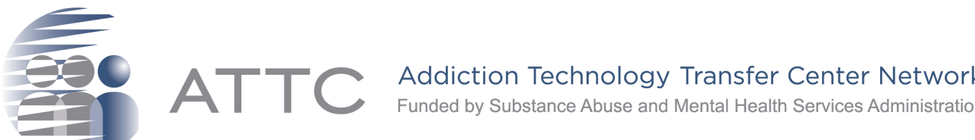
ESAS: Clinical Evaluation: Treatment Planning

Steven G. Steine

AI/AN National ATTC Manager

December 2022

IOWA



American Indian & Alaska Native Addiction Technology Transfer Center

U.S.-based ATTC Network

REGION 10
Northwest ATTC
University of Washington

REGION 7
Mid-America ATTC
Truman Medical Center

REGION 8
Mountain Plains ATTC
University of North Dakota

REGION 5
Great Lakes ATTC
University of Wisconsin-Madison

REGION 2
Northeast & Caribbean ATTC
NDRI, Inc.

REGION 1
New England ATTC
Brown University

REGION 9
Pacific Southwest ATTC
University of California, Los Angeles

REGION 3
Central East ATTC
Danya Institute

National Hispanic and Latino ATTC
National Latino Behavioral Health Association

National American Indian and Alaska Native ATTC
University of Iowa

REGION 4
Southeast ATTC
Morehouse School of Medicine

REGION 6
South Southwest ATTC
University of Texas, Austin

ATTC Network Coordinating Office
University of Missouri-Kansas City

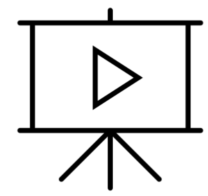
Alaska
Hawaii
Puerto Rico
U.S. Virgin Islands

The National American Indian and Alaska Native Addiction Technology Transfer Center is supported by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

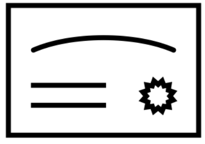
The content of this event is the creation of the presenter(s), and the opinions expressed do not necessarily reflect the views or policies of SAMHSA, HHS, or the American Indian & Alaska Native ATTC.

Follow-up

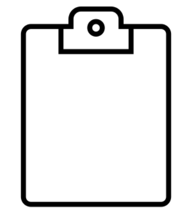
Following today's event, you will receive a follow up email, which will include:



Links to the presentation slides and recording, if applicable



Information about how to request and receive CEUs



Link to our evaluation survey (GPRA)

Land Acknowledgement

We would like to take this time to acknowledge the land and pay respect to the Indigenous Nations whose homelands were forcibly taken over and inhabited.
Past and present, we want to honor the land itself and the people who have stewarded it throughout the generations.

This calls us to commit to forever learn how to be better stewards of these lands through action, advocacy, support, and education.
We acknowledge the painful history of genocide and forced occupation of Native American territories, and we respect the many diverse indigenous people connected to this land on which we gather from time immemorial.

While injustices are still being committed against Indigenous people on Turtle Island, today we say thank you to those that stand with Indigenous peoples and acknowledge that land reparations must be made to allow healing for our Indigenous peoples and to mother earth, herself.

Today’s Speaker

[*STEVEN G. STEINE, MA, CADC*]

Project Manager at the National American Indian and Alaskan Native Addiction Technology Center, Iowa College of Public health

Email: steven-steine@uiowa.edu

Steve earned his B.A. in Communications (1994) and his M.A. in Substance Abuse Counseling Program (1997) from the University of Iowa. He has been a certified Alcohol and Drug clinician with the State of Iowa since 1997. He was born and raised in Iowa and has worked in the Behavioral Health Services and non-profit sector for 23 years, providing both direct patient care, as a clinician, and provided supervision as a clinical manager. Since January of 2019, he has been working for the National AI/AN ATTC at the University of Iowa. He has been in recovery for over 35 years and has committed his life and profession to helping others in the recovery process.

Goals and Objectives

- Define Treatment Planning
- Understanding of Correlation Between Assessment and Treatment Planning
- Overview of Treatment Planning Process
- Treatment Plan History
- Introduce the Treatment Planning M.A.T.R.S. Model
- Progress Notes

What is Treatment Planning?

What is a Treatment Plan?

- A result of collaborative process between the patient and the counselor
- Counselor + patient develop goals and identify strategies (interventions) for achieving those goals

(Addiction Counselor Competencies, CSAT, TAP 21, p. 39)

Thoughts on Tx Planning

- The treatment plan is a living document that can change during the course of a patient's treatment involvement…
- Continuing care planning and discussion should begin with the patient immediately and progress as the treatment process progresses post-admission.
- A patient's recovery plan truly begins the day they complete their primary treatment stay.
- The more we involve our patients in the Tx Planning process, the more meaning and purpose it will have to them.

Treatment Plans Incorporate Information Gathered from the Assessment

- Results of an ASI (+other instruments)
- Clinical Interview
- Collateral Information from sources such as family, legal, EAP, physicians, treatment facilities, spiritual advisor/leader
- Presenting Problems

Bridging Assessment with Treatment Planning

- Obtain and interpret all relevant assessment information
- An integrated treatment plan addresses substance abuse and mental illness through concurrent treatment
- First address pressing needs
- Evaluate patient motivation to address substance abuse
- Identify treatment goals and target behaviors
- Select interventions for achieving goals
- Choose measures to monitor outcomes of goal setting
- Follow up and modify treatment plans as necessary

Treatment Planning

- At a minimum the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs.

1) Obtain and interpret all relevant assessment information

- Stage of change and readiness for treatment, i.e. Prochaska and DiClemente
- The treatment planning process
- Motivation and motivating factors
- The role and importance of patient resources and barriers to treatment
- The impact that the patient and family systems have on treatment decisions and outcomes
- Other sources of assessment information

2) Explain assessment findings to the patient and significant others involved in potential treatment

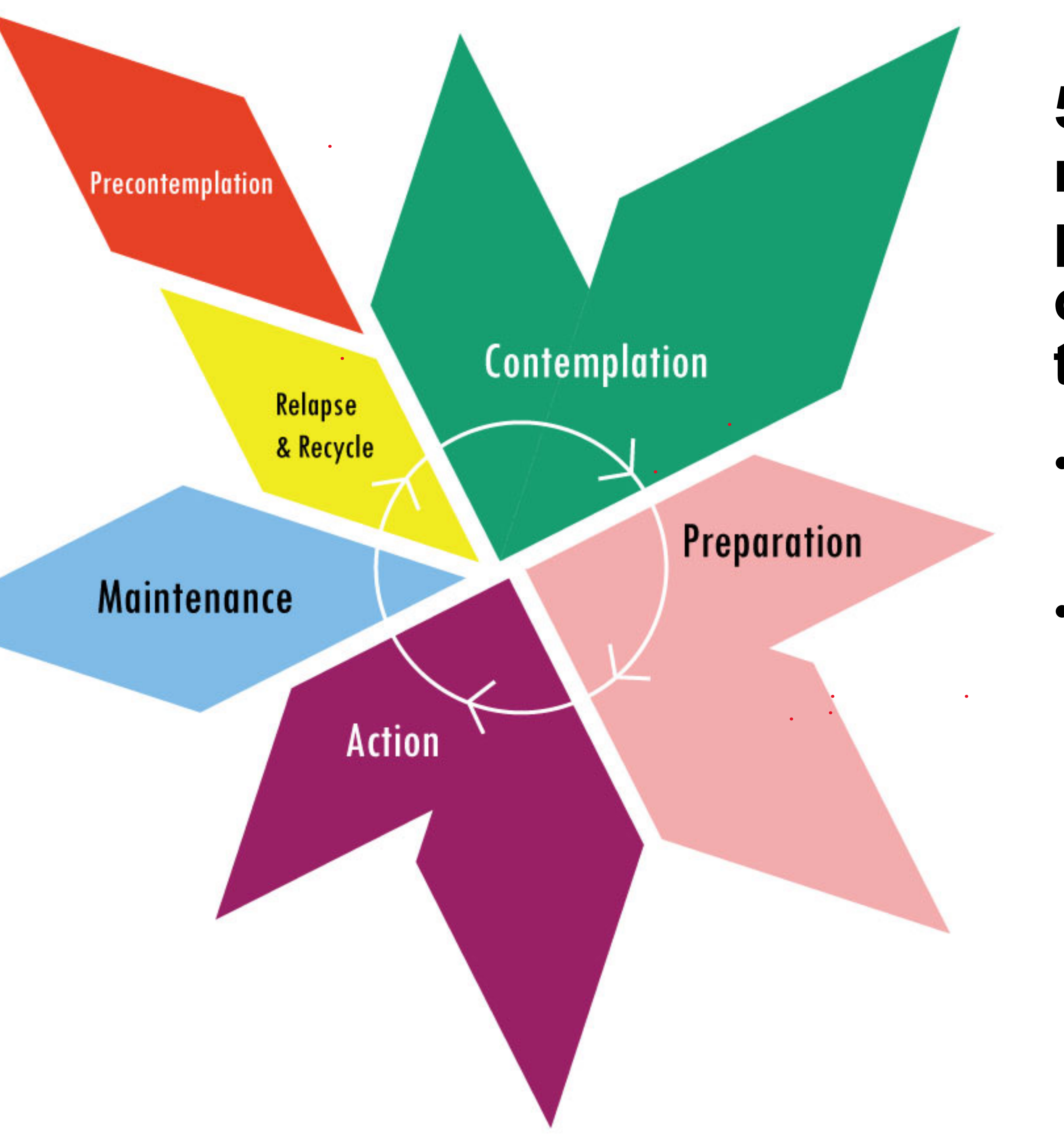
- Confidentiality regulations
- Effective communication styles
- Factors effecting the patient’s comprehension of assessment findings
- Roles and expectations of others potentially involved in treatment

3) Provide the patient and significant others with clarification and further information as needed

- Effective communication styles
- Methods to elicit feedback

4) Examine treatment implications in collaboration with the patient and significant others

- Available treatment modalities, patient placement criteria, and cost issues
- The effectiveness of the various treatment models based on current research
- Implications of various treatment alternatives, including no treatment



5) Confirm the readiness of the patient and significant others to participate in treatment

- Motivational processes
- Stages of change model

6) Prioritize patient needs in the order they will be addressed

- Treatment sequencing and the continuum of care
- Hierarchy of needs
- Interrelationship among patient needs and problems

7) Formulate mutually agreed upon and measurable treatment outcome statements for each need

- Levels of patient motivation
- Treatment needs of diverse populations
- How to write measurable outcome statements

8) Identify appropriate strategies for each outcome

- Intervention strategies
- Level of patient’s interest in making specific changes
- Treatment issues with diverse populations

9) Coordinate treatment activities and community resources

- Coordinate treatment activities and community resources with prioritized patient needs in a manner consistent with the patient's diagnosis and existing placement criteria
- Treatment modalities and community resources
- Contributions of other professions and mutual-help or self-help support groups
- Current placement criteria
- The importance of patient's racial or ethnic culture, age, developmental level, gender, and life circumstances in coordinating resources to patient needs

10) Develop with the patient a mutually acceptable plan of action and method for monitoring and evaluating progress

- The relationship among problem statements, desired outcomes, and treatment strategies
- Short- and long-term treatment planning
- Evaluation methodology

11) Inform patient of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations

- Federal, State, and agency confidentiality regulations, requirements, and policies
- Resources for legal consultation
- Effective communication styles

12) Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances

- Evaluate treatment and stages of recovery

- Review and revise the treatment plan

Treatment Planning

“The more we involve our patients in developing their healing plan, the greater meaning and purpose it will hold for them moving forward…”

Treatment Plans are often misunderstood as being…

- “Meaningful and time consuming”
- “Ignored”
- “Same plan, different names”

Other organizational considerations…

- Information requirements of funding entities/managed care?
- Is there duplication of information collected?
- Is technology used effectively?
- Is paperwork useful in treatment planning process?

Field of Substance Abuse Treatment: Early Work

- Program-Driven Plans
  - “One size fits all”
  - “Cookie cutter goals”
  - “Agency knows what the patient needs”

Program-Driven Plans

- Patient needs are not important as the patient is “fit” into the standard treatment program regimen
- Plan often includes only standard program components (e.g. group, individual sessions)
- Little difference among patients’ treatment plans

Program-Driven Plans

- Patient will:
- Remain abstinent from all substances (including alcohol)
- “Attend 3 AA meetings a week”
- Read pages 1-164 in the AA Big Book
- “Complete steps 1, 2, & 3”
- “Attend group sessions 3x/week”
- “Meet with counselor 1x/week”
- “Complete 28-day program”

Program-Driven Plans

- Often include only those services immediately available in agency
- Often do not include referrals to community services (e.g. parenting classes)

Treatment Planning: A Paradigm Shift

- Individualized treatment plans
  - Many options available
  - Custom style & fit
  - Living Document
  - Based on patient FB and in his/ her own words

Individualized Plan

- “Developed to match patient problems and needs”

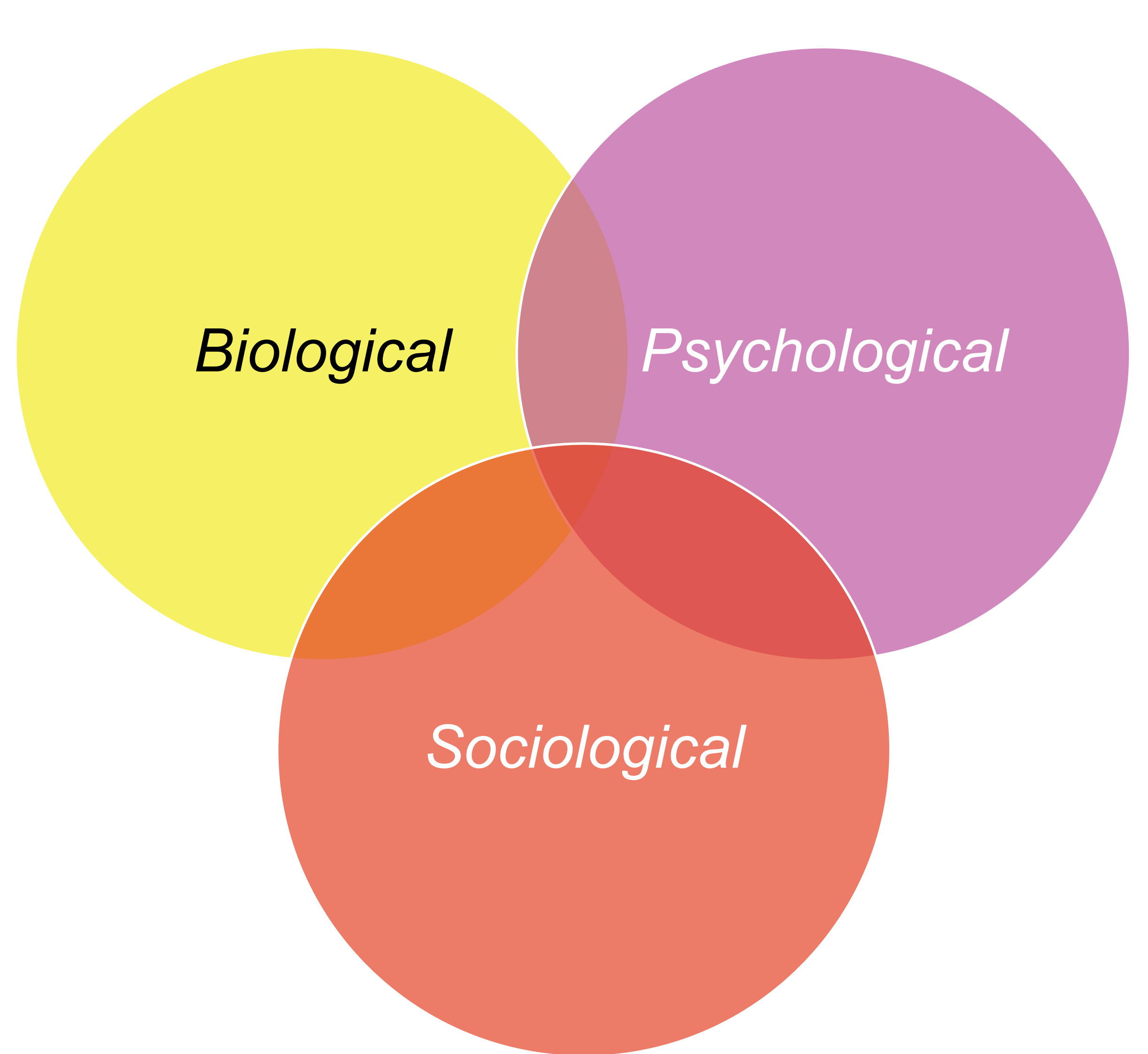
To individualize a plan, what information is needed?

- What does a counselor need to discuss before developing a treatment plan?
- Where do you get the information, guidelines, tools used, etc?

To individualize a plan, what information is needed?

- Possible sources of information might include:
- Probation reports
- Screening results
- Assessment scales
- Collateral interviews
- Examples of individualized Tx plans from previous patients
- Feedback/discussion with supervisor or mentor about Tx plans

Biopsychosocial Model

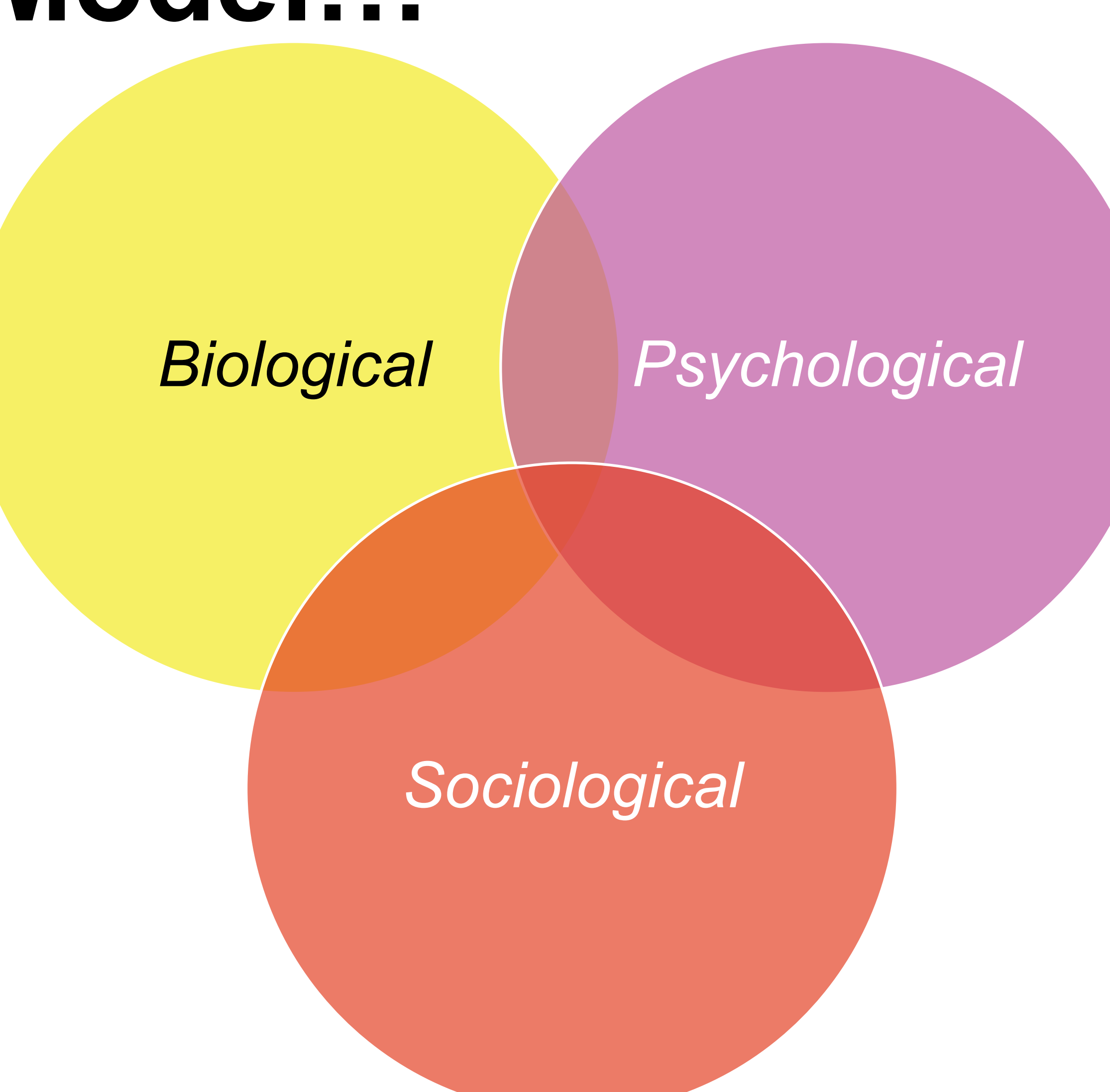


Biopsychosocial Model Example

- Does the patient have a car? Can they access public transportation?
- How close do they live to the treatment center?
- How available are drugs or alcohol in the home?

ASI Problem Domains and the Biopsychosocial Model…

- eg: Medical Status
- eg: Psychiatric Status
- eg: Family & Social Status



Why make the effort?

- Individualized Treatment Plans
- Leads to increased retention rates which are shown to lead to improved outcomes
- Empowers the counselor and the patient, and focuses counseling sessions
- Provides the patient with an attainable framework from which to build measurable recovery objectives

Why make the effort?

- Individualized Treatment Plans
- So that it “fits” the patient well

- ASI: Addiction Severity Index
- Like measurements, the ASI items are used to “fit” the patient’s services to her/his needs

What is included in any treatment plan?

Components in a Treatment Plan

1. Problem Statements (information from assessment)
2. Goal Statements (based on Problem Statement)
3. Objectives (what the patient will do)
4. Interventions (what the staff will do)

Treatment Plan Components

1. Problem Statements are based on information gathered during the assessment
2. Goal Statements are based on the problem statements and reasonably achievement in the active treatment phase
3. Objectives are what the patient will do to meet those goals
4. Interventions are what the staff will do to assist the patient

- Other common terms:
- Action Steps
- Measurable activities
- Treatment strategies
- Benchmarks
- Tasks

Discharge Plan Components

5. Patient Strengths* are reflected

6. Participants in Planning* are documented

Considerations in Writing…

- All problems identified are included regardless of available agency services
- Include all problems whether deferred or addressed immediately
- Each domain should be reviewed
- A referral to outside resources is a valid approach to addressing a problem

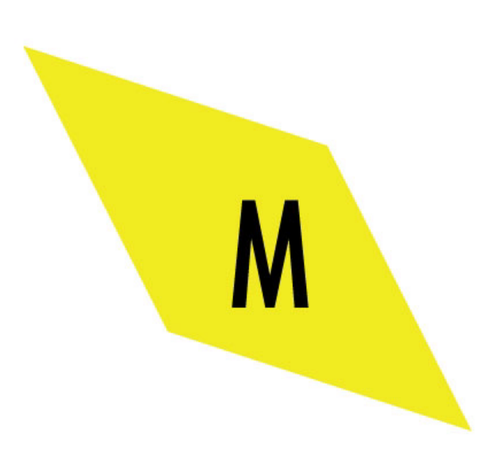
Tips on Writing Problem Statements

- Non-judgmental
- No jargon statements
  - patient is in denial
  - patient is co-dependent
- Use complete sentence structure

How we write an objective intervention statement: MATRS

- Treamtent MATRS (matters):
  - Measureable
  - Attainable
  - Time-limited
  - Realistic
  - Specific

Objectives & Interventions (MATRS)/: Measurable



- Objectives and Interventions are measureable
- Achievement is observable
- Measurable indicators of patient progress
  - Assessment scales/scores
  - patient report
  - Behavioral and mental status changes

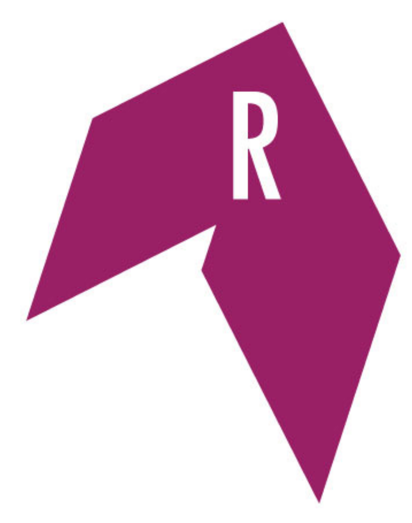
Objectives & Interventions (MATRS): Attainable

- Objectives and Interventions are attainable during active treatment phase
- Focus on “improved functioning” rather than cure
- Identify goals attainable in level of care provided
- Revise goals when patient moves from one level of care to another

Objectives & Interventions (MATRS): Time-limited

- Focus on time-limited or short-term goals and objectives
- Objectives and interventions can be reviewed within a specific time period

Objectives & Interventions (MATRS): Realistic



- Patient can realistically complete objectives within a specific time period
- Goals and objectives are achievable given patient environment, supports, diagnosis, level of functioning
- Progress requires patient effort

Objectives & Interventions (MATRS): Specific

S

- Objectives and Interventions are specific and goal-focused
- Address in specific behavioral terms how level of functioning or functional impairments will improve

The MATRS Test

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

Treatment Planning Process Review

- Conduct assessment
- Collect patient data and information
- Identify problems
- Prioritize problems
- Develop goals to address problems
- Remember MATRS
  - Objectives to meet goals
  - Interventions to assist patient in meeting goals

Five Components of an Effective Treatment Plan

1. Goals (or objectives)

- Every good treatment plan starts with a clear goal (or set of goals). Identify what your patient would like to work on and write it down. Don't be scared of limiting your work, you can always adjust these as time goes on. However, it's helpful to write down and discuss what your patient's purpose is for starting therapy. How will they know they are on the right path? What will you both use to determine when the patient is ready to terminate?

Treatment Planning (cont.)

2. Active participation

- A treatment plan then follows up with how each party will work to achieve the goal(s). This is really important and often missed. Talk with your patient about your role as a therapist and how you plan to help them achieve their desired outcome. This opens up a great discussion about the role of a therapist and how therapy looks with you, specifically, as compared with others.

Treatment Planning (cont.)

3. Support

- Another aspect of treatment planning that is so often forgotten in private practice settings is the client's support system. It's not just you and the client against the world. They'll need other supports in place to be successful throughout life. Identify any support as part of your treatment plan and you have already shown your client some of the tools in their toolbox.

Treatment Planning (cont.)

4. Outcomes

- The last important aspect of the written plan is the outcomes, or success. Make sure to write these down at various intervals. Maybe you visit the outcomes so far once a month, maybe every three months, etc. Choose what interval works best for your patient and your style and make sure to plan to talk with them about it.

Treatment Planning (cont.)

5. Client involvement

- I've saved the most important step to effective treatment planning for last. Involving your patients is crucial. Without their feedback, your treatment plan is no more meaningful than a term paper with a bunch of words on it.

- https://www.qaprep.com/blog/2015/6/28/5-steps-to-an-effective-treatment-plan

Documentation

Documentation: The Progress Note

- Documentation Includes:
  - Type of Session
  - Level of Care
  - Date
  - Patient Name
  - Counselor Name (typed)
  - Counselor Signature and Credentials

- Progress Note Formats
  - NAPT:
  - SOAP:
  - BIRP:
  - DAP:

Collaborative Documentation

- Collaborative Documentation sometimes referred to as **Concurrent Documentation**, is a process in which clinicians and patients collaborate in the documentation of the Assessment, Service Planning, and ongoing Client-Practitioner Interactions (Progress Notes).

  - https://www.10e11.com/blog/collaborative-documentation-improvement-tips

Documentation: Basic Guidelines

- Measureable:
  - Dated, signed, legible
  - Patient name, unique identifier
  - Start/stop time
  - Credentials
- Attainable:
  - Interventions used to address problems, goals, and objectives
- Time-limited:
  - Add new problems, goals, and objectives
- Realistic:
  - Content of session and patient response
  - Progess toward goals and objectives
- Specific:
  - Specific problems, goals, and objectives addressed

Documentation – Basic Guidelines

- Entries should include:
  - Your professional assessment
  - Continued plan of action
  - Progress Notes may be documented "collaboratively" with the patient's direct feedback and completed at the end of the session rather than post-service

Documentation – Basic Guidelines

- Describes:
  - Changes in patient status
  - Response to outcome of interventions
  - Observed behavior
  - Progress toward goals and completion of objectives

Summary

Presentation Summary: Treatment Planning

1. Obtain and interpret all relevant assessment information
2. Explain assessment findings to the patient and significant others involved in potential treatment
3. Provide the patient and significant others with clarification and further information as needed.
4. Examine treatment implications in collaboration with the patient and significant others
5. Confirm the readiness of the patient and significant others to participate in treatment (motivation level)
6. Prioritize patient needs in the order they will be addressed

Presentation Summary: Treatment Planning

7. Formulate mutually agreed upon and measurable treatment outcome statements for each need
8. Identify appropriate strategies for each outcome
9. Coordinate treatment activities and community resources with prioritized patient needs in a manner consistent with the patient's diagnosis and existing placement criteria
10. Develop with the patient a mutually acceptable plan of action & method for monitoring progress
11. Inform patient of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations
12. Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.

ASAM Criteria: Levels of Care

Assessment: ASAM, 3rd Edition

- American Society of Addiction Medicine (ASAM) Criteria:
- Clinically driven, not program driven
- Criteria do not involve a prescribed length of stay, but promote a flexible continuum of care
- Involve an interdisciplinary approach to care
- Include informed consent
- Are outcomes driven
- Clarify medical necessity

ASAM Levels of Care

- Level .05 Early Intervention (Relapse prevention/DUI class)
- Level 1: Outpatient (<9 hrs/wk)
- Level 2: IOP (9-19 hrs/wk)
- Level 2.5: PHP (20+ Hrs/wk)
- Level 3: Residential
- Level 4: Medically Managed Intensive Inpatient Services.

ASAM- Assessment, Reassessment & Discharge

- Physical
  - Acute intoxication/withdrawal potential
  - Biomedical Conditions
- Emotional/cognitive
  - Emotional/behavioral conditions
  - Treatment Acceptance/Resistance (Readiness to change)
- Behavioral
  - Relapse or Continued Use Potential
- Social/Environmental
  - Recovery Environment

Dimensions of ASAM

- Acute intoxication and withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential
- Recovery/Living environment
- *Severity in each dimension can be rated as mild, moderate or severe

Levels of Care-
Level 0.5 Early Intervention

- One-on-one counseling and educational programs (DUI class, MIP class, & Relapse Prevention)
- Patients do not meet criteria for Substance-Related Disorder
- Problems in Dimensions 1, 2 or 3 are stable or being addressed

Levels of Care: Level 1 - Outpatient Treatment

- Therapies include
  - Individual and group counseling
  - Motivational enhancement
  - Opioid substitution therapy
  - Family therapy
  - Educational groups
  - Occupational and recreational therapy
  - Psychotherapy
  - Other therapies
  - Continuing Care (post-primary treatment)

Level 1- Outpatient Treatment Dimensional Admission Criteria

- **Dimension 1**: No withdrawal signs or symptoms
- **Dimension 2:** Biomedical concerns stable
- **Dimension 3:** (a) or (b) and (c) and (d)
  - (a) No co-occurring mental disorder symptoms or symptoms are mild and stable
  - (b) Psychiatric symptoms are mild but mental health monitoring is needed
  - (c) Mental status doesn’t interfere with understanding and participation
  - (d) No risk of harm to self or others

Level 1 - Outpatient Treatment Dimensional Admission Criteria

- **Dimension 4:** (a) and (b) or (c) or (d)
- Willingness to comply with treatment plan
- Acknowledges substance use and wants help
- Ambivalent about substance use
- Doesn't recognize substance use

- **Dimension 5:** Able to achieve or maintain abstinence only with support

Level 1-Outpatient Treatment Dimensional Admission Criteria

- **Dimension 6:** (a) or (b) or (c)
- Supportive environment for treatment
- Inadequate support system but willing to obtain a support system
- Family is supportive but needs intervention to improve chances of success

Level 2.1 Intensive Outpatient Dimensional Admission Criteria

- **Dimension 1**: No withdrawal signs or symptoms
- **Dimension 2:** Biomedical stable or monitored concurrently with no interference

Level 2.1 Intensive Outpatient Dimensional Admission Criteria

Dimension 3: (a) or (b)

Abuse of family

Diagnosed emotional, behavioral or cognitive disorder that requires monitoring

Dimension 4: (a) or (b)

Need for structure

Need for repeated, structured interventions

Level 2.1 Intensive Outpatient Dimensional Admission Criteria

Dimension 5: Symptoms intensifying and functioning deteriorating at lower level of care

Dimension 6: (a) or (b)

Current environment makes recovery unlikely

Current social situation not helping recovery

Level 3.5 Residential Dimensional Admission Criteria

- **Dimension 1:** minimal risk of severe withdrawal/ or severe but manageable in 3.7 (detox)
- **Dimension 2:** None/ stable or receiving concurrent medical monitoring/ requires medical monitoring but manageable in 3.7 (detox)

Level 3.5 Residential Dimensional Admission Criteria

- **<u>Dimension 3: (a) or (b)</u>**
- Repeated inability to control impulses
- Personality disorder requires high structure to shape behavior

- **<u>Dimension 4: (a) or (b)</u>**
- Marked difficulty with, or opposition to treatment
- Dangerous consequences if not engaged in treatment

Level 3.5 Residential Dimensional Admission Criteria

Dimension 5: No recognition of skills needed to prevent continued use, with dangerous consequences

Dimension 6: (a) or (b)

Environment is dangerous

Patient lacks skills to cope outside of highly structured 24-hour setting

Withdrawal Management Overview

- Components of WM Services WM services (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) are provided as part of a continuum of five WM levels in the American Society of Addiction Medicine (ASAM).

- WM criteria include a continuum of care that ensures that patients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment levels.

Withdrawal Management (cont.)

- **Intake:** The process of admitting a patient into a substance use disorder (SUD) treatment program. This includes the substance abuse evaluation (SAE), the diagnosis of SUD, the assessment of treatment needs, and may include a physical examination and/or laboratory testing

- **Observation:** The process of monitoring the patient's course of withdrawal as frequently as deemed medically appropriate. This may include, but is not limited to, observation of the patient's health status.

- **Medication Services**: The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.

- **Discharge Services**: Preparing the patient for referral into another level of care, post treatment return, or re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.

Withdrawal Management (cont.)

- Licensing and Certification Requirements;
- In order to provide withdrawal management/detoxification services providers must obtain specific licensing and certification requirements according to the level of service provided.

Summary: ASAM Risk Rating and Level of Care

- General ASAM RR (Risk Rating)guidelines are as follows;
- -RR 0-1 = .05 EIS or Level 1 Continuing Care
- -RR 1-2 = Level 1 IOP
- -RR 2-3= Level 2.1 IOP
- -RR 3-4a/4b= 3.5 Residential

Crosswalk of the ASAM PPC-2R Adult Placement Criteria: Levels of Service 0.5 through IV

Criteria Dimensions	***LEVEL .05*** **Early Intervention**	***OMT*** **Opioid Maintenance Therapy**	***LEVEL I*** **Outpatient Treatment**	***LEVEL II.1*** **Intensive Outpatient**	***LEVEL II.5*** **Partial Hospitalization**
DIMENSION 1: **Alcohol Intoxication &/or Withdrawal Potential**	No withdrawal risk	Physiologically dependent on opiates and requires OMT to prevent withdrawal	Not experiencing significant withdrawal, or at minimal risk of severe withdrawal	Minimal risk of severe withdrawal	Moderate risk of severe withdrawal
DIMENSION 2: **Biomedical Conditions & Complications**	None or very stable	None or manageable with outpatient medical monitoring	None or very stable, or is receiving concurrent medical monitoring	None or not a distraction from treatment. Such problems are manageable at Level II.1.	None or not sufficient to distract from treatment. Such problems are manageable at Level II.5.
DIMENSION 3: **Emotions / Behavioral Conditions & Complications**	None or very stable	None or manageable in an outpatient structured environment	None or very stable, or is receiving concurrent medical monitoring	Mild severity, w/ potential to distract from recovery; needs monitoring	Mild to moderate severity, w/ potential to distract from recovery; needs stabilization
DIMENSION 4: **Treatment Acceptance / Resistance**	Willing to explore how current alcohol or drug use may affect personal goals	Ready to change the negative effects of opiate use, but is not ready for total abstinence	Ready for recovery but needs motivating and monitoring strategies to strengthen readiness. Or high severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.	Has variable engagement in tx, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change	Has poor engagement in tx, significant ambivalence, or lack of awareness of the substance use or mental health problem, requiring a near-daily structured program or intensive engagement services to promote progress through stages of change
DIMENSION 5: **Relapse / Continued Use Potential**	Needs an understanding of, or skills to change, current alcohol and drug use patterns	At high risk of relapse or continued use without OMT and structured therapy	Able to maintain abstinence or control use and pursue recovery or motivational goals w/ minimal support	Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems w/o close monitoring & support	Intensification of addiction or mental health symptoms, despite active participation in a Level I or II.1 program, indicates a high likelihood of relapse or continued use or continued problems w/o near-daily monitoring and support
DIMENSION 6: **Recovery Environment**	Social support system or significant others increase the risk of personal conflict about alcohol or drug use	Recovery environment is supportive and/or the client has skills to cope	Recovery environment is supportive and/or the client has skills to cope	Recovery environment is not supportive but, w/ structure & support, the client can cope	Recovery environment is not supportive but, w/ structure & support & relief from the home environment, the client can cope

"Client does not meet any level of ASAM Criteria" ____________________________ Clinician Date	Level 0.5 ___ OMT ___ Level I ___ Level II.1 ___ Level II.5 ___ Level III.1 ___ Level III.3 ___ Level III.5 ___ Level III.7 ___ Level IV ___	Client requires psychological evaluation: Yes ___ No ____ Not at this time ____ Client requires psychiatric evaluation: Yes ____ No ____ Not at this time ____ No need for treatment at this time ___ Referral out to: ____________________________

Thoughts, Questions, Feedback?

- Thank you for your participation in today's webinar.
- My contact information is:
  Avisgarciaphd@gmail.com

  I am open to requests on special topics for future presentations.
  The ATTC does travel to provide live in-person exam preparation classes.