What’s New in DSM-5 and the New ASAM Criteria?: Implications in an Era of Healthcare Reform

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Broader Perspective on Substance Use Problems and Addiction Illness

20.6 million
12 years and older
1.5%
National Survey on Drug Use and Health (NSDUH)
Past Year Perceived Need for and Effort Made to Receive Specialty Treatment Among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2012 Data (September 2013 SAMHSA)

Did Not Feel They Needed Treatment

Felt They Needed Treatment and Did Not Make an Effort

Felt They Needed Treatment and Did Make an Effort

20.6 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use
DSM - Why Diagnostic Criteria?

• Need for classification of mental disorders has been clear throughout history of medicine

• Little agreement on which disorders should be included; and optimal method for their organization

• Many nomenclatures (naming systems) have been developed during past 2,000 years - differed in their relative emphasis on phenomenology, etiology, and course as defining features
Why Diagnostic Criteria? (cont.)

• Some systems have included only handful of diagnostic categories; others have included thousands

• Various systems for categorizing mental disorders have differed with their principal objective for use in clinical, research, or statistical settings

• Creates a common language for communication between clinicians about the diagnosis of disorders
History of DSM

• 1952 – First edition
• 1968 – Second Edition DSM-II – only 136 pages
• 1980 – DSM-III published after work had began on DSM-III in 1974
• 1987 – Publication of DSM-III-R after APA appointed Work Group to revise and correct DSM-III
• 1994 – Publication of DSM-IV
• 2000 – Publication of DSM-IV- Text Revision
• 2013 – Publication of DSM-5
Chapter Organization, Enhancements

• **Lifespan approach** — disorders diagnosed in childhood e.g., neurodevelopmental disorders placed at beginning of manual and disorders more applicable to older adulthood e.g., neurocognitive disorders at end

• Consolidation of Autistic, Rett’s, Asperger’s, Childhood Disintegrative Disorders (Pervasive Developmental Disorders) —

• **Autism Spectrum Disorder (ASD)**

• ASD severity based on impairments of social communication and social interaction versus restrictive, repetitive patterns of behavior
Chapter Organization, Enhancements

• **Streamlined classification** of bipolar and depressive disorders (most commonly diagnosed conditions in psychiatry). Rather than separating definition of manic, hypomanic and major depressive episodes from definition of bipolar I, bipolar II and major depressive disorder, all component criteria included within respective criteria for each disorder.

• Transitioning in conceptualizing personality disorders – dimensional approach to personality disorders “Hybrid” model proposed in

**Section III, Conditions for Further Study** - new disorders and features
Chapter Organization, Enhancements

Alternative model of Personality Disorders proposes:

- **Criterion A: Level of Personality Functioning** – disturbances in self and interpersonal functioning constitute the core of personality psychopathology, evaluated on a continuum

- **Criterion B: Pathological Personality Traits** organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism
Dimensional Approach to Diagnosis

- Structural problems in previous DSM - large number of narrow diagnostic categories in clinical practice, research

- Substantial use of “not otherwise specified” NOS diagnoses - When full criteria not met, consider whether symptom presentation meets criteria for “other specified” e.g., “other specified depressive disorders, depressive episode with insufficient symptoms or “unspecified” designation

- Previous DSM - each diagnosis categorically separate from health and from other diagnoses. Did not capture sharing of symptoms and risk factors across disorders (mood swings in bipolar and substance use disorders)

- Most human ills, mental disorders heterogenous - genetic risk factors to symptoms e.g., 65 yo social drinker forced to retire versus 20 yo whose family history and role models point to heavy addiction at young age
Elements of a Diagnosis

**Diagnostic Criteria and Descriptors**

- Diagnostic criteria offered as guidelines for making diagnoses, and use should be informed by clinical judgment.
- After assessment of diagnostic criteria, clinicians should consider application of disorder subtypes and/or specifiers as appropriate.
- Severity and course specifiers should be applied to denote individual’s current presentation, but only when full criteria met.
- Where applicable, specific criteria for defining severity (mild, moderate, severe, extreme), descriptive features (with good to fair insight; in a controlled environment; and course (in partial remission, in full remission, recurrent) provided with each diagnosis.
- Combination of: clinical interview, text descriptions, criteria, and clinical judgment – a diagnosis.
Elements of a Diagnosis (con’t)

**Subtypes and Specifiers**

- DSM-5 diagnosis usually applied to individual’s current presentation. Previous diagnoses from which individual has recovered should clearly be noted as such e.g., specifiers indicating course e.g., in partial remission, in full remission may be listed after the diagnosis.

- Where available, **severity specifiers** provided to guide clinicians in rating intensity, frequency, duration symptom count, or other severity indicator of disorder. Indicated by instruction “Specify current severity”.

- **Descriptive features specifiers** have also been provided in criteria set and convey additional information that can inform treatment planning e.g., obsessive-compulsive disorder, with poor insight.

- **Not all disorders** include course, severity, and/or descriptive features specifiers.
No More Multiaxial System

- DSM-5 moved to **nonaxial** documentation of diagnosis
- **Multiaxial** distinction between Axis I, II and III did not imply fundamental differences - that mental disorders are unrelated to physical and biological factors or processes, or that general medical conditions unrelated to behavioral or psychosocial factors or processes
- In DSM-5 Axis III **combined** with Axes I and II, with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)
- Elimination of multiaxial diagnoses enhances a more holistic and integrative system
Principal Diagnosis

• When more than one diagnosis is given in inpatient setting, principal diagnosis is condition established after study to be chiefly responsible for occasioning admission of individual.

• When more than one diagnosis is given in an outpatient setting, reason for visit is condition that is chiefly responsible for ambulatory care medical services received during the visit.

• In most cases, principal diagnosis or reason for visit is also main focus of attention or treatment.
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

- “dependence” – as label for addiction confusing; only for physiological dependence

- Patients with normal tolerance and withdrawal labeled as “addicts.”, which is normal response to repeated doses of many medications (beta-blockers, antidepressants, opioids, anti-anxiety agents and other drugs)

- Tolerance and withdrawal symptoms not counted as symptoms for diagnosis of substance use disorder when occurring in context of appropriate medical treatment with prescribed medications
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• Organized according to substance versus according to diagnosis e.g., Hallucinogen Disorders vs Substance Intoxication or Substance Abuse or Dependence

• One criterion dropped, legal problems because: (a) very low prevalence in adult and many adolescent population samples; (b) low discrimination – legal problems doesn’t separate out distinctly who has SUD versus just social problems (developmental risk taking or antisocial personality, psychosis, mania and other mental health issues); (c) poor fit with other SUD criteria; (d) little added information in item response theory analyses. No patients had legal problems as their only criterion and none “lost” a DSM-5 SUD Dx.
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• **One criterion added, craving** because: (a) behavioral, imaging, pharmacology and genetic studies indirectly support this criterion; (b) craving and its reduction can be central to diagnosis and treatment; (c) craving is in ICD-10 dependence criteria so this increases consistency between the nosologies; (d) fits well with other SUD criteria; (e) clinically useful

• Also **Internet Gaming Disorder** for Section III. Substance-Induced Dissociative Disorder removed
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• **Cannabis withdrawal** and **Caffeine withdrawal** both added, but not **Caffeine Use Disorder (Section III)**

• **Tobacco Use Disorder** aligned with criteria for other substance use disorders.

• **New** severity specifiers and updated remission specifiers
Substance Use Disorder

Substance use disorder is defined by the following criteria in DSM-5:

A. A **problematic pattern** of substance use leading to clinically significant **impairment** or **distress** as manifested by at least two of the following occurring in a **12-month period**:
Substance Use Disorder Criteria

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use
5. Role obligation failure
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use
8. Use in situations where it is hazardous
9. Continued use despite knowledge of having physical or psychological problem caused or exacerbated by use
10. Tolerance
11. Withdrawal
SUD CRITERIA PRIMARILY IN SEVERE DESIGNATION ONLY

The “Big Five”

• Wanting to cut down/unable to do so
• Craving with compulsion to use
• Sacrifice activities to use
• Failure at role fulfillment due to use
• Withdrawal symptoms

(Norman G. Hoffmann, Ph.D.
President, Evince Clinical Assessments
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CRITERIA PREVALENT IN MILD & MODERATE GROUPS

• Unplanned use
• Time spent using
• Medical/psych. consequences of use
• Use where impairment is dangerous
• Interpersonal conflicts
• Legal problems and use to relieve emotional distress similar in distribution to these

(Norman G. Hoffmann, Ph.D.
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CLINICAL IMPLICATIONS

• Most of those in the “mild” designation can probably benefit from moderation and related harm reduction strategies

• Those in the “severe” designation will require more intensive and extended services where abstinence is essential to recovery

• The “moderate” group may contain cases that fit the mild or severe characteristics

(Norman G. Hoffmann, Ph.D.
President, Evince Clinical Assessments
evinceassessment@aol.com)
CLINICAL (Medical) NECESSITY

• Persons in the severe designation with positive “Big Five” findings will require a more intensive and longer continuum of care to achieve treatment effectiveness.

• Persons in the mild designation typically will benefit from brief interventions to achieve treatment efficiency.

• Each treatment plan can be informed by prior empirical outcome data on comparable cases and modified based on the individual’s treatment response.

(Norman G. Hoffmann, Ph.D.  
evinceassessment@aol.com)
Severity Scale DSM-5

The Severity of each Substance Use Disorder is based on:

- 0 criteria or 1 criterion: No diagnosis
- 2-3 criteria: **Mild** Substance Use Disorder
- 4-5 criteria: **Moderate** Substance Use Disorder
- 6 or more criteria: **Severe** Substance Use Disorder
Severity and Course Specifiers

In early remission:
- Full criteria for SUD were previously met
- None of the criteria for SUD have been met for at least 3 months, but for less than 12 months
- Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”

In a sustained remission:
- Full criteria for SUD were previously met
- None of the criteria for SUD have been met at any time during a period of 12 months or longer,
- Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”
Severity and Course Specifiers

• The following specifier applies as a further specifier of remission (e.g. “early remission in a controlled environment”, and “sustained remission in a controlled environment”) if the individual is in remission and in a controlled environment:

• **In a Controlled Environment.** This additional specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.
Assessing for substance use disorder - In assessing for substance use disorder, one initially attempts to determine whether the patient's substance use is causing negative consequences. If such consequences are significant and recurrent in a 12 month-period, then diagnosis of substance use disorder is warranted.
Assessing for substance-induced disorders – Even if client does not meet criteria for substance use disorder, there may be substance-induced withdrawal or intoxication; or variety of substance-induced disorders including anxiety, depression, psychosis, sleep disorder or sexual dysfunction
Co-Occurring and Substance-Induced Mental Disorders

• SUD and mental disorders frequently co-occur - many symptoms e.g., insomnia being criteria for intoxication, withdrawal syndrome, or other mental disorders

• DSM-IV: “primary” mental disorders if began prior to substance use or persisted > than 4 weeks after cessation of acute withdrawal or severe intoxication

• DSM-IV: Substance-induced mental disorders defined: occur during periods of substance intoxication or withdrawal or remitting within 4 weeks thereafter; Sxs need exceed expected severity of intoxication or withdrawal; expected to remit within days to weeks of abstinence – to improve poor reliability and validity
Co-Occurring and Substance-Induced Mental Disorders

• DSM-5 reversed these DSM-IV standardization criteria and implemented flexible approach that lacked specific symptom duration requirements and included addition of disorder-specific approaches:

Criterion A: Disorder represents clinically significant symptomatic presentation of relevant mental disorder
Co-Occurring and Substance-Induced Mental Disorders

Criterion B: Evidence from history, physical exam, or laboratory findings of both of following:

1. The disorder developed **during or within 1 month** of substance intoxication or withdrawal or taking a medication; and

2. The involved substance/medication is **capable of producing** the mental disorder.
Co-Occurring and Substance-Induced Mental Disorders

Criterion C: Disorder not better explained by independent mental disorder (i.e. one that is not substance-or medication-induced). Such evidence of independent mental disorder could include following:

1. Disorder **preceded** onset of severe intoxication or withdrawal or exposure to the medication; or

2. Full mental disorder **persisted** for substantial period of time (e.g., at least 1 month) after cessation of acute withdrawal or severe intoxication or taking medication. Criterion does **not apply** to substance-induced neurocognitive or hallucinogen persisting perception disorders, which persist beyond cessation of acute intoxication or withdrawal.
Co-Occurring and Substance-Induced Mental Disorders

Criterion D: The disorder does not occur exclusively during the course of a delirium

Criterion E: The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Example in DSM-5

Alcohol-Related Disorders:

305 Alcohol Use Disorder, severe
303 Alcohol Intoxication with use disorder, severe
291.81 Alcohol Withdrawal, with perceptual disturbances
Other Alcohol-Induced Disorder
291.9 Unspecified Alcohol-Related Disorder
DSM-5
Gambling Disorder

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by four (or more) of the following in a 12-month period.

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).

7. Lies to conceal the extent of involvement with gambling.

8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

9. Relies on others to provide money to relieve desperate financial situations caused by gambling.
B. The gambling behavior is not better accounted for by a manic episode.

Course Specifiers
- Episodic
- Persistent
- In early remission
- In sustained remission

Current Severity:
Mild: 4-5 criteria met
Moderate: 6-7 criteria met
Severe: 8-9 criteria met
ASAM PPC-2R

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders

SECOND EDITION—REVISED

American Society of Addiction Medicine, Inc.
Chevy Chase, Maryland

2001
Goal of *The ASAM Criteria*:

To unify the addiction field around a single set of criteria
ASAM Criteria Background

• Previous Editions
  • Patient Placement Criteria (1991)
  • Patient Placement Criteria-2R (2001)
ASAM Criteria Background

• Upcoming Edition:
  – *The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*
  – Released in Fall 2013
  – Editor-in-Chief: David Mee-Lee, MD
Underlying Concepts of The ASAM Criteria: Individualized, Clinically-driven Treatment
Assessment of Biopsychosocial Severity and Level of Function

1. Acute Intoxication and/or Withdrawal Potential

2. Biomedical conditions and complications

3. Emotional/Behavioral/Cognitive conditions and complications
Assessment of Biopsychosocial Severity and Level of Function

4. Readiness to Change

5. Relapse/Continued Use/Continued Problem potential

6. Recovery Environment
Broad Treatment Levels of Service: A Description of the Continuum of Care

Levels of Service

1. Outpatient Treatment
2. Intensive Outpatient and Partial Hospitalization
3. Residential/Inpatient Treatment
4. Medically-Managed Intensive Inpatient Treatment
Focus Assessment and Treatment

What Does the Client Want?

Does client have immediate needs due to imminent risk in any of six dimensions?

Conduct multidimensional assessment
Focus Assessment and Treatment (cont.)

- DSM-5 diagnoses?
- Multidimensional Severity/LOF Profile
- Which assessment dimensions are most important to determine Tx priorities
Focus Assessment and Treatment (cont.)

Specific focus/target for each priority dimension

What specific services needed for each dimension

What “dose” or intensity of these services needed
Focus Assessment and Treatment (cont.)

Where can these services be provided in least intensive, but “safe” level of care?

What is progress of Tx plan and placement decision; outcomes measurement?
DSM-5 diagnoses?

Multidimensional Severity/LOF Profile

Which assessment dimensions are most important to determine Tx priorities

Specific focus/target for each priority dimension

What specific services needed for each dimension

What “dose” or intensity of these services needed

Where can these services be provided in least intensive, but “safe” level of care?

What is progress of Tx plan and placement decision; outcomes measurement?
Broad Treatment Levels of Service:
A Description of the Continuum of Care

- More levels of care within each of the broad levels
- Changes from Roman numerals to Arabic numerals, e.g.:
  - “Level I” becomes “Level 1”
  - “Level II.1” becomes “Level 2.1”
  - “Level II.5” becomes “Level 2.5”
  - “Level III.1” becomes “Level 3.1”
What’s not new in The ASAM Criteria

• The six assessment dimensions

• The overall levels of care (though not Roman numerals) for addiction management

• The “decision rules,” which link Intensity of Service back to the Severity of Illness maintained except for some updates in Withdrawal Management (“Detox”)
What’s not new in *The ASAM Criteria*


- Oversight and revision of the criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria (CNCC)
What’s not new in *The ASAM Criteria*


- The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM *Patient Placement Criteria* in 1991
What’s new in *The ASAM Criteria*?

- **New Title:** *The ASAM Criteria -- Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*
- **Shift away from “placement” criteria to “treatment” criteria:** It’s more than just “placement”
What’s new in *The ASAM Criteria*?

- Diagnostic Admission Criteria terminology changed to be compatible with *DSM-5*
- Section on working with managed care
What’s new in *The ASAM Criteria*?

- Table of contents
  - Re-ordered to be more user-friendly
  - Follows the flow from Historical Foundations to Guiding Principles to Assessment, Service Planning, and Placement decisions
What’s new in *The ASAM Criteria*?

- Adolescent Criteria
  - No longer separate/stand-alone
  - Consolidated Adult and Adolescent content to minimize redundancy while preserving adolescent-specific content
What’s new in *The ASAM Criteria*?

- Appendices
  - Withdrawal Management instruments
  - Dimension 5 constructs
  - Glossary
What’s new in *The ASAM Criteria*?

- **Withdrawal Management**
  - The wording in the Levels of Care
  - Former section “Detoxification” becomes “Withdrawal Management”
  - Levels are now called WM-1, WM-2, WM-3, and WM-4
  - New approaches described to support increased use of less intensive levels of care for safe/effective management of withdrawal
What’s new in *The ASAM Criteria*?

- Updated/revised terminology
  - Contemporary, strength-based, recovery-oriented:
    - “dual diagnosis” becomes “co-occurring disorders”
    - “inappropriate use of substances” becomes “high risk use of substances”
What’s new in *The ASAM Criteria*?

- Opioid use disorder specialized services
  - Opioid Maintenance Therapy” (OMT) becomes “Opioid Treatment Services” (OTS)
    - Opioid antagonist medications
    - Opioid agonist medications
    - Their use in OTPs (regulated “Opioid Treatment Programs”) or in office-based opioid treatment (OBOT)
New Content and Sections

- Additional text to improve application to address addiction treatment for Special Populations:
  - Older Adults
  - Persons in Safety Sensitive Occupations
  - Parents with Children and Pregnant Women
  - Persons in the Criminal Justice System (CJS)
New Content and Sections

• Additional text to address treatment of conditions not traditionally included in specialty addiction treatment services:
  • Tobacco Use Disorder
  • Gambling Disorder
New Content and Sections

Revision of the text to address emerging issues:

- Healthcare Reform and the integration of addiction treatment into general medical care
- The role of physicians on the care team, addiction specialist physicians in particular (addiction medicine physicians, addiction psychiatrists)
The ASAM Criteria Software

- *The ASAM Criteria* book and *The ASAM Criteria Software* are companion text and application.
- The text delineates the dimensions, levels of care, and decision rules that comprise *The ASAM Criteria*. 
The ASAM Criteria Software

• The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text
The ASAM Criteria Software

• The text and software are used in tandem:
  – The text provides background and instruction for proper use of software
  – The software enables comprehensive, standardized evaluation
The ASAM Criteria Software

- The ASAM Criteria Software is undergoing nationwide open-source release by U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)
The ASAM Criteria
David Mee-Lee, MD
dmeelee@changecompanies.net
www.ASAMcriteria.org

The ASAM Criteria Software
David R. Gastfriend, MD
gastfriend@gmail.com
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THE ASAM CRITERIA

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New Edition!

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Understanding the Dimensions of Change

Creating an effective service plan

1. Understanding the Dimensions of Change

Dimension 2: Biomedical Conditions/Complications

Family history and healthy practices

- List any physical or medical conditions you are aware of in your family:

- Are there any other physical conditions you are worried about? (yes no... if yes, please explain):

- Use the space below to describe what you feel is most important about your health and physical condition. Then, share this information with your change team to come up with some strategies and solutions you can use to create an effective service plan. If you and your change team decide this is not a life area that needs to be addressed in your service plan at this time, check the box below and move on to page 16.

- I have discussed this area with a member of my change team and we have agreed that it will not affect my service plan.

2. Review with your change team

Now think about the times in your life when you were feeling physically healthy. What things were you doing at those times that helped maintain your physical health?

- You already may have some strategies and solutions in place for keeping yourself healthy. List these below and make sure to share them with your change team.

- These are the strategies my change team and I have developed to address my needs with my health and physical condition:

3. My strengths for Living a Healthy Lifestyle

- In an effort to eat well:
  - I have a structured workout routine I follow
  - I don’t get sick very often
  - If I notice a physical or medical problem, I take steps to make it better

- In an effort to get enough sleep:
  - I go to bed and get up at the same time each day
  - I exercise regularly

- In an effort to get and keep your body healthy:
  - I see a doctor regularly
  - I eat healthy, nutritious foods

- I schedule regular medical check-ups for myself.

- When a health concern arises, I can tolerate or cope with it without too much discomfort

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Staff initials</th>
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Moving Forward
Participant Journal

Setting effective program goals

You will be better prepared to make progress if you take your ideas about what you want to work on and turn them into goals for your time in this program. Your program goals are what you will use to determine how close you are getting to what you want.

And for each of your program goals, there is an action to be taken. This action often takes the form of learning, trying, or planning something that brings you closer to the goal.

You will set several action steps for each program goal. As you start to accomplish these steps, you may decide to set even more for yourself. Over time, these little steps will add up to equal big results.

On the following pages, you will set your first three goals to work on within this program. Pay close attention to the other action steps and consider what you can get your ARMS around.

ARMS

Your goals should be ACHIEVABLE — things that are possible and realistic. They don’t have to be easy. It’s okay for your goals to be challenging, just make them doable.

Your path should be REWARDING — things you want that would make life better for you or others. When possible, make your goals things you want to increase, improve, create or strengthen.

Your goals should be MEASURABLE — changes that you and others can observe. How will you know that you are making progress toward these?

Your goals should be SPECIFIC — goals that are clear and to the point. “I want to be a better person” isn’t clear enough to work on. For a long-term change project, decide on the steps you want to take.

Your first program goal:

On the next three pages you will work with your change team to record your program goals. You and your change team will use what you both have learned so far to create goals that are both important and unique to you. Be sure your program goals are Achievable, Rewarding, Measurable and Specific.

My first program goal: ____________________________

Date set: ____________________________

My reasons for setting this goal are:

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________

This goal will help me more toward getting what I want. [ ] Yes [ ] No

Those are the strengths, skills and resources I will rely on:

1. __________________________________________
2. __________________________________________
3. __________________________________________

Here are a few of the specific action steps I am working on taking to achieve this goal:

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
THE ASAM CRITERIA

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