## How to Develop Treatment Plans that Make Sense to Clients: Improving Documentation and Clinical Use of the Treatment Plan and Progress Notes

David Mee-Lee, M.D.  
Davis, CA  
(530) 753-4300; Voice Mail (916) 715-5856  
davidmeelee@gmail.com  
www.changecompanies.net

October 27, 2014  
Workshop 10 AM – 4:40 PM  
45th Annual MARRCH Conference – St. Paul RiverCentre, MN

### 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 motivation and goals 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.

### Indicate True or False:

<table>
<thead>
<tr>
<th></th>
<th>T</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms.</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>7. If a person is ambivalent, it is best to talk persuasively about the healthy choices.</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>8. The counselor’s role is to facilitate the client’s natural self-change process.</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>9. 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.</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>10. Progress Notes too often just document attendance at a session or compliance with treatment expectations, instead of specific information on response to treatment.</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
11. Goals should be written for the client as we know what is best for their recovery. ( ) ( )
12. Clients should be encouraged to express their concerns with the treatment plan. ( ) ( )
13. Clients in early stages of change need relapse prevention strategies. ( ) ( )

A. Common Treatment Planning Issues for Improvement

1. Problem Statements – Too general and non-specific
   Examples: “Psychiatric”; “Substance Abuse”; “Legal”

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”

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

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

B. Client-Directed, Outcome Informed; Feedback Informed Treatment (FIT)
1. **Assessment of Biopsychosocial Severity and Function** *(The ASAM Criteria 2013, pp 43-53)*

   The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health:

   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

2. **How to Target and Focus Treatment Priorities**

   - **What Does the Client Want? Why Now?**
     - Does client have immediate needs due to imminent risk in any of the six assessment dimensions?
   
   - **Conduct multidimensional assessment**
     - What are the DSM-5 diagnoses?
   
   - **Multidimensional Severity/LOF Profile**
     - Identify which assessment dimensions are currently most important to determine Tx priorities
   
   - **Choose a specific focus and target for each priority dimension**
     - What specific services are needed for each dimension?
   
   - **What “dose” or intensity of these services is needed for each dimension?**
   
   - **Where can these services be provided, in the least intensive, but safe level of care or site of care?**
   
   - **What is the progress of the treatment plan and placement decision; outcomes measurement?**

   *(The ASAM Criteria 2013, p 124)*
C. **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?

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

**Developing the Treatment Contract and Focus of Treatment**

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What?</td>
<td>What does client want?</td>
<td>What does client need?</td>
</tr>
<tr>
<td>Where?</td>
<td>Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment?</td>
</tr>
<tr>
<td>When?</td>
<td>When will this happen?</td>
<td>When? How soon?</td>
</tr>
<tr>
<td></td>
<td>How quickly?</td>
<td>What are realistic expectations?</td>
</tr>
<tr>
<td></td>
<td>How badly does s/he want it?</td>
<td>What are milestones in the process?</td>
</tr>
</tbody>
</table>

E. **Making Treatment Plans a “Living” Document**

(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 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 drinking” 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 drinking 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 meetings” treatment strategy; and counselor to arrange family meetings or contact to get reports back on how Sally’s drinking and family relationships are progressing or not.

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

- List three reasons the court sent you to treatment.
- Write down the most recent incidents involving alcohol and other drugs.
- Identify what happens if you don’t comply with probation requirements and report to group.
- List the positive and negative aspects if substance use.
- Attend at least one AA meeting and see if you can identify with anyone’s story.
- Verbalize in group, what things need to change in your life or not.
- Discuss the positive and negative consequences of continued substance use.
- Explore early childhood history of violence through individual therapy once per week. Focus on what kind of role models the client had.
- 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.
- Share in group what has been working to prevent relapse and get other suggestions.

(g) **Understanding Continued Service and Discharge Criteria** *(The ASAM Criteria 2013, pp 299-306)*

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;
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;

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.

F. Relapse/Continued Use/Continued Problem Potential - Dimension 5 (The ASAM Criteria 2013, pp 401-410)

A. Historical Pattern of Use

1. Chronicity of Problem Use
   - Since when and how long has the individual had problem use or dependence and at what level of severity?
   2. Treatment or Change Response
      - Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

3. Positive Reinforcement (pleasure, euphoria)
4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

5. Reactivity to Acute Cues (trigger objects and situations)
6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

7. Locus of Control and Self-efficacy
   - Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?
8. Coping Skills (including stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior
   - Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting the person’s recovery and precipitating cravings to use or other impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.
The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

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

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and “doing time” rather than “doing treatment and change,” explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute recurrance of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about “triggering” others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for...
triggering others. Group members and/or other patients in a residential setting are best helped to deal with such “triggering” with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.

G. Case Presentation Format (The ASAM Criteria 2013, pp 119 -126)

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 brief explanation for each rating, note whether it has changed since 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)
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

<table>
<thead>
<tr>
<th>Severity Profile</th>
<th>Dimension</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wanda on Welfare

Wanda is a 46-year-old divorced, female who was married at 18 to a male who was emotionally and physically abusive and lived at home less than half of the time of their eight-year marriage. The marriage was also characterized by infidelities by both her and her husband and regular and sometimes heavy marijuana and alcohol use. Two children resulted from this marriage, a son, Juan, now 26 and a daughter, Rosa, now 24. She has had no contact with either of these children for the last 12 years after she became pregnant and delivered a baby girl, Gloria, from an African-American father, whom she claims she met in a bar one night and doesn’t even know his name. She was referred for assessment by her caseworker.

In the last 20 years, since the divorce, her drinking and marijuana use have increased markedly and she would often spend her days at home alone with Gloria, drinking and smoking heavily and neglecting her daughter. On one occasion the authorities became involved and threatened to remove Gloria from the home. As a result, she began seeing a counselor and at her suggestion, she began attending AA and NA briefly. Her counselor retired from practice and Wanda discontinued recovery group meeting attendance. The issue of custody apparently ceased being an issue but Wanda does not know why.
She is the child of an alcoholic father whom she alternately idolized and feared and who was seductive but not openly sexual with her as she was growing up. He father was killed in barroom brawl when she was 30 years old. Her mother 67 years old, lives alone and is still in denial about Wanda’s father’s alcoholism. She is the younger of two female children and her older sister is a teetotaler and a pillar of her church. They have not had contact in about three years.

A year ago she again began attending AA and claims she enjoys it. She attends weekly. She now drinks about once a week without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about her current drinking. She had considered finding another counselor because of her dissatisfaction with her life but never translates this into action. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

She lives with Gloria in a rented apartment and spends most of her day watching television and considers herself a “soap opera addict.” She is in a relationship with a drug dealer although she claims not to use any of the cocaine or heroin that her boyfriend sells. She likes him because “he buys her things.” He also helps with the rent although he does not live there. Gloria is doing poorly in school and has been picked up for a shoplifting offense. On two occasions she told Wanda that she was spending the night with a girlfriend and this was later determined to be untrue. Wanda has no idea where she was each of those nights. They are in a constant struggle with Gloria calling her mother a “slob” and Wanda calls Gloria a “tramp.”

She has been on welfare for most of her adult life and sees nothing unusual or undesirable about it. She has never worked outside of a few brief stints earlier as a dishwasher (2 times, once for 2 weeks and once for 3 weeks) and as attendant in a car wash (1 month). Both jobs came to an end because of her failure to show up for work because of using, oversleeping or being hung over. She has no job skills and is not particularly interested in acquiring such skills or working. She is aware that her welfare benefits will be terminated if she doesn’t do something about work and feels that the State is being unfair.

Wanda said she has no medical problems although she states that she can’t wait for menopause because her periods are so painful and her bleeding so heavy. She later added that she has migraine headaches although has never seen a doctor about them. Her affect is slightly flattened but beyond that, she neither appears depressed nor does she claim to be depressed. She has never sought substance abuse or mental health treatment except for the earlier six-month period with the counselor.

LITERATURE REFERENCES AND RESOURCES


International Center for Clinical Excellence – www.centerforclinicalexcellence.com
Post Office Box 180147 Chicago, IL 60618-0573

For more information on the new edition: www.ASAMcriteria.org


RESOURCE FOR ASAM E-LEARNING AND INTERACTIVE JOURNALS

E-learning module on “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”– 5 CE credits for each module. “Introduction to The ASAM Criteria” (2 CEU hours) “Understanding the Dimensions of Change” – Creating an effective service plan” – Interactive Journaling “Moving Forward” – Guiding individualized service planning” – Interactive Journaling

To order: The Change Companies at 888-889-8866; www.ASAMcriteria.org

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

The Change Companies’ MEE (Motivational, Educational and Experiential) Journal System provides Interactive journaling for clients. It provides the structure of multiple, pertinent topics from which to choose; but allows for flexible personalized choices to help this particular client at this particular stage of his or her stage of readiness and interest in change.

To order: The Change Companies at 888-889-8866. www.changecompanies.net.

To Buy: www.changecompanies.net/search.php

FREE MONTHLY NEWSLETTER

“TIPS and TOPICS” – Three sections: Savvy, Skills and Soul and additional sections vary from month to month: Stump the Shrink; Success Stories and Shameless Selling. Sign up on www.changecompanies.net.