

Treatment planning and levels of care

Problems, goals, measurable objectives and interventions; the golden thread; the continuum of care and the ASAM dimensions; and when to step up, step down, revise or terminate.

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Treatment Planning became its own domain in the current blueprint, nine percent of the exam, and it is the most learnable domain because it tests a small set of rules. A plan has a structure, every piece connects to every other, the client belongs at the least restrictive level that is safe and likely to work, and a plan that is not working gets revised with the client rather than continued or abandoned. This guide gives the structure, the levels, the decision rules and the documentation, with worked items and thirty cards.

The anatomy of a plan

A treatment plan has four layers, and the exam tests the vocabulary precisely. The problem statement describes what is happening in behavioral, observable terms drawn from the assessment: "Client reports panic attacks three to four times a week and has stopped driving on highways." The goal is the broad direction of change, ideally in the client's own words: "Drive to work without panic." The objective is the measurable, time-limited step toward the goal: "Client will drive the two-mile route to the grocery store twice a week for four consecutive weeks by March 15, rating peak anxiety at 5 or below on a 0–10 scale." The intervention is what the counselor will do, with the modality and frequency: "Weekly individual sessions using interoceptive exposure and graded in-vivo exposure; psychoeducation on the panic cycle in sessions one and two."

Objectives are where candidates lose points, because a well-meaning goal is not an objective. An objective is written so that two people reading the chart would agree on whether it was met: a behavior, a measure, a criterion and a date. "Client will feel less anxious" fails on every count. "Client will reduce her Beck Anxiety Inventory score from 28 to below 16 within eight weeks" passes. Objectives are revised as they are met or missed, and a plan with no dates is a plan that cannot be evaluated. Strengths and resources, the client's and the environment's, are recorded because interventions are built on them.

The plan is collaborative: the client participates in setting goals, agrees to the interventions, signs the plan, and receives a copy, and the exam penalizes plans written without the client in the room. It is individualized, culturally responsive, and tied to the diagnosis and the formulation. Discharge criteria, what has to be true for treatment to end, are written at the start, which is also where the exam puts the beginning of termination planning.

Layer	What it is	Test	Example
Problem	Behavioral description from the assessment	Observable; specific	Panic attacks 3–4×/week; avoids highways
Goal	Broad direction, client's words	Meaningful to the client	Drive to work without panic
Objective	Measurable, time-limited step	Behavior + measure + criterion + date	Drive the grocery route 2×/week for 4 weeks by March 15, anxiety ≤ 5
Intervention	What the counselor does	Modality, technique, frequency	Weekly sessions; interoceptive and in-vivo exposure
Discharge criteria	What ends treatment	Written at the start	No panic attacks for 8 weeks; driving unrestricted

From formulation to plan: the golden thread

The case formulation is the bridge between assessment and plan: a working explanation of why this person has this problem now, drawn from the biopsychosocial assessment, the diagnosis and a theoretical frame. A cognitive-behavioral formulation names the triggers, thoughts, behaviors and maintaining factors; a psychodynamic one names the conflict and the defenses; a systemic one names the pattern and the function of the symptom. The exam tests that the formulation drives the interventions: an intervention that does not follow from the formulation is the wrong answer even if it is a good technique.

The golden thread is the exam's and the auditor's term for the line that runs from the diagnosis through the problem statement, the goal, the objective, the intervention and into every progress note. Anyone reading a note should be able to trace it back to an objective in the plan, and anyone reading the plan should be able to trace it back to the assessment. Items test the thread by breaking it: a progress note describing work on grief when the plan names only panic, an intervention with no objective it serves, a diagnosis of major depression with no depression-related objective. When an option describes documentation that does not connect to the plan, it is wrong whatever the clinical merit.

Evidence-based practice is part of the thread: interventions are chosen because research supports them for this problem with clients like this one, integrated with the counselor's expertise and the client's culture, values and preferences. The exam tests the three-part definition and penalizes both ignoring research and applying a manual without regard to the client. Treatment matching, choosing the approach by the client's problem, stage of change, culture and preferences, is the practical form of the same principle. Common factors, the alliance, hope and the client's own resources, account for a large share of outcome regardless of model, and items that pit the alliance against technique favor the alliance.

Exam tip. When a plan item asks what is wrong with a described plan, look for the broken link: an objective without a measure or a date, an intervention with no objective, a note with no objective, a plan without the client's participation. One broken link is usually the keyed answer.

The continuum of care

Levels of care run from least to most restrictive. Outpatient counseling, typically weekly, is the base. Intensive outpatient programs provide roughly nine or more hours a week of structured treatment, often three evenings, with the client living at home and usually working. Partial hospitalization or day treatment provides about twenty hours a week, most of the day most days, with nights at home. Residential treatment provides twenty-four-hour care in a non-hospital setting for weeks to months. Inpatient hospitalization provides medically managed, locked, twenty-four-hour care for acute risk, psychosis with impaired judgment, or medically dangerous withdrawal, and is measured in days. Crisis stabilization units and respite care sit between outpatient and inpatient for short stays.

For substance use disorders, the ASAM Criteria formalize the ladder into numbered levels: 0.5 early intervention; 1 outpatient; 2.1 intensive outpatient and 2.5 partial hospitalization; 3.1 through 3.7 residential, from clinically managed low-intensity through medically monitored intensive; and 4 medically managed intensive inpatient. Placement is made on six dimensions, and the exam tests that the dimensions, not the substance or the quantity, decide the level: acute intoxication and withdrawal potential; biomedical conditions; emotional, behavioral and cognitive conditions; readiness to change; relapse, continued use or continued problem potential; and recovery environment. A client with low withdrawal risk, no medical issues, high motivation and a stable home can be treated at level 1 regardless of how long he has been drinking; a client with dangerous withdrawal potential needs level 3.7 or 4 regardless of motivation.

Other levels appear by name: assertive community treatment, a multidisciplinary team delivering services in the community for people with serious mental illness; case management; supported employment and housing; and peer support. Wraparound services for children and families coordinate across systems. The exam expects you to know what each provides and to recognize the client it fits.

Level	Structure	Client fits when
Outpatient	Weekly or biweekly sessions	Safe, functioning, supports at home, mild to moderate symptoms
Intensive outpatient (ASAM 2.1)	9+ hours/week, lives at home, often works	Needs more structure than weekly; safe at night; motivated
Partial hospitalization (ASAM 2.5)	~20 hours/week, days, home at night	Daily structure and monitoring needed; no acute risk overnight
Residential (ASAM 3.1–3.7)	24-hour non-hospital care, weeks to months	Unsafe or unsupportive environment; repeated failure at lower levels
Inpatient (ASAM 4)	Locked, medically managed, days	Imminent risk; psychosis with impaired judgment; dangerous withdrawal
ACT team	Multidisciplinary, in the community	Serious mental illness; frequent hospitalization; poor engagement

Least restrictive, step up and step down

The rule the items are built around is that the client belongs at the least restrictive level that is safe and likely to work. Two errors are tested in equal measure. Under-placing: keeping a client in weekly outpatient care who has active suicidal intent, a plan and means and no supports, or who is in medically dangerous withdrawal.

Over-placing: hospitalizing a client with passive ideation, no plan, a safety plan and a family at home, or sending a motivated client with a stable home to residential treatment because he has been drinking for a long time. The data that justify escalation are specific: suicidal or homicidal intent with plan and means, inability to care for basic needs, psychosis with impaired judgment, dangerous withdrawal, or documented failure at the current level despite adequate treatment.

A step up is the planned move to a more intensive level in response to deterioration or risk; a step down is the planned move to a less intensive level as the client stabilizes, and the exam expects every inpatient stay to be followed by a step-down plan rather than a return to nothing. Intensification within a level, more frequent sessions, a psychiatric consultation, a safety plan, phone check-ins, is often the keyed answer when the stem describes worsening without acute risk, because it is less restrictive than a change of level. The decision is documented with its reasoning and revisited, which is what makes it a treatment planning item rather than a crisis item.

Involuntary commitment is the most restrictive option and the exam tests its grounds and limits: danger to self, danger to others, or grave disability, under state law, with a time-limited emergency hold followed by judicial review. Counselors in most states do not commit; they initiate the evaluation through emergency services or a designated professional. Least restrictive alternative is the legal principle behind the whole continuum, from *Lake v. Cameron* and the deinstitutionalization era, and it appears in items as the reason an outpatient commitment or a crisis unit is preferred to a hospital when it will do.

Exam tip. Read the risk data in the stem first. Intent plus plan plus means, or dangerous withdrawal, justifies a step up. Passive ideation with a safety plan and support does not. The stem gives you exactly what you need to choose the smallest adequate step.

Stage of change and treatment matching

Prochaska and DiClemente's transtheoretical model gives the exam its matching rule: the intervention fits the stage. Precontemplation, the client does not see a problem: raise awareness, express empathy, develop discrepancy and keep the door open, which is motivational interviewing. Contemplation, the client is ambivalent: explore both sides with decisional balance and resolve ambivalence without pushing. Preparation, the client intends to act soon: build a concrete plan with small first steps and remove barriers. Action, the client is changing: provide skills, structure, reinforcement and support. Maintenance, the change has held for six months or more: relapse prevention, identifying high-risk situations and rehearsing coping. Relapse or recycling: normalize it as part of the process and re-engage at whatever stage the client now occupies.

A plan that offers relapse prevention to a precontemplator or a decisional balance to a client already in action has mismatched stage and intervention, and the exam writes those plans as distractors. The processes of change, consciousness raising, self-reevaluation, self-liberation, counterconditioning, stimulus control, contingency management and helping relationships among them, map onto the stages, with the experiential processes early and the behavioral processes later.

Treatment matching also means fitting the modality to the problem and the person: individual, group, couple or family; brief or long-term; a specific protocol for a specific disorder, such as exposure and response prevention for OCD, DBT for borderline personality disorder, behavioral activation or cognitive therapy for depression, trauma-focused CBT for children, or motivational interviewing plus a level-appropriate program for substance use. Culture, language, religion, disability, age and the client's preferences shape the match, and the exam's keyed plans name them. Adjunctive services, medication evaluation, medical care, legal advocacy, housing, employment and peer support, are part of the plan when the formulation says they are.

Monitoring, revision and termination

Progress is measured against the objectives, using the same instruments and behavioral counts that defined them: a PHQ-9 or BAI at intake and at intervals, panic attack frequency, days abstinent, school attendance. Routine outcome monitoring, measuring every session or every few sessions and feeding the results back into the plan, improves outcomes and is the exam's preferred answer to "how should progress be evaluated." Progress notes record the date, the objective addressed, the intervention used, the client's response, risk, and the plan for the next session; SOAP, subjective, objective, assessment and plan, and DAP, data, assessment and plan, are the common formats, and the standard is that what is not documented was not done.

When the client is not improving, the exam's sequence is nearly always the same: measure, discuss with the client, revisit the formulation and the diagnosis, revise the plan collaboratively, and consider what to add, a medication evaluation, a different modality, a higher level of care. Continuing the plan unchanged because sessions remain, extending it by eight more sessions without changing the approach, or terminating and referring abruptly are the three distractors. Barriers to progress are assessed in the client, the environment and the treatment itself, including the alliance, and a rupture in the alliance is repaired before anything else is changed.

Termination is planned from the first session, when discharge criteria are written, and it is a phase rather than an event: reviewing progress against the goals, consolidating gains, anticipating setbacks with a relapse prevention plan, processing the ending, and arranging follow-up or referral. Appropriate reasons to end are that the goals are met, the client is no longer benefiting, the client chooses to stop, or the counselor can no longer provide competent service; in the last two cases a referral is made and the transition is supported. Abandonment, ending without notice and referral, is the ethics violation; premature termination by the client is explored and the door is left open. Relapse prevention, from Marlatt and Gordon, treats a lapse as a learning event rather than a failure, identifies high-risk

situations and seemingly irrelevant decisions, and addresses the abstinence violation effect.

Three items, worked

A client with major depressive disorder has completed eight of twelve planned sessions and her PHQ-9 has moved from 19 to 18. The counselor should: continue the plan, since four sessions remain; terminate and refer to psychiatry; review progress with the client, revisit the formulation and revise the plan collaboratively, including discussion of a medication evaluation; or extend the plan by eight sessions. The third option is keyed. The first ignores the data; the second skips the client and treats referral as an exit rather than an addition; the fourth changes the quantity and not the approach.

A 34-year-old man with alcohol use disorder, severe, has a stable job and marriage, no medical problems, no history of withdrawal seizures, and says he is ready to stop. His wife wants him in a thirty-day residential program. The most appropriate level of care is: inpatient detoxification; residential treatment; intensive outpatient treatment with medical evaluation for withdrawal management; weekly outpatient counseling. The ASAM dimensions decide: low withdrawal potential pending medical evaluation, no biomedical issues, high readiness, stable recovery environment. Intensive outpatient with a medical evaluation is the least restrictive adequate level; residential is over-placement driven by the wife's preference rather than the dimensions, and weekly outpatient may be too little for a severe disorder at the start.

A counselor writes the following objective for a client with social anxiety: "Client will become more comfortable in social situations." What is wrong with it? It is not measurable, has no criterion and no date, and cannot be evaluated; a corrected version is "Client will initiate one conversation with a coworker each workday for three consecutive weeks by April 30, rating anxiety at or below 4 of 10." The distractors will say that the objective is too ambitious, that it belongs in the goal section, or that it lacks an intervention; the last is true of every objective and is not what is wrong with this one. The question is almost always about measurability.

Treatment planning and levels of care: fold-and-cut cards

Print these pages single-sided. Cut along the dashed lines, then fold each strip on the dotted line so the term is on the front and the answer on the back. Shuffle in with your other cards; the ones you miss come back first.

TREATMENT PLANNING AND LEVELS OF CARE · 1

Four layers of a treatment plan

Problem statement, goal, objective, intervention (plus discharge criteria).

TREATMENT PLANNING AND LEVELS OF CARE · 2

Problem statement

Behavioral, observable description drawn from the assessment.

TREATMENT PLANNING AND LEVELS OF CARE · 3

Goal

Broad direction of change, ideally in the client's words.

TREATMENT PLANNING AND LEVELS OF CARE · 4

Objective requirements

A behavior, a measure, a criterion and a date; two readers would agree whether it was met.

TREATMENT PLANNING AND LEVELS OF CARE · 5

Intervention

What the counselor does: modality, technique, frequency.

TREATMENT PLANNING AND LEVELS OF CARE · 6

Discharge criteria

What must be true for treatment to end; written at the start of treatment.

TREATMENT PLANNING AND LEVELS OF CARE · 7

Case formulation

Working explanation of why this person has this problem now; drives the interventions.

TREATMENT PLANNING AND LEVELS OF CARE · 8

Golden thread

Diagnosis -> problem -> goal -> objective -> intervention -> every progress note, traceable in both directions.

TREATMENT PLANNING AND LEVELS OF CARE · 9

Evidence-based practice (3 parts)

Best research evidence + clinical expertise + client characteristics, culture and preferences.

TREATMENT PLANNING AND LEVELS OF CARE · 10

Common factors

Alliance, hope, client resources; account for a large share of outcome regardless of model.

TREATMENT PLANNING AND LEVELS OF CARE · 11

Intensive outpatient

About 9+ hours a week; lives at home; ASAM 2.1.

TREATMENT PLANNING AND LEVELS OF CARE · 12

Partial hospitalization

About 20 hours a week, days; home at night; ASAM 2.5.

TREATMENT PLANNING AND LEVELS OF CARE · 13

Inpatient criteria

Imminent danger to self or others, inability to meet basic needs, psychosis with impaired judgment, dangerous withdrawal. ASAM 4.

TREATMENT PLANNING AND LEVELS OF CARE · 14

ASAM six dimensions

Withdrawal potential; biomedical; emotional/behavioral/cognitive; readiness to change; relapse potential; recovery environment.

TREATMENT PLANNING AND LEVELS OF CARE · 15

What decides ASAM placement

The six dimensions, not the substance or how long the client has used.

TREATMENT PLANNING AND LEVELS OF CARE · 16

Least restrictive rule

The least restrictive level that is safe and likely to work.

TREATMENT PLANNING AND LEVELS OF CARE · 17

Under-placing vs. over-placing

Outpatient for active intent with plan and means vs. hospital for passive ideation with supports and a safety plan.

TREATMENT PLANNING AND LEVELS OF CARE · 18

Step up vs. step down

Planned move to more intensive care for deterioration vs. to less intensive care as the client stabilizes.

TREATMENT PLANNING AND LEVELS OF CARE · 19

Intensification within a level

More frequent sessions, psychiatric consult, safety plan, check-ins; often the answer when worsening without acute risk.

TREATMENT PLANNING AND LEVELS OF CARE · 20

Grounds for involuntary commitment

Danger to self, danger to others, or grave disability under state law; time-limited hold, judicial review.

TREATMENT PLANNING AND LEVELS OF CARE · 21

Assertive community treatment

Multidisciplinary team delivering services in the community for serious mental illness.

TREATMENT PLANNING AND LEVELS OF CARE · 22

Stages of change

Precontemplation, contemplation, preparation, action, maintenance (6+ months), relapse/recycling.

TREATMENT PLANNING AND LEVELS OF CARE · 23

Intervention for precontemplation

Raise awareness, empathy, develop discrepancy; motivational interviewing. Not a plan.

TREATMENT PLANNING AND LEVELS OF CARE · 24

Intervention for maintenance

Relapse prevention: high-risk situations, coping rehearsal.

TREATMENT PLANNING AND LEVELS OF CARE · 25

Routine outcome monitoring

Measure every session or few sessions with the same instruments; feed results back into the plan.

TREATMENT PLANNING AND LEVELS OF CARE · 26

SOAP and DAP

Subjective, objective, assessment, plan / data, assessment, plan. Not documented = not done.

TREATMENT PLANNING AND LEVELS OF CARE · 27

Client not improving: sequence

Measure, discuss with the client, revisit formulation, revise collaboratively, consider adding (medication evaluation, modality, level).

TREATMENT PLANNING AND LEVELS OF CARE · 28

Abandonment

Ending services without notice and referral; an ethics violation.

Marlatt and Gordon

Relapse prevention: lapse as a learning event; high-risk situations; abstinence violation effect.

"Client will feel less anxious" fails because

No behavior, no measure, no criterion, no date. Not measurable.