[NAME] of Agency
Individualized Care: Biopsychosocial Assessment, Individualized Treatment Planning Process, Documentation and Progress Notes, and Transfer/Discharge Planning

July 1, 2025

Section 1: Policy

It is the policy of [NAME] to ensure all patients receive individualized, person centered substance use services that integrate best practices and support the patient in achieving and maintaining recovery. [NAME] will involve patients in the creation, review, and updating of a biopsychosocial assessment and an individualized treatment plan, and provide education on evidence-based interventions for the patient's substance use disorder (SUD), including medication assisted treatment (MAT). It is the policy of [NAME] to develop a transfer/discharge plan for patients at admission, and with their input, to follow up after they are transferred or discharged from treatment. [NAME] shall document a progress note after each significant patient contact. Case consultations may be completed on cases for quality review or on complex cases. The individualized treatment plan, case consultation notes, and transition plan will be maintained in the patient chart.

Section 2: Biopsychosocial Assessment

1. Individualized treatment planning and transfer/discharge planning will begin on the first day of admission.
2. Treatment staff that are trained on the American Society of Addiction Medicine (ASAM) 3rd edition criteria and knowledgeable about substance use treatment interview the patient to complete the individualized, comprehensive biopsychosocial assessment of the patient's SUD. If the patient was referred by another program and a biopsychosocial assessment was completed no more than 6

months prior to referral, staff will review the biopsychosocial assessment with the patient and update as needed. This process is to be completed with the first three sessions of admission and guides the development of the individualized treatment plan and the transfer/discharge plan.

3. The biopsychosocial assessment is an assessment that shall focus on the patient's strengths, problems/needs, skills/abilities, preferences, priority formulation, and desired goals.
4. The biopsychosocial assessment must include an ASAM assessment that identifies strengths, needs, and treatment priorities and renders a score in each of the six dimensions and may include an ASAM summary sheet. The ASAM summary sheet is a multidimensional assessment of the strengths and needs of the individual is used to make or validate placement determinations. The ASAM assessment, in combination with the biopsychosocial assessment, will be used to identify the clinically appropriate level of care.
5. Clinical staff will ensure that the biopsychosocial assessment includes a substance use and addictive disorders history, which will be reviewed by a physician as necessary. This includes the substance(s) used (both current and past), the frequency and intensity of use, and route of use, and an assessment of the impact of substance use (current and past) on the patient's life domains.
6. If clinical staff finds a patient has a co-occurring mental health disorder, they ensure that the level of care the patient is referred to is appropriate and able to meet the patient's substance use and mental health needs. If specialty mental health services are clinically indicated, the program ensures the patient is able to access services that can meet their substance use and mental health needs.
7. If the patient is admitted to a MAT program, monitoring, including biomarkers and/or toxicology or urine drug screen (UDS) must be completed at intake. If a patient is admitted to outpatient, intensive outpatient, or partial hospitalization program, monitoring, including biomarkers and/or toxicology or UDS may be completed at intake.
8. The client and the counselor discuss the treatment areas of focus and develop goals and interventions.
9. If the patient has a history of or is currently using opioids or alcohol, the biopsychosocial assessment will include current MAT details (e.g., name of medication, dosage, frequency, prescriber).
10. If the patient is currently using opioids or alcohol and is not engaged in MAT, clinical staff will objectively educate the patient on the use of medications as part of treatment, the types of medications typically used, and considerations of the benefits and risks of MAT. Clinical staff will offer reputable written materials or

websites for additional resources and document that education was provided in the biopsychosocial assessment.

11. Clinical staff will review with patient the current MAT services available at this agency or where the patient may be referred to receive the MAT services.
12. The patient will make an informed decision on whether they would like to receive MAT services or decline to participate in MAT services, which will be documented in the biopsychosocial assessment.
13. If the patient chooses to participate in MAT services not offered on-site, the clinical staff will make a referral to an agency to accommodate the MAT services the patient chose.
14. If the patient chooses to participate in MAT services offered at the agency, staff will include this in the individualized treatment plan and will follow procedure to get the patient enrolled in MAT services and referrals for continuing these services after treatment.
15. FOR 1.0, 2.1, AND 2.5 ONLY – [NAME] will ensure that the patient receives a physical examination within a reasonable time period, based on medical conditions, within [BLANK] days according to established protocols. If the patient has a personal physician, [NAME] will coordinate care with them. If the patient does not have a personal physician, [NAME] will offer referral to help identify and connect with a personal physician. [NAME] will coordinate review of the initial biopsychosocial assessment by a physician, if necessary.
16. FOR 1-WM AND 2-WM ONLY – [NAME] ensures that the biopsychosocial assessment includes a physician examination and comprehensive medical history is performed within a reasonable timeframe, within [BLANK] days according to established protocols, and the completed biopsychosocial assessment is reviewed by a physician or physician extender as part of the admission process.
17. FOR CO-OCCURRING ENHANCED ONLY – [NAME] ensures that patients with co-occurring mental health diagnoses receive a psychodiagnostic assessment and psychiatric history and examination within a reasonable time, within [BLANK] days according to established protocols and based on the patient's psychiatric condition, a mental status examination is completed, and evidence-based diagnosis specific assessments as applicable are used.
18. FOR ADOLESCENT ONLY – [NAME] will ensure the biopsychosocial assessment includes an initial withdrawal assessment, including a medical evaluation or medical review of an evaluation, performed within the 48 hours preceding admission, or within 7 days preceding admission for a patient who is stepping down from a residential setting. Information for assessment may be obtained from a parent, guardian, or other important resource (such as a teacher or probation

officer). Adolescent patients who are experiencing or are at risk of acute withdrawal syndrome should not be treated at Level 1.

Section 3: Individualized Treatment Plan – Content

1. The individualized treatment plan is developed by staff in collaboration with the patient generally within the first three sessions of treatment, and should reflect the patient's unique treatment needs, and the interventions [NAME] will provide in relation to the patient's goals.
2. The individualized treatment plan is guided by the biopsychosocial assessment, and includes:
    a. Problem identification linked to the six ASAM dimensions
    b. Needs
    c. Strengths
    d. Skills
    e. Priority problem formation
    f. Short- and long-term treatment goals
    g. Measurable treatment objectives
    h. Activities designed to achieve the goals and objectives as they apply to the management of the withdrawal syndrome or of the patient's SUD
3. The individualized treatment plan ensures that the duration of treatment varies with the severity of the individual's illness.
4. The individualized treatment plan includes monitoring, including biomarkers and/or toxicology testing in adherence to the program requirements.
5. UDS may be included as an intervention to support monitoring treatment compliance, assessing treatment progress, identifying possible relapse, tailoring treatment decisions, and encouraging open communication.
6. Clients may have goals requiring additional support services such as medical, dental, or psychiatric care and the program is responsible for identifying resources and/or arranging care.
    a. FOR ASAM 1-WM AND 2-WM – the individualized treatment plan includes:
        i. Problem identification in ASAM dimensions 1 through 6 and development of treatment goals and measurable objectives, as well as activities designed to meet those objectives as they apply to the management of withdrawal
        ii. Daily assessment of progress during withdrawal management and any treatment changes, or less frequently if the severity of withdrawal is sufficiently mild or stable

iii. Referral and linking arrangements for counseling, medical, psychiatric, and continuing care
iv. Serial medical assessments, using appropriate measures of withdrawal (optional)

b. FOR CO-OCCURRING ENHANCED PROGRAMS:
    i. Treatment plan for patients in a co-occurring enhanced program may be supported by general mental health clinicians (therapists, counselors, psychologists, advanced practice mental health nurses, general psychiatrists), general addiction clinicians (licensed and/or certified counselors, nurses, psychologists, and physicians, all of whom, as addiction specialists, should have general skills in the assessment and management of co-occurring conditions); and professionals specially trained and credentialed to work with the most complex cases (e.g., certified and/or licensed addiction psychiatrists). These services are typically provided by the program.
c. ADOLESCENT-SPECIFIC CONSIDERATIONS:
    i. Elements of the treatment planning may also include information from a parent, guardian, or other important resource (e.g., teacher, probation officer) as well as (when clinically and/or medically indicated):
        1. Ongoing withdrawal monitoring assessments, performed several times a week.
        2. Ongoing screening for medical and nursing needs, with medical and nursing evaluation available through consultation or referral.
d. ASAM LEVELS 1-WM AND 2-WM ONLY – [NAME] a patient receiving WM services will be provided those services separate from other treatment services at Level 1 and Level 2. The intensity of the WM services need not match the intensity of the other treatment services.

7. Once the treatment care plan is completed, it is reviewed with the client and signed by both the counselor and the client. The client is then given a copy.

Section 4: Individualized Treatment Plan – Update

1. Treatment plan reviews are conducted at specified times, as noted in the plan, or more frequently as determined by the appropriate credentialed professional. At minimum the individualized treatment plan will be updated at least every 30 days. Goals and action steps that require revision, deletion, or modification must be

changed or modified at that time. Updates should occur prior to the scheduled time if there are significant changes or updates in the patient's treatment or condition, or to ensure the treatment plan accurately reflects the patient's level of progress at a continued stay review,

   a. ASAM 2.1/2.5: Service Reviews – Co-Occurring Mental and Substance-Related Disorders – The clinician reviews the services of ASAM 2.1 and 2.5 treatment plans to ensure that they are appropriate for patients with co-occurring mental and substance-related disorders if the mental health and addiction treatment services are integrated into the intensive outpatient or partial hospitalization program. Such patients require active mental health services, which should be delivered through Level 2.1/2.5 co-occurring capable or co-occurring enhanced programs. Staff for such interventions can include general mental health clinicians (therapists, counselors, psychologists, advanced practice mental health nurses, general psychiatrists) working in collaboration with general addiction clinicians (certified and/or licensed counselors, nurses, psychologists, and physicians). All of these addiction specialists are working in collaboration with mental health clinicians and professionals who are specially trained and credentialed to work with the most complex cases (e.g., addiction psychiatrists, working in collaboration with other members of the interdisciplinary team).

2. The individualized treatment plan update will include an assessment of the patient's progress in relationship to the stated goals of the comprehensive treatment plan and the six dimensions of ASAM.
3. The individualized treatment plan and continued service reviews shall be individualized, person centered and based on the clinical assessment and needs of the client. The continued service review is based on patient progress and does not have a fixed length of stay (such as an 8-week outpatient, intensive outpatient, or partial hospitalization program).
4. The individualized treatment plan update will also evaluate the following:
   a. The patient's strengths, needs/weaknesses, abilities/interests, and personal preferences with regards to treatment/recovery program.
   b. Have problems or issues that have been identified in the individualized treatment plan been impacted upon through treatment?
   c. Do the goals need to be revised or restated?
   d. Do the treatment strategies or action steps need to be modified?
   e. Was transfer/discharge planning discussed, if appropriate?
   f. Is closure reflected when goals have been achieved?

5. The individualized treatment plan is updated to reflect progress and his or her response to treatment.
6. The individualized treatment plan update will be signed and dated by the primary counselor and include their credentials (as appropriate).
7. The individualized treatment plan update will be signed and dated by the patient.
8. The individualized treatment plan update will be signed and dated by the Clinical Supervisor or Clinical Coordinator and include their credentials (as appropriate).
9. The individualized treatment plan update will be signed and dated by the physician, when required.

Section 5: Transfer/Discharge Planning

1. Transfer/discharge plans are required at all times after 14 days of admission.
2. Transfer/discharge plans are not required when patients:
    a. Have left treatment against advice within 14 days of admission
    b. Refuse to participate in a transfer/discharge plan
    c. Are administratively discharged within 14 days of admission
    d. Are referred to another agency for further treatment within 14 days of admission

    In these circumstances, staff should complete a note indicating why a transfer/discharge plan was not completed.
3. The primary counselor, with the patient's input, is responsible for the development and the completion of the patient's transfer/discharge plan. When applicable and with appropriate consent, the person’s family/natural supports/legal guardian, or legally authorized representative will participate in the development of initiatives for transfer/discharge planning.
4. Based on the needs of the patient as identified by the counselor during the assessment process, the counselor will utilize individual and group sessions to help the patient work toward a transfer/discharge plan that will meet the identified needs. This may include interviews for other programs, appointments with the public welfare office, phone interviews, etc. The counselor or agency identified staff will coordinate these appointments, etc.
5. Prior to discharge the patient and the counselor will meet to finalize a specific written transfer/discharge plan for the patient’s discharge.
6. The counselor and the patient sign and date the completed form and the patient is given a copy; patients may decline a copy of the plan. The original form is placed in the patient's medical record.

7. Once the client has completed the treatment plan and meets criteria for discharge, the client can be discharged from care. Discharge occurs once aftercare planning is completed.
8. ASAM 1-WM: If a patient is not responding to treatment or symptoms are intensifying upon service review, the patient is re-assessed and referred to the clinically indicated higher level of care. Transfer should be based on a reassessment using the ASAM criteria and the measure(s) of withdrawal used at admission.
9. The patient continues in Level 1-WM services until:
    a. Withdrawal signs and symptoms are sufficiently resolved that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring; or,
    b. The patient's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified such that transfer to a more intensive level of withdrawal management service is indicated; or,
    c. The patient is unable to complete withdrawal management at Level 1-WM, despite an adequate trial. For example, he or she is experiencing intense craving and evidences insufficient coping skills to prevent continued alcohol, tobacco, and/or other drug use concurrent with the withdrawal management medication, indicating a need for more intensive services (such as addition of a supportive living environment) and transfer to a more intensive level of withdrawal management service is indicated.

Section 6: Care Coordination

1. [NAME] ensures that medical and psychiatric consultation is available within the following time frames for the following levels of care:

Level of care	**Via telephone/telehealth**	**In person**
1.0	Within 24 hours	Within a timeframe appropriate to the severity/urgency of the consultation requested
2.1/2.5	Within 24 hours	Within 72 hours
2.5 – Adolescent	Within 8 hours	Within 48 hours depending on the urgency of the situation

2. [NAME] has direct affiliation with, or close coordination through referral, both more intensive and less intensive levels of care to ensure patient's current substance use,

physical health, mental health, and social determinant of health needs (including housing) are addressed.

3. [NAME] provides coordination throughout the treatment episode to address additional clinical and non-clinical needs through consultation or referral including:
    a. Psychological services
    b. Laboratory services
    c. Toxicology services
    d. Educational and occupational (Adolescent 2.5)
4. Emergency services are available by telephone 24 hours a day, 7 days a week.

Section 7: Case Consultation

1. Difficult cases may be reviewed whenever complications arise in treatment. The counselor can initiate a case consultation at any time by calling the treatment team together for a review. For all patients requiring additional counseling during involvement with the program, the counselor will complete the case consultation documenting the following information:
    a. Patient Being Reviewed
    b. Patient Number
    c. Date of Review
    d. Staff Attending (name, credentials, and discipline)
    e. Reason for Review
    f. Discussion Summary
    g. Disposition of the Case
    h. Assessment/Action Plan
    i. Counselor Signature, Credentials, Title, and Date
    j. Physician's Signature and Date (*outpatient, intensive outpatient, partial hospitalization program medical assistance patients only)
2. The case consultation may be used for any of the following reasons:
    a. For initial review
    b. Patient's lack of progress in treatment
    c. Complications in the treatment process
    d. Co-occurring mental health or general medical conditions that impact substance use treatment
    e. Positive UDS
    f. Violations of the rules
    g. Multidisciplinary review
    h. Warm hand-off and/or transfer in level of care

i. To discuss a patient or group of patients for the purpose of counselor training
j. Patients requiring positive behavioral interventions (e.g., mental/medical/relapse concerns)

Section 8: Documentation and Progress Notes

1. A progress note will be charted on the agency approved progress note form after each significant patient contact, contact attempts, and collateral contacts and attempts.
2. Each progress note will include date, time, signature, and credentials (as appropriate) of the individual making the entry.
3. Individualized progress notes in the patient's record clearly reflect implementation of the patient's treatment plan and the patient's response to therapeutic and evidence based interventions for all disorders treated, as well as subsequent amendments to the plan. The progress note includes: **data**, **assessment**, and **plan** relative to treatment:
    a. Data (D): Information presented by the patient during the counseling session, counselor observations and interventions, and information about the patient from other sources.
    b. Assessment (A): The interpretive statement(s) based upon both new and previous information and includes the counselor's analysis of and conclusions regarding the patient's current situation or status.
    c. Plan (P): The plan (strategies) should reflect the counselor's actions to be taken in light of the evaluation and indicate the direction of treatment and include action steps, counselor plan(s), and patient assignments or tasks.
4. If group sessions are conducted, group progress notes will be written for each patient.

5. A progress note will be completed when a UDS is requested of a patient. The note should include the reason the UDS was requested (e.g., staff suspects the patient has returned to use, or as a routine part of therapy), and if the patient consented to the UDS or declined. If a patient declines to complete a UDS, it will be treated in the same manner as if the UDS returned with a positive result. The treatment plan and assessment will be updated with the UDS results and to determine next steps for treatment.

Section 9: Co-Occurring Capable Programs

1. Co-occurring capable and co-occurring enhanced program staff integrate the patient's mental health problems, the relationship between the patient's mental and substance-related and addictive disorders, updated mental status examinations, reassessment of psychotropic medications, and the patient's current level of mental functioning in each progress note.

Section 10: ASAM 1-WM

1. Clinical staff are required to document withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) as outlined in the treatment plan.