ASAM Criteria® Treatment Planning Template

A core principle of *The ASAM Criteria* is that *treatment plans are individualized based on patient needs and preferences*. Treatment plans are informed by multidimensional assessments that consider the broad range of biological, psychological, social, and cultural factors that contribute to addiction and recovery.

Role of ASAM Criteria Assessments in Treatment Planning

Level of Care Assessment

Level of care recommendation and selection

Identify Dimensional Drivers

Treatment Planning Assessment

Describe concerns in each dimension

Identify strengths to build upon

Considers patient preferences and barriers to care

Reassessment and Treatment Plan Reviews

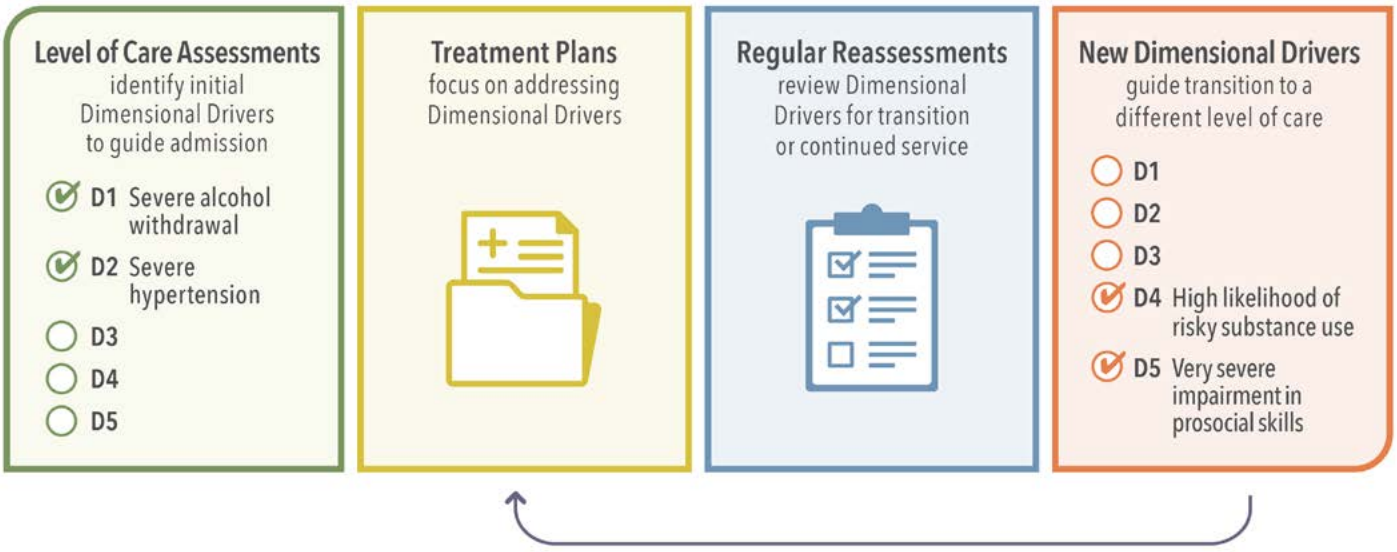
Progress toward goals

New or evolving concerns

Inform treatment plan updates

A Level of Care Assessment is used to identify an appropriate level of care and the patient's Dimensional Drivers – the concerns that cannot be safely and effectively treated in a less intensive level of care (Figure 2 below). Treatment plans should focus on addressing the Dimensional Drivers. Resolution of the Dimensional Drivers determines when a patient should transition to a less intensive level of care.

The ASAM Criteria Dimensional Drivers*



*The Dimensional Drivers presented in this figure are illustrative; Dimensional Drivers should be individualized to each patient.

A Treatment Planning Assessment is a comprehensive biopsychosocial assessment that gathers detailed information for longer-term treatment planning. While assessment and treatment planning should be an ongoing process, the initial Treatment Planning Assessment should cover each of *The ASAM Criteria* dimensions and subdimensions (Figure 3, at right) in enough depth to develop the first treatment plan.

Reassessments and Treatment Plan Reviews are used to track the patient's progress and inform clinical decision-making, including updates to the treatment plan and determining when the patient should transition to a more or less intensive level of care.

For more information, see Section III: Assessment and Treatment Planning in The ASAM Criteria, *Fourth Edition*.

A Patient-Centered Approach

Developing the treatment plan should be a collaborative process with the patient and their care team. The patient should be engaged in a shared decision-making process that starts with an initial question of what they want from treatment, and why now. Clinicians should work with the patient to explore which interventions have previously been successful, which have not, and the patient's thoughts on why.

Motivational interviewing approaches can be used throughout the treatment planning process to assess the patient's readiness and confidence for change in each area, discuss any ambivalence toward change, help the patient formulate their own goals, and increase or sustain motivation for treatment.

Treatment planning should be conducted in a trauma-sensitive and culturally humble manner. The treatment plan goals should clearly reflect the factors that motivate the patient to participate in treatment in their own words. The treatment plan should:

- reflect the patient's personal goals;
- incorporate the patient's inherent strengths and supports;
- be informed by the patient's cultural identities, preferences, and practices; and
- consider potential vulnerabilities such as those resulting from the patient's trauma history, socioeconomic status, environmental factors, or comorbid physical or mental health conditions.

Family involvement can be an important component of addiction treatment. Family-focused services can be helpful for the patient and for the family unit. In addition, family involvement can increase treatment engagement and treatment completion, and improve outcomes. If appropriate for the individual patient, the clinician and patient should consider involving key members of the patient's family or support system in the treatment planning process. Treatment planning should also consider the need for family-focused interventions including family therapy.

ASAM Criteria Dimensions and Subdimensions

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[1]

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations

- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

[1] Risky substance use and SUD-related behaviors refer to any use or behaviors linked to substance use or SUD, respectively, with significant risk for adverse medical, psychological, emotional, social, financial, and/or legal consequences.

The Treatment Planning Process

1 Determine the Areas of Focus

First identify the problem areas that will be the focus of the patient's treatment at the current level of care. The Areas of Focus should include:

A. Dimensional Drivers: What issues represent Dimensional Drivers – or concerns that must be addressed before the patient can be safely and effectively treated in a less intensive level of care?

B. Transition Barriers: What level of care is the patient most likely to transition to once their Dimensional Drivers have been addressed? Are there any barriers that would prevent the patient from making this transition – such as housing, childcare, or transportation challenges?

C. Patient Priorities: What does the patient want from treatment? What concerns are most pressing for them?

2 Develop Problem Statements and Goals

Next, assist the patient with formulating problem statements and goals within each Area of Focus. Problem statements and goals should be written in the patient's own words. The use of "I" statements or the patient's first or preferred name promotes patient engagement and buy-in. It is also important that this process be non-judgmental, focused on change, and utilize person-first thinking – the patient has a problem, the patient is not the problem.

Problem statements should identify concerns to be addressed in the current level of care. At minimum, the problem statements should address the patient's Dimensional Drivers.

Example problem statement: My drinking is causing problems in my marriage and job.

Goals should be clear and focused on what the patient wants to achieve in this phase of treatment. They may be short term or long term. Goal statements should be written in the patient's own words.

Example goal: I want to cut down on my drinking so that I can show up to work on time and improve trust with [spouse's name].

3 Define Objectives and Action Steps

For each goal, work with the patient to define objectives and action steps. Objectives are stepping stones toward achieving the identified goal. Action steps may include (1) actions the patient will take independently – such as attending mutual help meetings or making an appointment with an external provider; (2) services provided by program staff - such as psychotherapy, counseling, psychoeducation, medical services, recovery support, or referrals; and (3) any services the patient is receiving from external service providers – such as mental health treatment services or recovery support services.

When identifying action steps, the clinicians should consider:

- The patient's readiness for change and any motivational enhancement needs
- Which interventions have previously been helpful, and which have not
- Availability and wait times for proposed services
- Potential barriers to care and how these barriers may impact motivation
- The patient's strengths and how they can be built upon
- Incorporating the patient's family and/or community support persons, as appropriate

Objectives: The objectives should be Specific, Measurable, Attainable, Realistic, and Timebound (SMART) to ensure that they are clearly written and specific to what the patient seeks to achieve.[1]

Example objective: Over the next two weeks, I will identify at least three triggers for heavy alcohol use and three healthy coping skills to manage triggers, urges, or cravings.

Action Steps: Action steps should identify:

A. the steps the patient will take to meet an objective,
B. the services the addiction treatment program will provide to help the patient meet an objective, and
C. the services any external providers and/or programs will provide and how care will be coordinated.

Action steps may include referrals for services from external providers as well as care coordination with external providers when needed. Action steps for services should include modality, frequency, and responsible clinician or staff. It is helpful to note if any action items are court mandated, or otherwise required. If the patient has not had a recent physical examination, the treatment plan should include action steps towards completion of one within the time frame outlined in *The ASAM Criteria* level of care standards.

Example action steps:

I will participate in relapse prevention group one time per week, process group one time per week, weekly individual counseling with [primary therapist name].

I will receive monthly addiction medication injection with [primary care provider name], and mental health medication management with [psychiatrist name].

[Therapist name/title] will provide me with psychoeducation on distress tolerance skills.

[Therapist name/title] will coordinate my mental health care with [mental health provider's name].

[1] Bjerke MB, Renger R. Being smart about writing SMART objectives. Eval Program Plann. 2017 Apr;61:125-127. doi: 10.1016/j.evalprogplan.2016.12.009. Epub 2016 Dec 23. PMID: 28056403.

4 Consider Transition Planning Needs

Transition planning should begin at admission; treatment plans should consider what the patient will need to support an effective transition to a less intensive level of care and ways to objectively define what readiness to transition will look like. For example, the transition plan should consider:

A. **The anticipated next level of care.** What level of care is the patient most likely to transition to after their Dimensional Drivers have resolved? What programs are available in their local area? How should care be coordinated across the transition?

B. **Physical and mental health service needs.** What physical and mental health services is the patient expected to need? For example, is the patient expected to need a co-occurring enhanced (COE)[2] program or a program that can provide mobility assistance?

C. **Medication access.** Is the patient expected to need continued access to medication, including psychiatric and addiction medication? For example, does the patient need a program that can support continued access to methadone or buprenorphine?

D. **Recovery support service needs.** What recovery support services does the patient need to help support an effective transition? For example, what are the patient's anticipated needs for housing, transportation, and/or childcare assistance to enable participation in a less intensive level of care? What type of peer-support services can help support an effective transition?

E. **Overdose prevention and harm reduction needs.** What services or supports does the patient need to reduce their risk for overdose and other substance use-related harms following transition to a less intensive level of care?

5 Develop a Safety Plan (if applicable)

In outpatient settings, the treatment planning process should include the creation of a safety plan. Safety plans should clearly identify the steps that the patient should take in the event of an emergency outside of treatment hours and include resources that are accessible in the patient's geographic location. Safety plans may also be included in residential or inpatient settings when needed, such as when a patient is at risk for self-harm or violent behavior. Safety plans should consider:

- What does a crisis look like for this individual patient?
- What physical, emotional, social, and/or environmental triggers might heighten the risk of return to use or a mental health crisis?
- What early warning signs for potential return to use or mental health crisis should the patient and/or program be alert to?
- What strategies can the patient and/or program use to prevent substance use or mental health-related risks when warning signs emerge?
- Who can the patient reach out to if they need support?
- In an outpatient setting:
  - Does the patient have family, friends, or a sponsor they can count on after hours?
  - Does the program have staff on-call after hours?
  - When should the patient call 911?
  - When should the patient call 988?
- In a residential or inpatient setting:
  - When will the program contact the on-call provider?
  - When will the program call 911 or 988?

[2] In *The ASAM Criteria*, programs that have enhanced resources to routinely serve patients with more serious co-occurring mental health or cognitive conditions.

Treatment Plan Updates

Treatment plan updates should capture the patient's progress toward their goals. Routine review of the treatment plan helps to determine a patient's progress toward their stated goals and identify new or evolving needs — such as when a patient demonstrates progress, when there are challenges to progress, and when new problems are identified that need to be incorporated into the patient's treatment plan. While formal updates to the treatment plan occur on a regularly scheduled cadence, treatment planning is a continuous process. The clinician should not delay if the treatment plan needs to be updated prior to the scheduled Treatment Plan Review — as indicated by new information or a lack of sufficient engagement or progress. Treatment Plan Reviews should also consider whether the patient is ready to transition to a less intensive level of care or would be better served in a more intensive level of care (see the Transition and Continued Service Criteria in Chapter 10). Treatment Plan Reviews should consider:

- Which strategies are working? Which are not?
- What objectives has the patient achieved? What skills or insight have they gained?
- What goals or objectives has the patient struggled to meet? What would be more realistic?
- What, if anything, got in the way of progress?
- Should any goals, objectives, or action items be changed or removed?

When updating the treatment plan, document how the plan has been changed and the rationale. This includes documenting the patient's successes as well as challenges. Treatment plans may also need to be updated when a patient experiences a significant event that impacts their needs such as the loss of child custody, death of a loved one, or end of a significant relationship. When documenting the patient's progress, discuss any significant events and how the treatment plan has been updated in response.

ASAM Criteria® Treatment Plan Form

PATIENT INFORMATION	
Patient's name:	Primary counselor's name:
Level of care: Choose Item	
Initial Treatment Plan Date:_____	Updated treatment plan date:_____
Recent physical exam: ☐ Yes ☐ No	Date of physical exam (or date scheduled): _____

DIAGNOSES	

AREAS OF FOCUS	
Dimensional Drivers	
Subdimension	Describe the patient's risks in this subdimension

Patient Priorities
Priority 1:
Priority 2:
Priority 3:

Transition Barriers
Describe any barriers to transition to a less intensive level of care (eg, housing, transportation, childcare)

PROBLEM 1		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 2		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 3		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 4		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

SUMMARY OF SERVICES

Are accommodations needed to enable the patient to participate in treatment? ☐ Yes ☐ No
If so, what accommodations will be provided:

☐ **Individual counseling** _____x per week

☐ **Group counseling** _____x per week

☐ **Medication management**
- Last appointment:
- Next appointment:

☐ **Case management** _____x per week

☐ **Medical services** (note appointment dates):
- Physical exam: _____
- Primary care appointment: _____
- Specialist appointment (specify): _____
- Prenatal/postnatal: _____
- Dental: _____
- Other (specify): _____

☐ **Mental health services**
- Group counseling _____x per week
- Individual counseling _____x per week
- Psychiatric assessment (date):_____
- Cognitive assessment (date):_____
- Other:_____

☐ **Crisis intervention**
- Date of last crisis intervention:_____

☐ **Drug testing/Breathalyzer**
- Date of last test: _____
- Anticipated frequency of testing:_____
- Clinical purpose of drug testing: _____

☐ **Recovery support services:**
- ☐ Peer support services ____x per week
- ☐ Mutual support group ____x per week
- ☐ Patient navigation: _____
- ☐ Social service navigation:
  - ☐ Housing services
  - ☐ Transportation support
  - ☐ Supplemental nutrition benefits
  - ☐ Health insurance
  - ☐ Intimate partner violence services
  - ☐ Legal services
  - ☐ Child protective services
- ☐ Educational services:
  - ☐ Parenting
  - ☐ Financial management
  - ☐ Self-care
  - ☐ Other (specify):_____

☐ **Harm reduction services:**
- ☐ Overdose reversal training
- ☐ Naloxone
- ☐ Safer use education
- ☐ Safer sex education
- ☐ Referral to harm reduction organization
- ☐ Other (specify): _____

Care coordination needs: Identify the responsible staff member, the external provider they will coordinate with, and the services provided (eg, psychiatric services, HIV care).

TRANSITION PLAN
Anticipated next level of care: Choose Item
Anticipated medication-related needs:
Anticipated need for mental health services:
Anticipated medical support needs (eg, mobility assistance, dialysis, wound care):
Recovery support service needs:
Harm reduction service needs:
Referral needs:
Services needed to prepare for transition (eg, housing, transportation):

SAFETY PLAN (IF APPLICABLE)
I am at risk for (eg, return to use, risky behavior, self-harm):
I will reach out for support if I see these signs that I am at risk:
I will use the following strategies to prevent risks to my safety and/or recovery:
If I see signs that I am at risk, I will reach out someone on this list who I trust to support me:
I will call 911 if:
I will call 988 if:

SIGNATURES	
Patient signature:	Date:
Parent or guardian signature (if applicable):	Date:
If patient is unable to sign the treatment plan, please explain:	
Clinician signature/credentials:	Date:
Clinical supervisor signature (if applicable):	Date: