WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Understanding and Using ASAM Criteria in Substance Use Disorder Treatment Planning

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QUIZ TIME!

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.

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.

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.

It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms.

True

False

Goals should be written for the client as we know what is best for their recovery.

True

False

Clients should be encouraged to express their concerns with the treatment plan.

True

False

How ASAM's Criteria Works:

- ASAM's treatment criteria provide separate placement criteria for adolescents and **adults** to create **comprehensive and individualized treatment plans.**
- Adolescent and **adult** treatment plans are developed through a **multidimensional patient assessment** and are provided through five broad levels of care that are based on:
  - the degree of direct medical management provided,
  - the structure,
  - safety and security provided,
  - and the intensity of treatment services provided.

Individualized treatment is about collaborating on a treatment plan that matches the specific needs of the participant, makes sense to the participant and therefore has the best chance to actually work and succeed.

David Mee-Lee

Common Treatment Planning Issues

Problem Statements – Too general and non-specific

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

Problem & Client Statement:

✓The “Problem” is initially identified in the Assessment and that need is carried over to the treatment plan.

✓The “Client Statement” describes the specific functional impairment the client has described, include paraphrase or quote by client.

✓ Brief and behavioral to allow measurable outcome

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”

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; Dual Recovery Anonymous;

Progress Notes – General; often focused on attendance and compliance rather than documenting client’s clinical progress

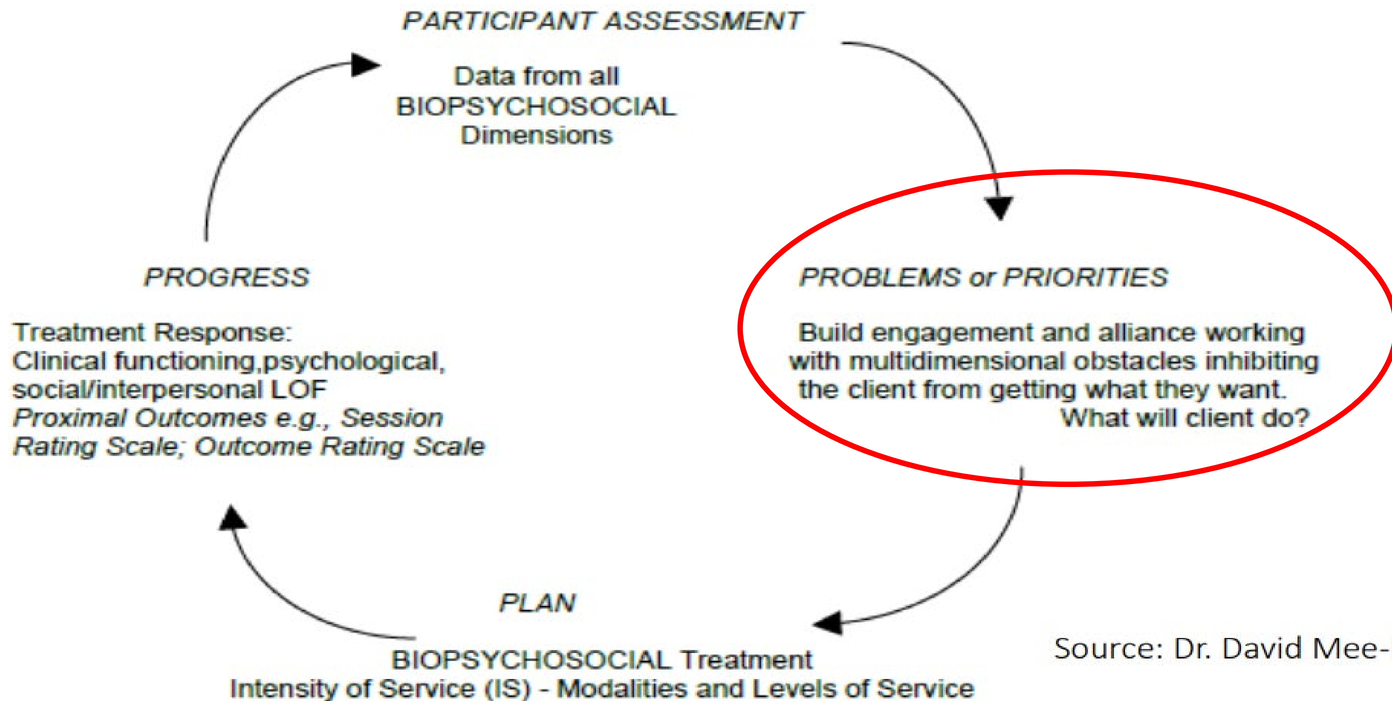
- participation in group”; “Attended and participated in all scheduled groups”; “Plan: Continue to monitor”

  - 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

Client-directed, Outcome Informed, Feedback-Informed Treatment



Source: Dr. David Mee-Lee

Service Planning and Placement

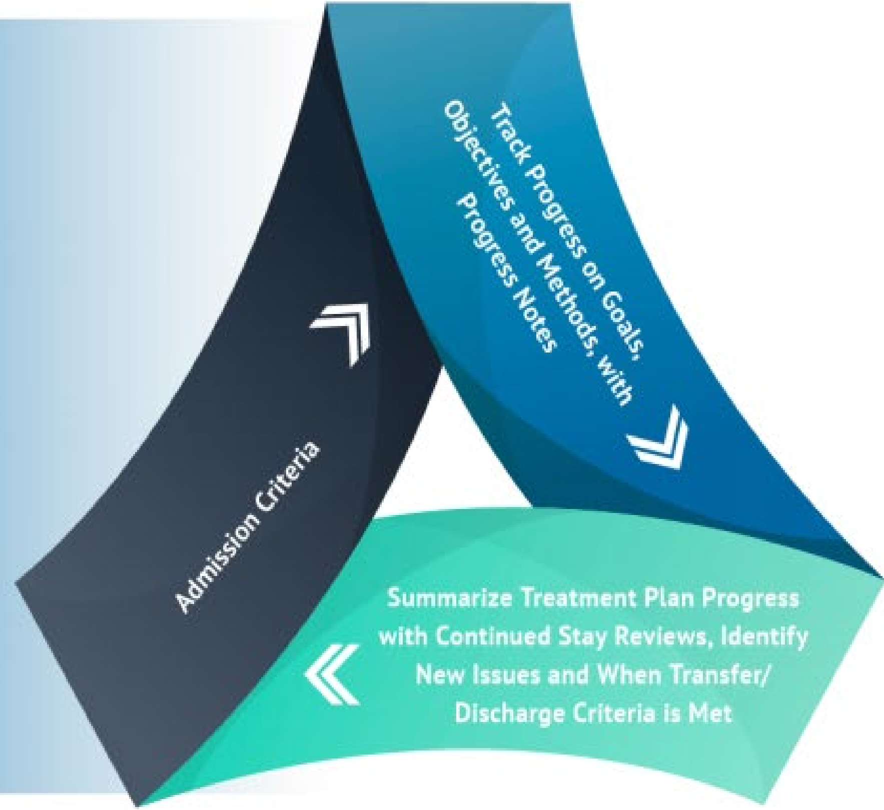
- Multidimensional severity/level of function profile
- Identify which assessment dimensions are currently most important to determine treatment priorities
- Choose specific focus and target for each priority dimension
- What specific services are needed for each dimension?

The ASAM Criteria – Decisional Flow page 124

Treatment Plan Elements

Treatment Plan Elements

1. Describe problem.
2. Reflect data that supports dimensional admission or continued stay criteria.
3. Describes specific behavior that manifests problem.
4. Indicates why it's a problem ("as evidenced by") or consequences. Does NOT state what patient "doesn't have" or "lacks."
5. Describes patient's view of problem.



The 5Ms of Treatment Planning Objectives & Interventions

Considerations in Treatment Planning

1. Motivate – Dimension 4
2. Manage – All Six Dimensions
3. Medication – Dimensions 1, 2, 3, 5 - MAT
4. Meetings – Dimensions 2, 3, 4, 5, 6
5. Monitor – All Six Dimensions

This person

in this setting

on this day

at this stage of interest or readiness to change

ANN's Case

- Ann is a 32-year-old Black, divorced female. She has been abstinent for 48 hours from alcohol and reports she has remained so for up to 72 hours during the past 3 months. (Dimension 1, Acute Intoxication/Withdrawal Potential; Dim. 5, Relapse, Continued Use, Cont. Problem Potential)
- When she has abstained from alcohol, she states she has experienced sweats, internal tremors and nausea. However, she has never hallucinated, experienced D.T.'s or seizures.(Dimension 1, Acute Intoxication/Withdrawal Potential)

- Vital signs within normal limits – Blood pressure and pulse rate. Ann states she is in good health except for alcoholic hepatitis for which she was just released from the hospital 1 week ago. (Dim. 2, Biomedical Conditions & Complications; Dim. 4 Readiness to Change)
- She was in the hospital for 72 hours and was stabilized for her liver and withdrawal symptoms. Her doctor referred her for assessment of her Alcohol Use Disorder.(Dim. 2, Biomedical Conditions & Complications; Dim. 4 Readiness to Change)
- Currently she is slightly anxious but not flushed or in any distress. (Dimension 1, Acute Intoxication/Withdrawal Potential & Dim 2)

- Ann describes 2 past suicide attempts with sleeping pills. Her most recent attempt was 3 years ago. She sees a psychiatrist once a month for medication. She takes fluoxetine(Prozac) for depression and doesn't report misuse of her medication. (Dimension 3, Emotional, Behavioral, Cognitive Conditions and Complications, Dim 4)
- Ann made the appointment and showed up on time.(Dim 4)
- She has thought about quitting many times in the past, but this is the first time she showed up to an appointment. (Dim 4)

- She doesn’t know much about addiction but wants to learn more. (Dim. 4 & 5)
- She smokes up to 3 or 4 joints a day but stopped yesterday. (Dim. 1, 4 & 5)
- Her last drink of alcohol was 48 hours ago.(Dim 1,2, 5)
- She has managed only 72 hours without a drink in the past 90 days. (Dim 5)
- She has one son, age 11, who doesn’t see any problems with her drinking and doesn’t know about her marijuana use. (Dim. 6)

- Her ex-husband is not in the picture.(Dim 6)
- Ann has few friends in the area. (Dim 5 & 6)
- Ann currently lives in an apartment. (Dim 6)
- She has a car, but her license is suspended. (Dim 5 & 6)
- Ann has not lost previous jobs due to addiction but was recently laid off when her company closed. (Dim 6)

Dimension 1-6 Risk Ratings

- D1: Risk Rating- 1 Mild Risk
- D 2: Risk Rating- 2 Moderate Risk
- D 3: Risk Rating-1 Mild Risk
- D 4: Risk Rating- 2 Moderate Risk
- **D 5: Risk Rating- 3 Severe risk**
- D 6 : Risk Rating- 2 Moderate Risk

- High likelihood of flare of substance use without assistance with significant dimension 2 physical health problems.
- This makes dimension 5 a high priority for treatment in the next 12-24 hours since she is approaching the 72-hour mark beyond which she has been unable to remain abstinent.

Ann's Treatment Plan

1. Intox'n/WD: In mild withdrawal, with only low intensity WD management needed. **RR 1**
2. Biomed: Recent hospitalization for alcoholic hepatitis but if her use flares up again, Ann is immediately at significant risk of physical health problems. We need more info from Dr. **RR 2**
3. Emotional, Behavioral, Cognitive: Comorbid depression, past suicide attempt, now stable on fluoxetine. Further assessment needed of the relationship between depression and substance use. **RR 1**
4. Readiness to Change: 1st time she has made & kept an addiction treatment appointment – after hospitalization & told to by MD. Open to learning about addiction. Limited skills, blames ex-husband, still drank after hospitalization. **RR 2**
5. **Relapse, Cont. Use/Prob Potential: High risk with no demonstrated skills to not use beyond 72 hours; just stopped marijuana and a flare up of alcohol use can cause serious physical health problems-RR 3**
6. Recovery Environment: Little identified support, transportation barrier, is child safe?, unemployed with potential money problems threatening her apartment, but does have job skills. **RR 2**

Priority Goals, Objectives & Interventions

- Dim 5: Potential to Relapse
- Dim 2: Biomedical
- Dim 4: Readiness to Change
- Dim 6: Recovery Environment
- Dim 3: Emotional, Behavioral, Cognitive
- Dim 1: Intox’n/WD

Goal:

- Ann has a high risk of relapse on Alcohol AEB a hx of her being unable to remain abstinent beyond 72 hours.

Objective:

- Will develop with assessor/therapist an agreed upon 24hr plan to stay abstinent.
- Ann will stay with a friend who can support her through the night.
- Ann will attend 2.5 LOC (Day Tx) the very next morning.

Intervention

- Assessor/therapist will assist client in development of a agreed upon 24hr plan to remain abstinent.
- Therapist will obtain an ROI to speak with Ann’s friend about plan of action(24hr plan).
- Therapist will coordinate Day Tx services for 7/21/2021 with “We Got Your Back Recovery Clinic.”

Ann's Case – Level of Care

- Ann needs at least ***Level 2.5 Partial Hospital (Day Tx) treatment environment.*** The patient has a friend who can stay with her through the night, so going home with the friend plus Level 2.5 would meet the needs of the patient.

Questions???

Developing the Treatment Contract and Focus of Treatment

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