheimer T, Lorig K, Holman H, Grumbach K (2002): “Patient Self-management of Chronic Disease in Primary Care” JAMA 288:2469-2475)

- Patients with chronic conditions make day-to-day decisions about their illnesses – self manage is inevitable
- New chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education
- Programs teaching self-management skills are more effective than information only patient education in improving clinical outcomes
- Self-management education for chronic illness may soon become an integral part of high-quality primary care

**3. Illness Management and Recovery** (Mueser KT, Corrigan PW, Hilton DW et al (2002): “Illness Management and Recovery: A Review of the Research” Psychiatric Services 53:1272-1284; Drake RE, Essock SM, Shaner A et al (2001): “Implementing Dual Diagnosis Services for Clients with Severe Mental Illness” Psychiatric Services 52:469-476; Carey KB, Carey MP, Maisto SA, Purnine DM (2002): “The Feasibility of Enhancing Psychiatric Outpatients’ Readiness to Change Their Substance Use” Psychiatric Services 53: 602-608)

- “Illness management is a broad set of strategies designed to help individuals with serious mental illness collaborate with professional, reduce their susceptibility to the illness, and cope effectively with their symptoms”
- Involves psychoeducation to improve people’s knowledge of mental illness; behavioral tailoring to help people take medication as prescribed; relapse prevention to reduce symptom relapses and rehospitalizations; coping skills training to reduce severity and distress of persistent symptoms
- Comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; help clients acquire skills and supports to manage both illnesses and pursue functional goals; cultural sensitivity and competence
- Empowerment corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires consumers live with consequences of their choices (Mueser, Corrigan et al., 2002; Drake, Essock et al., 2001; Carey, Carey et al., 2002; Jacobson & Greenley, 2001).

**4. Evidence-Based Practices and Quality Improvement:** Guidelines for the redesign of health care were published in “Crossing the Quality Chasm: A New Health System for the 21st Century” (2001) and “Improving the Quality of Health Care for Mental and Substance-Use Conditions” (2005) – both reports from the Institute of Medicine. Of the 10 rules originally published to guide the redesign of the health care system, at least 5 involve “patient-centered care”:

- The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
- Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information
- The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.
- The health system should anticipate patient needs, rather than simply reacting to events.

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## C. Principles of Focused, Targeted Treatment Planning - Why Individualize Treatment?

### (i) 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

### (ii) Common Treatment Planning Issues for Improvement

#### 1. Problem Statements – Too general and non-specific

Examples: “Psychiatric”; “Substance Abuse”; “Legal”

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#### 2. Goals – Not understood by clients

Examples: By six months, “develop awareness of cognitive deficits” and utilization of cognitive rehabilitation resources”; “Client will reduce the frequency of distorted, negative thoughts, use reframing skills”

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#### 3. Interventions – Generic and not individualized

Examples: Substance abuse education weekly – work on healthy living behaviors; Pros and cons of complying with prescribed treatment activities and medications; Contemplator Discovery Group; Dual Recovery Anonymous; MISA Consultation

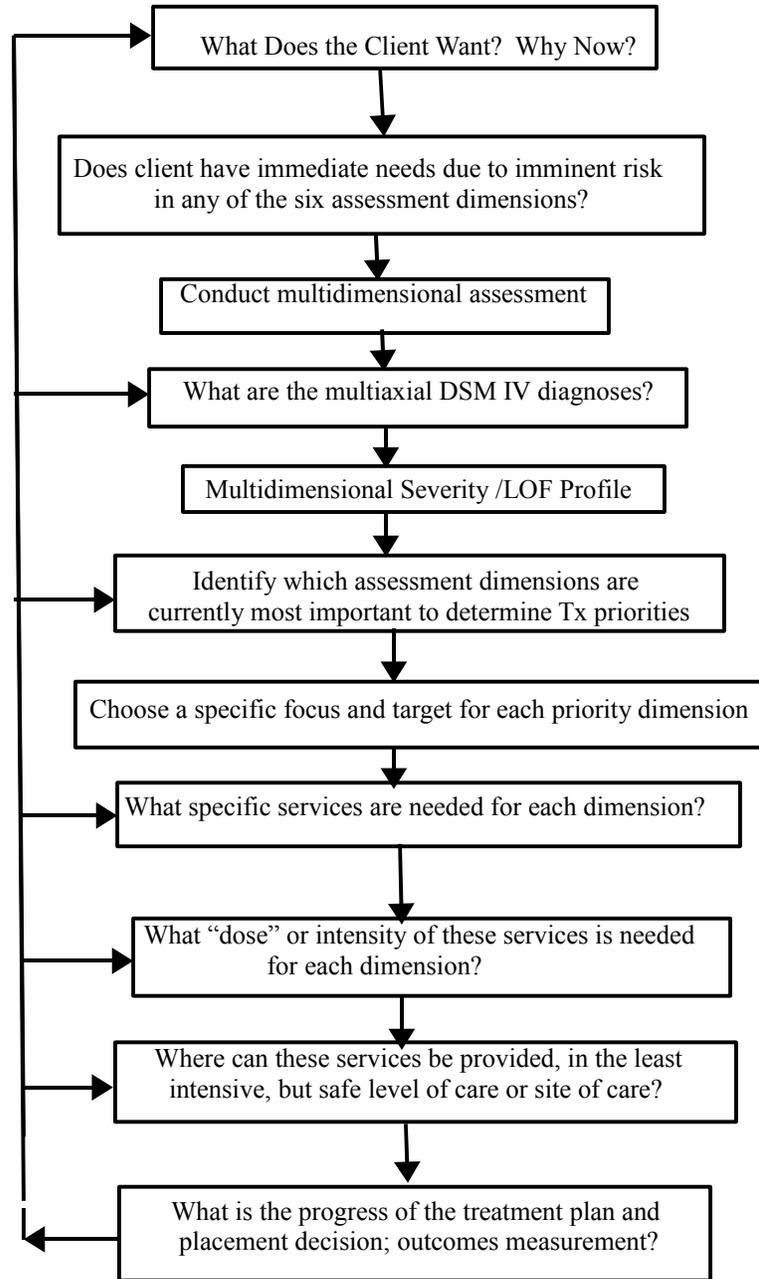
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#### 4. Progress Notes – General; often focused on attendance and compliance rather than documenting client's clinical progress

Examples: “More willing to follow rules and compliant with treatment activities”; “Compliant participation in group”; “Attended and participated in all scheduled groups”; “Plan: Continue to monitor”

- Long progress notes
- No notes related to problems e.g., Substance Abuse
- Difficult to see what the progress note relates to in the Treatment Plan

**D. How to Target and Focus Treatment Priorities in Behavioral Health**



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**E. 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 (gambling, 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?***F. Skill-Building in Developing and Communicating the Treatment Plan****1. Engaging Clients into Participatory Treatment and Recovery****(a) Compliance versus Adherence**

Treatment or medication *compliance* is a term that has had long use in the health care field in general and the addiction and mental health sectors in particular. Webster's Dictionary defines "to comply" as "to act in accordance with another's wishes, or with rules and regulations." By contrast, it defines "adhere" as "to cling, cleave (to be steadfast, hold fast), to stick fast."

In this age of empowerment and collaborative service planning, it is not an appropriate role for a counselor or other professional to develop a plan with which a patient must comply. "Stages of change" models and motivational enhancement therapies have been found to be effective in engaging patients and changing attitudes and behavior. Over the past 30 years, more than 2,000 research papers have been published on the concept of the therapeutic alliance. These findings emphasize the importance of developing the alliance with patients, especially in the early phases of treatment (CSAT, 2005; DiClemente, 2003; Horvath & Bedi, 2002; IOM, 2001, 2005; Miller, Duncan et al., 1997; Miller & Rollnick, 2002; Norcross, 2002).

**(b) Natural Change and Self-Change**

(DiClemente CC (2006): "Natural Change and the Troublesome Use of Substances – A Life-Course Perspective" in "Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It" Ed. William R Miller and Kathleen M. Carroll. Guildford Press, New York, NY, pp 91; 95.)

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But "treatment is an adjunct to self-change rather than the other way around." "The perspective that takes natural change seriously...shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change." (DiClemente, 2006)

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**(c) What Works in Treatment - The Empirical Evidence**

(a) Extra-therapeutic and/or Client Factors (87%)

(b) Treatment (13%):

- 60% due to “Alliance” (8%/13%)
- 30% due to “Allegiance” Factors (4%/13%)
- 8% due to model and technique (1%/13%)

(Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.

Miller, S.D., Mee-Lee, D., & Plum, B. (2005). Making Treatment Count. In J. Lebow (ed.). *Handbook of Clinical Family Therapy*. New York: Wiley).

**(d) Stages of Change**

\* **12-Step model** - surrender versus comply; accept versus admit; identify versus compare

\* **Transtheoretical Model of Change** (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible “problem” and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.\_

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

\* **Readiness to Change** - not ready, unsure, ready, trying, (doing what works) (Miller and Rollnick)

**(e) Developing the Treatment Contract and Focus of Treatment**

	<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<u>What?</u>	What does client want?	What does client need?	What is the Tx contract?
<u>Why?</u>	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
<u>How?</u>	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<u>Where?</u>	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
<u>When?</u>	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?

**G. Is the Recovery or Treatment Plan Making Sense to the Client?**

**How do you assess and monitor whether your treatment plan is making sense to the client?**

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1. **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 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.

**List the reasons why clients drop out of treatment?**

## 2. **Be proactive about retention in treatment and change how you view resistance**

- Possible reasons clients stop coming to treatment:
  1. Feeling better with no perceived need for more treatment
  2. Feeling worse and therefore not confident that help is available
  3. Money concerns and inability to pay;
  4. Barriers that extensive paperwork creates for engaging clients
  5. Poor fit of the client with the therapist and no client confidence that he/she can be helped with this counselor.
  6. Readiness to change issues: a client may not believe he has a mental health or addiction problem
  7. If someone thinks they have a problem they may be ambivalent about getting treatment.
  8. Psychotic illness is affecting their judgment and adherence.
  9. Relapse can be embarrassing and there's shame to return to treatment.
  10. Poor alliance with the clinician- client is not interested in the goals or methods used by the clinician.
- Avoid viewing resistance as pathology

When you observe resistant behavior, don't view this as pathology which resides in the client, and is to be confronted, interpreted or analyzed. See it as an interactive process that you can increase or decrease depending on how you address the apparent lying, ambivalence or readiness to change problems.
- Use motivational strategies

To change how you deal with resistance is where you will need your knowledge and skills in motivational enhancement. When you build an alliance with your client, they will experience that their lying, negative and resistant behavior does not get them what they want.

Example: If you lie to me that you used drugs and your Probation Officer (PO) catches that in random drug testing, I cannot advocate for you. If we work together and you make a mistake and use, but are willing to change your treatment plan in a positive direction, I can explain to your PO that you are still in treatment and compliant with court orders.

Example: If you keep breaking your curfew, how can I help get your parents off your back and from getting mad at you? Do you still want me to help you with that? Or have you changed your mind and actually want them mad at you? You don't need my help with that.

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## H. Making Treatment Plans a “Living” Document

### 1. Stages of Change and Therapist Tasks

<u>Stage of Change</u>	<u>Catalyst, Process of Change</u>	<u>Goal</u>	<u>Strategies and Interventions</u>
Precontemplation	Consciousness Raising Social Liberation	Raise doubt	<ul style="list-style-type: none"> <li>Establish a relationship and identify the treatment contract</li> <li>Develop discrepancy between client’s goals and current behavior</li> <li>Use leverage to create incentives to change</li> </ul>
Contemplation	Consciousness Raising Social Liberation Emotional Arousal Self-Reevaluation	Tip the balance	<ul style="list-style-type: none"> <li>Allow and explore ambivalence</li> <li>Decisional Balance – pros and cons; costs and benefits</li> <li>Elicit self motivational statements</li> </ul>
Preparation	Social Liberation Emotional Arousal Self-Reevaluation Commitment	Determine best course	<ul style="list-style-type: none"> <li>Clarify and reinforce client’s goals and strategies</li> <li>Identify obstacles to following through</li> <li>Declare plans to change to others</li> </ul>
Action	Social Liberation Commitment Reward Countering Environment Control Helping Relationships	Take steps to change	<ul style="list-style-type: none"> <li>Strategize on how to reach client’s goals and start actual behaviors and changes in thinking</li> <li>Identify what has worked and what is working and do more of that – Solution-focused</li> <li>Establish support network and coping skills</li> </ul>
Maintenance	Commitment Countering Environment Control Helping Relationships	Prevent relapse	<ul style="list-style-type: none"> <li>Strengthen and support lifestyle changes</li> <li>Celebrate successes and rewards of change</li> <li>Identify relapse situations, triggers and develop a plan to avoid or deal with relapse</li> </ul>
Relapse/Recycling	Depends on which stage relapse returned to	Renew processes of change	<ul style="list-style-type: none"> <li>Positively reinforce client’s honesty to admit relapse and their return for help</li> <li>Identify to which stage client returned</li> <li>Examine where client got “off track” and how what needs to change to resume recovery</li> </ul>

#### (a) Principles

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

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 - from the perspective of "what the client will be able to do after attending treatment sessions" and not from the perspective of what you as the counselor will do during treatment e.g. "Client will receive education about the effects of drinking on the family"

Begin each Goal with a verb that denotes an observable action, such as: "Define, Describe, List, Explain, Discuss, and Apply" e.g., "Bill will be able to describe how each family member has been affected by his addiction" Avoid words that indicate emotions, feelings or other things that occur in the head, such as "know, learn, appreciate, understand, recognize", etc.

Example: "Bill will appreciate the negative effects and consequences of his addiction on the family"

5. One goal per problem 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., Sally is to try the "I have strong willpower, no AA meeting" treatment strategy; and counselor to arrange family meetings or contact to get reports back on how Sally's work function and family relationships are progressing or not.

**(f) Sample Strategies for Treatment Plans**

1. List three reasons the court sent you to treatment.
2. Write down the most recent incidents involving alcohol and other drugs.
3. Identify what happens if you don't comply with probation requirements and report to group.
4. List the positive and negative aspects of substance use.
5. Attend at least one AA meeting and see if you can identify with anyone's story.
6. Verbalize in group, what things need to change in your life or not.
7. Discuss the positive and negative consequences of continued substance use.
8. Explore early childhood history of violence through individual therapy once per week. Focus on what kind of role models the client had.
9. For the next incident of rage and anger, fill in the date, trigger, physiological signs and behavior taken; and then discuss how he or she could deescalate the rage.
10. Share in group what has been working to prevent relapse and get other suggestions.

**2. Understanding Admission, Continued Stay and Discharge Criteria (PPC-2R)**

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

**Continued Service Criteria:** It is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
**or**
2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
**and/or**
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient's new problems can be addressed effectively.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient's existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

**Discharge/Transfer Criteria:** It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;  
**or**
2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;

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or

3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

or

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

### **I. Consider Steps to Reframe “pathological” views into Recovery and Strength-based Universal Human Needs**

(a) *Look for the feelings, needs and values* behind your pathological (and sometimes judgmental) view of the client's goals

- e.g., “He just wants to get his benefits so he can get more drugs to get high.” Who among us does not want to feel good and has the need for pleasure?
- e.g., “He is so unrealistic wanting to get a job when he can't even take his medication as prescribed.” Who doesn't feel good when productive so you can get financial freedom and security?
- e.g., “She is just here to get her kids back and not really interested in abstinence.” Who doesn't feel frightened when threatened with losing loved ones and needs love and family togetherness?

(b) *Reframe to yourself and the client* what you are hearing in his or her request or goal to further assess what the real needs are

- e.g., “So when you use run out of your disability money and use it to buy drugs, are you still getting a good high from the drugs? Or are you needing drugs to get rid of withdrawal problems and don't get much of a high anymore?”

Versus: “See how drug addicted you are that you are spending all your money and don't even have enough for food for the month?”

- e.g., “So when you say you want a job, what do you see the job will do for you? Do you want something to do to occupy your time? Or are you wanting more money and frustrated that you have a representative payee who is controlling all your money?”

Versus: “How do you think you can get a job when you can't even get to your doctor appointments on time and don't take you medication regularly?”

- e.g., “So when you say you're here otherwise you won't get you kids back, are you missing them so much that you'll do whatever it takes to be with them again? Or is it really hard to make it financially without the child support payments? Or is it both, which I can totally understand too?”

Versus: “You have to comply with the program and be abstinent if you want a good report for child protective services”

(c) *Address the universal human and recovery need of the client, not just your assessed treatment plan*

- e.g., “So let’s find a way so you feel better and don’t have to be so uncomfortable and worried about withdrawal.” – the need for comfort; avoidance of pain
- e.g., “Let’s see what would have to happen for you to regain control of your money –the need for autonomy and financial security
- e.g., “Let’s figure out together how to reunite your family; and what people are seeing that makes them think that you are not safe to be with your children – the need for love and connection

### **J. Stage of Readiness to Change: Assessment and Matching**

<b><u>Stage of Change</u></b>	<b><u>Service Track</u></b>	<b><u>Treatment Processes Used</u></b>	<b><u>Level of Care</u></b>
Precontemplation	Discovery Track	Consciousness-Raising, Social Liberation	Early Intervention, OP
Contemplation	Discovery Track	As above, plus Emotional Arousal, Self-Evaluation	OP
Preparation	Mix of Discovery & Recovery Tracks	Emotional Arousal, Self-Evaluation, Commitment	OP through partial hospital services
Action	Recovery Track	Commitment, Reward, Countering, Environment Control, Helping Relationships	OP through partial hospital services
Relapse, Recycling	Relapse Track	Based on assessed Stage of Change to which client has regressed or recycled	OP through residential services

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## Angie

Identifying information: Angie is a 37 year old homeless married woman, mother of two children, one adult son and one teen daughter.

Adult History: Angie lost contact with both of her children about 10 years ago via Child Welfare Services, and she believes both children were adopted when she was unable to follow through with her CWS case plan. She does not know where they are anymore. She is also not in contact with her husband (not the father of her children); they were homeless together about 4 years ago and he left her. She has heard through the grapevine that he moved to San Diego. She has a boyfriend who is currently in jail due to an assault of another man while intoxicated and under the influence of methamphetamine.

Childhood History: Angie was herself adopted out of the CWS services because of her birth mother's substance abuse and neglect. She was repeatedly molested in foster care prior to her adoptive placement. Her adoptive parents divorced when she was 12, about 7 years after she was adopted.

Mental Health History: Angie always seemed to have problems with performance in school, acted out, earned poor grades, and refused to attend school at age 16. She was treated for ADHD and depression during her school years, but was unable to develop stability at that time.

In adulthood, she has been hospitalized for mental health crises 5 times, and has had two serious suicide attempts. She has a history of cutting on her arms and legs and has extensive scarring. She continues to cut on herself about once a month, and about three months ago she overdid it and cut too deeply, leaving a prominent scar that punctuates the others.

Angie describes a lifelong struggle with depression and anxiety. She has difficulty grooming herself regularly, has an exaggerated startle response, and tends toward isolation. After she was raped on the streets, she became even more isolative, but now has a tendency toward anger outbursts when under stress. She has indicated that sometimes she hears voices, but has difficulty describing symptoms. Angie can be difficult to interact with; can be accusing and aggressive, and alternately withdrawn and isolative.

Substance Abuse History: Angie began drinking at age 10, was drinking as often as possible almost immediately. She began using marijuana at age 11, and experimented with many different drugs before settling into regular use of opioids. She has also had periods of heavy use of methamphetamine. She has used drugs intravenously (both heroin and methamphetamine).

Physical Health: About 13 years ago, Angie was involved in two car accidents, and about 10 years ago she seriously hurt her back and shoulder trying while working in a very physical job. She has problems with her teeth. She has been diagnosed with Hepatitis C. She is in fairly constant pain.

Work History: Angie has had jobs waitressing, retail, and doing construction work. She has not been able to hold a job in the last 7 years. She has General Assistance and Food Stamps as her current income.

Legal History: Angie has been in trouble with the law multiple times for drunk in public and has 2 DUI's in her past. She has also had possessions charges, and is currently in trouble for writing bad checks.

### Diagnosis:

Axis I: Major Depressive Disorder, Recurrent, Severe, with Psychotic Features  
Posttraumatic Stress Disorder  
Polysubstance Dependence

Axis II: Borderline Personality Disorder

Axis III: Hepatitis C, Chronic Shoulder and Back Pain

Axis IV: A-Problems with primary support group, D-Occupational Problems, E-Housing Problems,  
F-Economic Problems, H-Problems related to interaction with the legal system/crime

Axis V: GAF Current: 42 Past Year: 45

Presenting Issue: Angie came to Mental Health Services because she wants housing. She thinks she has mental health issues, she does not want to talk about her past (much of the above was learned in a piecemeal fashion after the initial assessment), and she feels she needs her pain medication. She states she wants to be clean and sober, but her boyfriend uses drugs and is in poor health, and she feels that she can't  
1 leave him.

Goals (& Stage of Change): Angie would like to find a way to get housed (determined), finish school (contemplative), find her children (determined), help her boyfriend become motivated to quit using (action), quit using herself (contemplative), take pain meds without addictive behavior (contemplative), be less depressed (determined), be more confident (contemplative), stop cutting on herself (determined), get divorced (contemplative), get an income via work or disability (determined), and stay out of jail (determined), stay out of inpatient hospitalization (determined), and have no further suicide attempts (determined). Note: Angie vacillates frequently between the stages of change for each issue.

Stage of Change: Angie is motivated to come to sessions to discuss issues. She is contemplative about medication because she is unsure whether it will work. She is contemplative about quitting using because she is not sure she can, and she is intimidated by 12 step groups. She is hesitant about how to proceed to change her life, and her conversations are punctuated with progressive-oriented and regressive-oriented statements. She is in the contemplation stage overall for her life issues.

**What is Angie a “customer” for that will drive the assessment and service planning?**

- 1.
- 2.
- 3.

**List what Problems/Issues need to be the focus of treatment from this assessment**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

---

Treatment Plan:

Through development of strategy, relationship, trust, and Angie's willingness, engage her in what services she will accept. Options include: regular individual/group sessions, meetings and medication. The effort is to assist her to become ready to prioritize and address each of her goals over time, and maintain gains once they are established.

The themes/issues in treatment will be: assisting Angie in recognizing triggers toward addiction issues and mental health issues, developing coping/self-soothing and problem solving strategies to use when troubled, resolving concerns about medication and take/adjust meds when ready; developing/using skills to stay clean/sober while determining a strategy for taking pain medication at lowest level possible; understanding and addressing issues of trauma and low self worth and understand their contribution to her behavioral pattern, increasing ability to be assertive with others; building sense of self-confidence and efficacy; seeking housing and financial options, determining what to do about her relationship with her boyfriend; staying out of the hospital/jail; seeking medical treatment; and pursuing longer-term issues such as divorce, school, and finding children as possible.

### **Jessica**

Client: Single Caucasian, unemployed mother of three daughters ages 13, 10, and 5. The two older girls were removed from mother's home several years ago and adopted by extended family. The other daughter was removed from home a few months ago due to report to CWS over concerns she might have been molested by family friend's son.

Family history: Ct's parents both alcoholics, father also had mental health issues. Mother extremely emotionally and physically abusive, often cursing at client. Parents divorced at client's age 10; father died shortly thereafter. Client began acting out, truant, placed in foster care until she was 18. Client raped during her teen years and subsequently raped multiple times. History of domestic violence and rape by partners.

Education: GED

Employment: Seeking employment as a cook

Mental Health Dx: Axis I – Major Depressive Disorder, OCD with hoarding,  
Generalized Anxiety Disorder with Agoraphobia, PTSD,  
Bipolar traits  
Alcohol Abuse – claims 2 months  
Marijuana Abuse – claims 2 months  
Axis II - Borderline Personality Disorder with Avoidant Traits  
Axis III – early stage COPD, migraines, sleep disorder  
Axis IV – Lack of social support, employment problems,  
CWS Family Reunification case

Client has been in either drug and alcohol services and/or mental health services off-and-on since 2000 when CWS removed children from household.

Symptoms: Extreme abandonment fears, unstable family and intimate relationships, impulsive self-destructive with extreme sexuality and overspending, some dissociative symptoms with big memory gaps, poor insight, very low self esteem, poor financial management, rapid mood shifts, chaotic and unstable relationships, reports no friends or social life, some social phobia due to fear of being judged or embarrassed, alcohol abuse w/out legal problems, heavy smoker. Wants to get medical marijuana card so can smoke legally.

Presentation: Appropriate appearance, OK personal hygiene, expansive or withdrawn affect, intact and concrete thought processes, full x4 orientation, impaired judgment, impaired insight, cooperative, record of keeping 65%-70% appointments.

Stage of change with drinking and THC: Action

Stage of change with MH symptoms: Swings between precontemplation and contemplation

Client scaled at "Undecided" on most items of URICA scale

Client reported as "Mostly Dissatisfied" on QOL scale

**What is Jessica a "customer" for that will drive the assessment and service planning?**

- 1.
- 2.
- 3.

**List what Problems/Issues need to be the focus of treatment from this assessment**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Treatment Plan: (Pre MEI)– One weekly group for those w/ borderline dx w/ MFT  
One weekly individual session w/ primary CDD

- Goals:
1. Learn about interaction of alcohol abuse and mental health symptoms and how gaining and maintaining total sobriety will have positive impact on reducing MH symptoms.
  2. Client will improve, stabilize and maintain ability to function and complete activities of daily living and be consistent with psychotropic medications

Objectives:

1. Client will be able to verbalize and demonstrate increased capacity for coping with stress
2. Client will reduce the frequency of distorted, negative thoughts, use reframing skills
3. Client will use coping skills to reduce old patterns of self-destructive behaviors
4. Client will learn about clear boundaries and how to set them
5. Client will develop increased positive self image by coping with and processing feelings and stressful life events instead of repressing them
6. Client will attend AA or DRA meetings at least 1x/week

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Current Goals: Client wants to learn what it might feel and look like to be “normal” and be able to do what others do so easily, e.g., relationships. As client doesn’t really know what she wants to change other than how she is in her own skin, she will just try her best to listen and learn and let all the rest go.

- Action Plan:
1. Attend borderline group and individual sessions weekly
  2. Practice having two positive thoughts for every negative thought
  3. Go for a half hour walk every day
  4. Work at accepting that she has strengths and is lovable

**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/Prob. Potential	5(a) Is client currently under the influence or intoxicated?		
5. as above	5(b) Is client likely to continue to use or relapse in an imminently dangerous manner, without immediate care?		

**. 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?		
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**. 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.****Rating of Severity/Function:** Using assessment protocols that address all six dimensions, assign a severity rating of **0 to 4** for each dimension that best reflects the client's functioning and severity. Place a check mark in the appropriate box for each dimension.

Risk Ratings	Intensity of Service Need	Dimensions				
		1.	2.	4.	5.	6.
<b>(0) No Risk or Stable</b> – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.					
<b>(1) Mild</b> - Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings					
<b>(2) Moderate</b> - Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training, or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.					
<b>(3) Significant</b> – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in, or near imminent danger.					
<b>(4) Severe</b> - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	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.					

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**CLINICAL ASSESSMENT AND PLACEMENT SUMMARY (cont.)**

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 Readiness	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**

<p><b>Level of Care/Service Indicated</b> - 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; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter</p>	
<p><b>Level of Care/Service Received</b> - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service</p>	
<p><b>Reason for Difference</b> - 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 (Specify):</p>	
<p><b>Anticipated Outcome If Service Cannot Be Provided</b> – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):</p>	

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