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

| Workshop 4 | Leader's Guide |

Treatment Planning M.A.T.R.S.:
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LEADER FOCUS
Workshop 4

Workshop 4

EMPHASIS AREAS:

FOCUS

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

Recap of Workshops 1, 2, and 3
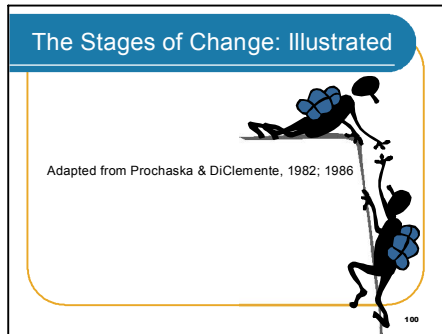Components of treatment planning reviewed
ASI applications in treatment planning
Differences between programme-driven and
individualized treatment plans (old method vs.
new method)
Biopsychosocial model of addiction
The mechanics of treatment planning, including
writing and prioritising problem statements
Practise writing goal statements
Introduce M.A.T.R.S. criteria

KEY CONCEPTS

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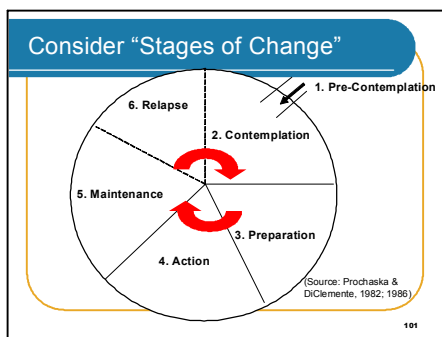Readiness to Change
Documentation Guidelines

Workshop 4 will focus on:
Writing M.A.T.R.S. Objectives and Interventions
Client Involvement and Readiness to Change
Writing Documentation Notes

Workshop 4: Putting Treatment
Planning M.A.T.R.S. into Practise

Workshop 4 Handouts
1. Example ASI Treatment Plan – Medical Domain
2. Example SOAP Note
3. SOAP Note Formats Used in Documenting Consumer
Progress
4. Case Note Scenario

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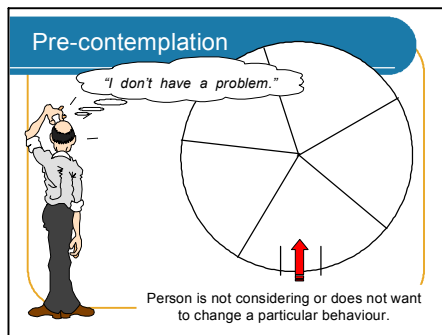| Workshop 4 | Leader's Guide |

Overhead 100

Overhead 101

Other Considerations in Treatment Planning

Client Involvement and Readiness to Change
ð Since this training is about the process of treatment planning, it might be helpful to look at a theory of how people make changes. We can view clients, ourselves, our agency—even the whole system—through these stages of change. This theory or model is called *Transtheoretical Stages of Change Model*.

ð The client's treatment needs, along with her or his readiness to change, should be accurately assessed before treatment recommendations are developed.

Stages of Change
ð According to Prochaska and DiClemente (1982; 1986), behavioural change is a multi-step process, rather than a one-time event. Different stages of the change process include:

ð *Pre-contemplation:* change is not considered
ð *Contemplation:* change is being considered
ð *Preparation:* some action steps towards change have occurred
ð *Action:* active steps towards change are happening
ð *Maintenance:* maintaining behavioural change until it becomes permanent
ð *Relapse:* return to previous pattern of behaviour

ð Determining a client's stage of change can help the counsellor "fit" the treatment plan to the client's readiness and needs. This may help prevent the client from rejecting all or parts of the treatment plan.

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Pre-Contemplation
ð The first stage of change is referred to as **Pre-contemplation.** People in this stage are not thinking about changing. There may be several reasons for this. Perhaps they don't see anything that needs to be changed. Perhaps they have tried and failed to change and no longer have hope. For whatever reason, they are not thinking about changing.
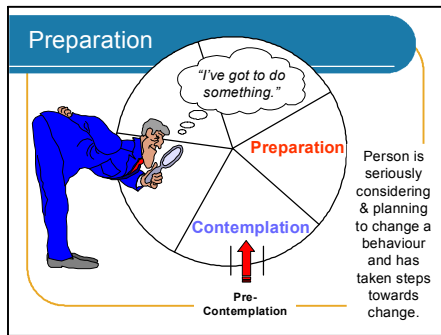
Stages of Change Exercise
ð Have participants think for a moment about a change they are considering or have recently considered making but have not made.

ð Remind them that they will not have to discuss this change with the group unless they want to. This change can be about a job, marriage, smoking, diet, exercise, education, etc.

ð Ask participants the following: "How long have you considered making this change?" (e.g., one week, two weeks, one month, three months, six months, or one year?)
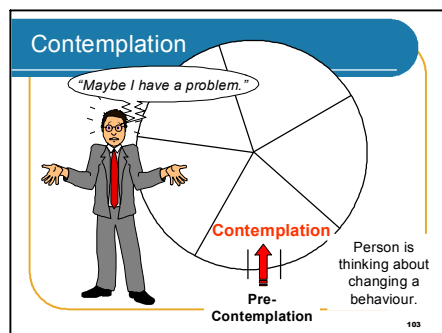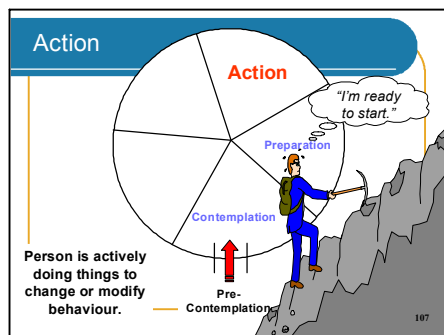

Overhead 103

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

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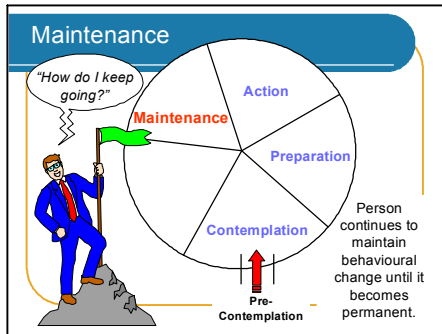| Workshop 4 | Leader's Guide |

Overhead 104

Overhead 105

Preparation

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

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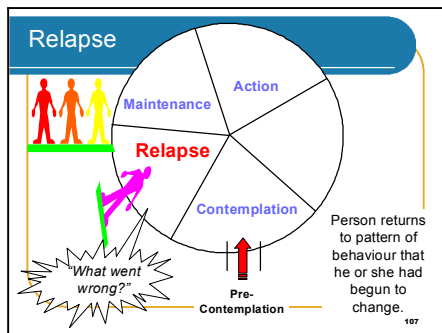 ð Try medication?
  ð Try self-help?

Action

ð The **Action** stage is just what it describes. People in this stage are actively taking steps to change but have not reached a point of stability.

ð Treatment programmes often focus on interventions that assume the client is in the Action phase.

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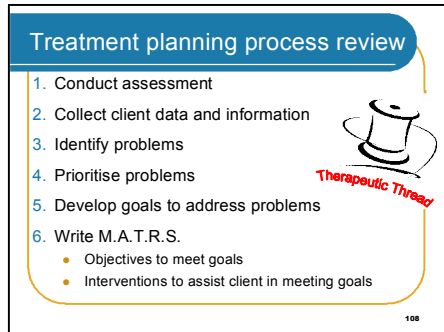| **Workshop 4** | **Leader's Guide** |

Overhead 106

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Maintenance

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

Relapse

ð People in the **Relapse** or **Recurrence** stage have experienced a return to the behaviours or symptoms and must now decide what to do next.

ð A relapse is a common occurrence in behavioural change.

ð It is helpful to define success or progress in smaller increments by moving from one stage to the next.

ð Keep in mind these stages of change when writing goals, objectives, and interventions.

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Treatment Planning Process Review

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

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

In today's training we have:

- ð Reviewed a sample Master Problem List (#1).
- ð Developed Problem Statements for three domains (#2).
    - ð Alcohol/drug domain
    - ð Medical domain
    - ð Family/social domain
- ð Discussed ways to prioritize Problem Statements (#3).
- ð Written goal statements for the three domains (#4).

In this workshop, we'll focus on writing:

- ð Treatment Planning M.A.T.R.S. objectives and interventions
- ð Documentation notes reflecting treatment plan progress

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Leader Note:
Before writing M.A.T.R.S. treatment objectives and interventions, review the ASI Treatment Plan Format with participants.

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

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M.A.T.R.S. objectives & interventions

1. Alcohol / Drug Domain

- Write 2 objective statements
  - Required or optional for discharge?
- Write 2 intervention statements
  - Assign service codes and target dates

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Overhead 110

M.A.T.R.S. objectives/interventions test

- Measurable? Attainable?
  Can change be documented? Is it achievable within active treatment phase? Is it reasonable to expect the client will be able to take steps on his or her behalf?
- Time-Related? Realistic?
  Is time frame specified? Will staff be able to review within a specific period of time? Is it agreeable to client and staff?
- Specific?
  Will client understand what is expected and how programme/staff will assist in reaching goals?

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Writing Activity

Write M.A.T.R.S. Objectives and Interventions for the Alcohol/Drug Domain:
1. Focus on just the "Alcohol and Drug Domain" for now.
2. Using the ASI Treatment Plan Handout provided, write 2 M.A.T.R.S. objective statements.
3. Using the ASI Treatment Plan Handout provided, write 2 M.A.T.R.S. intervention statements.
4. Assign service codes and target dates.

Leader Note:
ð Allow 15 minutes for writing activity.

Check-In Discussion Questions
ð Are the objectives and interventions written in such a way that change or progress can be easily documented?
ð Would a client be able to understand what is expected? Are specific staff persons responsible for assisting clients and/or providing counselling services?
ð Are the objectives and interventions
  ð Measurable?
  ð Attainable?
  ð Realistic?
ð Is the time frame specified? Will staff be able to review within a specific period of time?
ð Is it reasonable to expect the client to take steps on his or her own behalf?
ð Would these statements be agreeable to a typical client and staff member?
ð Are the objectives and interventions SPECIFIC?

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M.A.T.R.S. objectives & interventions

2. Medical Domain
3. Family/Social Domain

- Write 2 objective statements
  - Required or optional for discharge?

- Write 2 intervention statements
  - Assign service codes and target dates

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Overhead 112

Writing Activity

Write M.A.T.R.S. Objectives and Interventions for the Medical and Family/Social Domains

1. Now, move on to the "Medical and Family/Social Domains."
2. Continuing to use the ASI Treatment Plan Handout provided, write 2 M.A.T.R.S. objective statements. Specify if you think the objectives should be required or optional for client.
3. Write 2 M.A.T.R.S. intervention statements and assign service codes and target dates.

Leader Note:
ð Allow 15-20 minutes for writing activity.

Check-In Discussion Questions
ð Are the objectives and interventions written in such a way that change or progress can be easily documented?
ð Would a client be able to understand what is expected? Are specific staff persons responsible for assisting clients and/or providing counselling services?
ð Are the objectives and interventions
  ð Measurable?
  ð Attainable?
  ð Realistic?
ð Is the time frame specified? Will staff be able to review within a specific period of time?
ð Is it reasonable to expect the client to take steps on his or her own behalf?
ð Would these statements be agreeable to a typical client and staff member?
ð Are the objectives and interventions SPECIFIC?

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Other required elements

New, improved DENS Software (2005)

Guides counsellor in documenting:

● Client strengths

● Participants in planning process

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Overhead 113

**Other Required Elements of a Treatment Plan**

Leader Note:

This slide should be omitted if none of the participants is using the DENS software.

ð   Acknowledge additional elements typically required in most treatment plans.

ð   **Client Strengths** are often included in treatment plan.

ð   **Participation in Treatment Planning Process** is a second element included in most treatment plans and/or documentation notes.

ð   ***The New and Improved ASI DENS Treatment Planning Software (2005)*** guides the counsellor in completing these elements and documents these in the treatment plan report.

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Ongoing Documentation (Progress Notes)

Case notes are the narrative portion of the client's treatment record—the "story" of what has occurred during the beginning, middle, and ending phases of treatment. Case notes also provide a connection to the treatment plan. A counsellor not familiar with a client's case should be able to read the case notes section of the treatment record and understand exactly what has occurred in treatment.
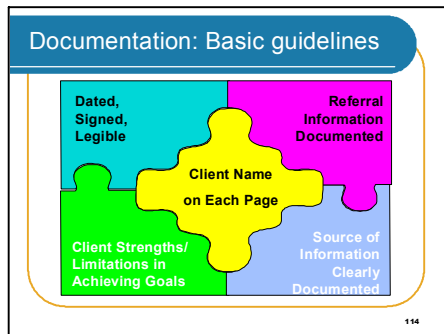
Basic Guidelines
ð   Notes are dated, signed, and legible.
ð   Client name and identifier are included on each page of the clinical record.
ð   Referral information has been documented.
ð   Sources of information are clearly documented.
ð   Client strengths and limitations in achieving goals are noted and considered.
ð   The style of documentation should be consistent and standardized throughout the agency/institution.
ð   Abbreviations should be standardized and used in consistent context.
ð   Documentation should reflect changes in client status including response to and outcome of interventions.

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Documentation: Basic guidelines

Entries should include . . .

- **Your professional assessment**
- **Continued plan of action**

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Basic Guidelines
> Entries should include the clinician's professional assessment and continued plan of action.

Documentation: Basic guidelines

Describes . . .

- Changes in client status
- Response to and outcome of interventions
- Observed behaviour
- Progress towards goals and completion of objectives

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

Documentation: Basic guidelines

The client's treatment record is a legal document

Clinical Example:
Agency Trip

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Legal Issues and Documentation:
- ð The client's treatment record is a legal document.
  - ð The treatment record can be subpoenaed.
  - ð The treatment record may be reviewed by local or government authorities.

Appelbaum and Gutheil (1982) recommend that counsellors take the perspective of future readers when writing treatment records. Entries will be read or reviewed by others.

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Documentation: Basic guidelines

Legal Issues & Recommendations:

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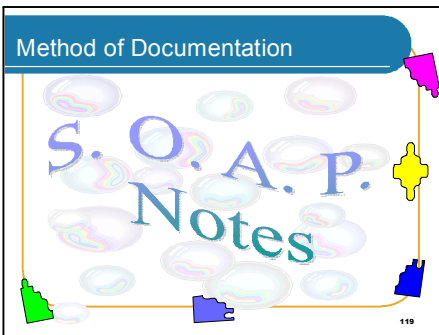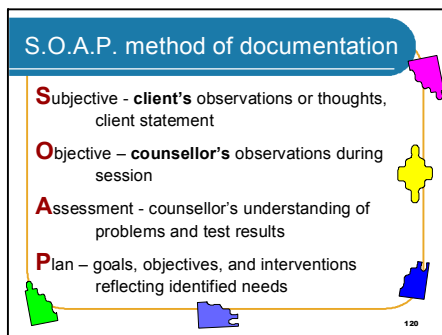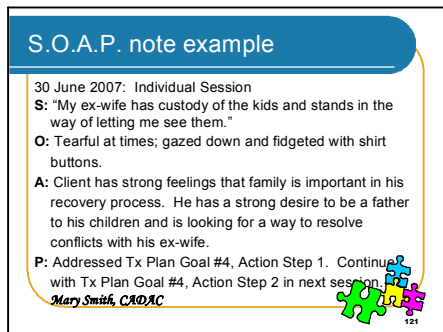- Note limitations of the treatment provided to the client

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Legal Issues and Recommendations

ð Document non-routine calls, missed sessions, and consultations with other professionals.

ð Avoid reporting staff problems in the case notes, including staff conflict and rivalries.

ð Chart client's non-conforming behaviour.

ð Record unauthorized discharges and elopements.

ð Note limitations of the treatment being provided to the client.

ð Ask your audience to provide examples of legal issues that they would need to take into account when writing a treatment record.

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Problem-Oriented S.O.A.P. Notes

ð In 1968, Lawrence Weed published his proposal of the S.O.A.P. note. This style is one of the most widely used methods of reporting ongoing progress.

ð S.O.A.P. was designed to standardize and improve the structure of the medical record.

ð It encouraged a logical thought process and approach to record keeping with an aim to produce less unstandardized, narrative note-taking.

ð Information was more concise and communicated client activities clearly to other clinicians.

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

ð **S**ubjective – the patient's observations or thoughts, a client's direct statement

ð **O**bjective – the clinician's observations during the session

ð **A**ssessment – the clinician's understanding of the problem and test results

ð **P**lans – goals, objectives, and interventions reflective of problems/needs identified during assessment or ongoing assessment

S.O.A.P. Note Example

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Tx Plan Reflected in Documentation?

Client quote → **S:** "My ex-wife has custody of the kids and stands in the way of letting me see them."

Physiological observations? → **O:** Tearful at times; gazed down and fidgeted with shirt buttons.

Problem statements, test results, ASI severity ratings, non-judgemental professional assessment → **A:** Client has strong feelings that family is important in his recovery process. He has a strong desire to be a father to his children and is looking for a way to resolve conflicts with his ex-wife.

Goals, objectives, interventions → **P:** Addressed Tx Plan Goal #4, Objective 1. Continue with Tx Plan Goal #4, Objective 2 in next session.

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C.H.A.R.T. method of documentation

Client Condition

Historical significance of client condition

Action – What action counsellor took in response to client condition

Response – How client responded to action

Treatment Plan – How it relates to plan

(Source: Roget & Johnson, 1995)

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Is the Treatment Plan Reflected in Documentation?
ð   Notice the connection between treatment plan components and the documentation note.

Other Recognized Documentation Formats

C.H.A.R.T. (Roget & Johnson, 1995)
ð   **C** = Client **condition**
ð   **H** = **Historical** significance of client condition
ð   **A** = What **action** did the counsellor do in response to client condition?
ð   **R** = Client **response** to treatment plan
ð   **T** = How response relates to **treatment plan**

General Discussion: What Other Formats Are Used?
ð   What other styles are used in your country/agency?
ð   Identify and/or review country-specific documentation requirements.

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Optional Writing Activity:

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

The Treatment Plan is the pivotal point in which all other documentation activities revolve. The plan is like the hub of a Wheel—without the hub, the spokes have no way to connect.
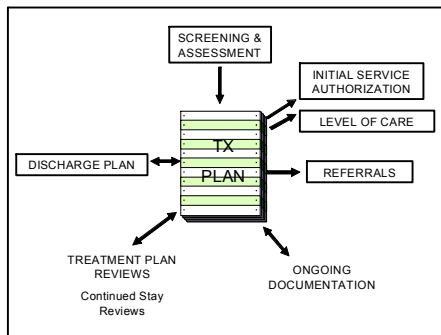
Overhead 126

The Role of the Treatment Plan in Clinical Records

ð The *assessment* is the first step in treatment planning. (If the ASI is incorporated in the assessment process, problem areas are identified leading to a Master Problem List. Problems are addressed in goals, objectives, and interventions of the treatment plan.)

ð When managed care (private or public) is involved in authorizing client services, the *initial service authorization* determination is based on the assessment information.

ð *Referrals* to outside resources are reflected in the treatment plan.

ð *Ongoing documentation* (i.e., progress notes) must be recorded in the client record after each encounter. Progress notes reflect the treatment plan.

ð *Treatment plan reviews/continued stay reviews* reflect the client's progress in relation to the problems/goals identified in the most current treatment plan and may also adjust the level of care.

ð Most programme certification/licensing practise guidelines require a *discharge plan* be developed soon after admission to a treatment programme. Discharge criteria are determined by the problem and goals addressed in the treatment plan.

NOTE: discharge criteria may be deemed "required for discharge" OR "optional for discharge."

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Other organisational considerations

1. Information requirements of funding entities / managed care?
2. Is there duplication of information collected?
3. Is technology used effectively?
4. Is paperwork useful in treatment planning process?

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Other Organizational Considerations

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

ð Clinical record processes are often subjected to incremental changes when funding or programme credentialing entities introduce new information requirements.

ð Taking a "bird's eye view" of clinical record-keeping processes often reveals duplication of information.

ð Use of computer technology in creating and maintaining clinical documentation could streamline the process.

ð Use ASI DENS software, which prompts and guides the clinician in developing a treatment plan and ongoing documentation.

Leader Note:

ð The above organizational considerations were previously covered; see Workshop 2.

Post-assessment

Please respond to the post-assessment questions in your workbook.

(Your responses are strictly confidential.)

⏰ 10 minutes

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Conduct Post-Assessment

1. Ask participants to complete the 5 post-assessment questions for this module. They have 20 minutes to complete these questions.

2. Remind participants that the assessments are confidential and that they do not need to provide any personal information.

3. Explain that these assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improvement.

Thank you for your time!

Thank participants for their time, attention, and participation!