What Using The ASAM Criteria Really Means: Skill-Building and Systems Change

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Pretest Questions

Select the Best Answer:

1. The best treatment system for addiction is:
   (a) A 28-day stay in inpatient rehabilitation with much education.
   (b) A broad continuum of care with all levels of care separated to maintain group trust.
   (c) Not possible now that managed care has placed so much emphasis on cost-containment.
   (d) A broad range of services designed to be as seamless as possible for continuity of care.
   (e) Short stay inpatient hospitalization for psychoeducation.

2. The six assessment dimensions of the ASAM Criteria:
   (a) Help assess the individual’s comprehensive needs in treatment.
   (b) Provide a structure for assessing severity of illness and level of function.
   (c) Requires that there be access to medical and nursing personnel when necessary.
   (d) Can help focus the treatment plan on the most important priorities.
   (e) All of the above.

3. A multidimensional assessment in behavioral health treatment:
   (a) Should include psychosocial factors such as readiness to change.
   (b) Is ideal, but not necessary within a managed care environment.
   (c) Should include biomedical and psychiatric problems, but not motivation or relapse potential.
   (d) Is best done after withdrawal management is completed.
   (e) Should be completed by the primary therapist only.

4. Assessment of a person’s goals and motivations is important to:
   (a) Match treatment to the client’s readiness to change.
   (b) Ensure residential care is not wastefully utilized.
   (c) Avoid confrontational approaches that alienate the client.
   (d) Individualize the referral and treatment plan.
   (e) All of the above.

5. 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.
6. The 2013 edition of the ASAM Criteria includes:
   (a) Changing all the Admission Criteria for all the levels of care.
   (b) New sections on sex and internet addiction.
   (c) Adding sections on the application of Criteria to older adults and parents with children.
   (d) Changing the names of the six assessment dimensions of The ASAM Criteria.

7. ASAM’s Definition of Addiction is incorporated in the new edition as follows:
   (a) It provides guidelines to have all addiction services be provided by addiction physicians.
   (b) It encourages using all the levels of care for chronic disease management of addiction.
   (c) It describes addiction as an acute care illness that makes Dimensions 1, 2 and 3 paramount.
   (d) It requires all patients to have a chaplain involved for the spiritual aspects of treatment.

8. In an era of health care reform:
   (a) The ASAM Criteria’s primary goal is to keep addiction separate and safe from mental health.
   (b) Accountable care organizations and health homes will pay attention to addiction even less now.
   (c) The ASAM Criteria can help integrate addiction into general healthcare.
   (d) None of the above

9. The true spirit and content of The ASAM Criteria ensures that:
   (a) All withdrawal management occurs in a medically-monitored level to provide maximum safety.
   (b) The length of stay is variable depending on the severity of illness and the patient’s progress.
   (c) The patient stays and graduates from each level of care as determined by the primary counselor.
   (d) Long-term residential treatment is always necessary if the client lives in a toxic environment.

10. The following changes are made in The ASAM Criteria:
    (a) “Patient Placement” was removed in the book title, as the book no longer has placement criteria.
    (b) Opioid Maintenance Therapy (OMT) was changed to Office-Based Opioid Treatment (OBOT).
    (c) Merging all the adolescent criteria into the adult criteria.
    (d) “Detoxification” changed to “Withdrawal Management”. The liver detoxifies, but clinicians manage withdrawal.

**Indicate True or False:**

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

12. There are six broad levels of care in the ASAM Criteria ( ) ( )

13. Dimension 5 focuses on internal attitudes, beliefs and coping skills to deal with relapse. ( ) ( )

14. The level of care placement is the first decision to make in the assessment ( ) ( )

15. The Tobacco Use Disorder section encourages all programs to become tobacco-free. ( ) ( )

16. In criminal justice populations, it is important to ensure patients “do treatment” not “do time” just focused on how long they have to stay. ( ) ( )

17. The ASAM Criteria helps increase access to care and use resources efficiently. ( ) ( )

18. The co-occurring disorders section added a “complexity capable” description. ( ) ( )

19. Clients in early stages of change need relapse prevention strategies. ( ) ( )
A. Underlying Principles and Concepts of the ASAM Criteria

1. Generations of Clinical Care

(a) Complications-driven Treatment

- No diagnosis of Substance Use Disorder
- Treatment of complications of addiction with no continuing care
- Relapse triggers treatment of complications only

(b) Diagnosis, Program-driven Treatment

- Diagnosis determines treatment
- Treatment is the primary program and aftercare
- Relapse triggers a repeat of the program

(c) Individualized, Clinically-driven Treatment
d) Client-Directed, Outcome-Informed Treatment (Feedback Informed Treatment)

2. Assessment of Biopsychosocial Severity and Function (The ASAM Criteria 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health services:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment and Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication and/or Withdrawal Potential</td>
<td>Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
<tr>
<td>3. Emotional, Behavioral or Cognitive Conditions and Complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services</td>
</tr>
<tr>
<td>4. Readiness to Change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</td>
</tr>
<tr>
<td>5. Relapse, Continued Use or Continued Problem Potential</td>
<td>Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services</td>
</tr>
</tbody>
</table>

PARTICIPANT ASSESSMENT

Data from all BIOPSYCHOSOCIAL Dimensions

PROGRESS

Treatment Response:
Clinical functioning, psychological, social/interpersonal LOF
Proximal Outcomes e.g., Session Rating Scale; Outcome Rating Scale

PROBLEMS or PRIORITIES

Build engagement and alliance working with multidimensional obstacles inhibiting the client from getting what they want.
What will client do?

PLAN

BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service
3. Biopsychosocial Treatment - Overview: 5 M’s

- Motivate - Dimension 4 issues; engagement and alliance building
- Manage - the family, significant others, work/school, legal
- Medication – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
- Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
- Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service *(The ASAM Criteria 2013, pp 106-107)*

1. Outpatient Services
2. Intensive Outpatient/Partial Hospitalization Services
3. Residential/Inpatient Services
4. Medically-Managed Intensive Inpatient Services

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### ASAM Criteria Level of Withdrawal Management Services for Adults

<table>
<thead>
<tr>
<th>ASAM Criteria</th>
<th>Level</th>
<th>Note: There are no separate Withdrawal Management Services for Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Withdrawal Management without Extended On-Site Monitoring</td>
<td>1-WM</td>
<td>Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management with Extended On-Site Monitoring</td>
<td>2-WM</td>
<td>Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.</td>
</tr>
<tr>
<td>Clinically-Managed Residential Withdrawal Management</td>
<td>3.2-WM</td>
<td>Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery</td>
</tr>
</tbody>
</table>

### ASAM Criteria Levels of Care

<table>
<thead>
<tr>
<th>ASAM Criteria</th>
<th>Level</th>
<th>Same Levels of Care for Adolescents except Level 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td>0.5</td>
<td>Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1</td>
<td>Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>2.1</td>
<td>9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>2.5</td>
<td>20 or more hours of service/week for multidimensional instability not requiring 24 hour care</td>
</tr>
<tr>
<td>Clinically-Managed Low-Intensity Residential</td>
<td>3.1</td>
<td>24 hour structure with available trained personnel; at least 5 hours of clinical service/week</td>
</tr>
<tr>
<td>Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)</td>
<td>3.3</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community</td>
</tr>
<tr>
<td>Clinically-Managed High-Intensity Residential</td>
<td>3.5</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community</td>
</tr>
<tr>
<td>Medically-Monitored Intensive Inpatient</td>
<td>3.7</td>
<td>24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient</td>
<td>4</td>
<td>24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment</td>
</tr>
<tr>
<td>Opioid Treatment Services</td>
<td>OTS</td>
<td>Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone</td>
</tr>
</tbody>
</table>
B. **Guiding Principles of The ASAM Criteria 2013** *(The ASAM Criteria 2013, pp 3-11)*

- Moving from one-dimensional to multidimensional assessment
  *The ASAM Criteria* continues to encourage moving away from treatment based on diagnosis alone (i.e., seeing a diagnosis as a sufficient justification for entering a certain modality or intensity of treatment) toward treatment that is holistic and able to address multiple needs.

- Moving from program-driven to clinically driven and outcomes-driven treatment
  Rather than focusing on “placement” in a program, with a fixed length of stay, *The ASAM Criteria* supports individualized, person-centered treatment responsive to assessed needs and Tx.progress.

- Moving from fixed length of service to variable length of service
  Because no one treatment is effective for all patients, length of stay must be individualized, based on the severity and level of function of the patient’s illness, as well as based on their response to treatment, progress, and outcomes. At the same time, research does show a positive correlation between longer treatment in the continuum of care and better outcomes.

- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
  Treatment is delivered across a continuum of services that reflect the varying severity of illnesses treated and the intensity of services required. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. A patient may begin at a required level and move to a more or less intensive level of care, depending on his or her individual needs.

- Identifying adolescent-specific needs
  Adolescents who use alcohol, tobacco and/or other drugs differ from adults in significant ways. While substance use disorders in adolescents and adults may have common biopsychosocial elements of etiology, they are different in many aspects of their expression and treatment. Adolescents must be approached differently from adults because of differences in their stages of emotional, cognitive, physical, social and moral development. Examples of these fundamental developmental issues include the extremely potent influences of the adolescent’s interactions with family and peers, the expected immaturity of most adolescents’ independent living skills, and the fact that some amount of testing limits is a normative developmental task of adolescence. *The ASAM Criteria* distinguishes and highlights adult and adolescent treatment information, where appropriate.

- Clarifying the goals of treatment
  Treatment that is tailored to the needs of the individual and guided by an individualized treatment plan, developed in consultation with the patient, is helpful in establishing a therapeutic alliance and therefore contributing significantly to treatment outcomes.

- Moving away from using “treatment failure” as an admission prerequisite
  This term has been used by some reimbursement or managed care organizations as a prerequisite for approving admission to a more intensive level of care (for example, “failure” in outpatient treatment as a prerequisite for admission to inpatient treatment). This does not recognize the obvious parallels between addictive disorders and other chronic diseases such as diabetes or hypertension. For example, failure of outpatient treatment is not a prerequisite for acute inpatient admission for diabetic ketoacidosis or hypertensive crisis.

- Moving toward an interdisciplinary, team approach to care
  *The ASAM Criteria* maintains and builds on ASAM’s previous efforts to respond to ongoing changes and needs within the special field of addiction treatment. It also recognizes that with health reform, more services to persons with addiction will be delivered outside of a separate (and separately funded) specialty treatment system for addiction and will be delivered inside of general medical and general behavioral health settings. Addiction care has always been built around services involving interdisciplinary teams of professionals, including and sometimes led by physicians. With health reform, addiction care as well as mental health care will increasingly be delivered by clinicians.
working in interdisciplinary teams of not only “addiction professionals” but also general medical care professionals.

- Clarifying the role of the physician
  Due to their prevalence, substance use and addictive disorders are health conditions that have significant impact on public health. Physicians are an essential part of the healthcare delivery system for addiction, as well as for all acute and chronic medical and surgical conditions. Increasingly, teams of professionals are working in a coordinated fashion to deliver healthcare. While mental health care has been offered through interdisciplinary teams for decades, especially in public sector settings, general medical care is only recently developing models to involve a range of health, social services, rehabilitation, and other professionals to manage chronic diseases. The Patient Centered Health Care Home model is a prominent example of this.

- Focusing on treatment outcomes
  Increasingly, funding will be based not on the service provided, but on the outcomes achieved. Treatment services and reimbursement based on patient engagement and outcome is consistent with trends in disease and illness management, especially when conducted in real-time during the treatment experience, as with the management of hypertension or diabetes. With these chronic illnesses, changes to the treatment plan are based on treatment outcomes and tracked by real-time measurement at every visit (e.g., blood pressure or blood sugar levels are monitored to determine the success of the current treatment regimen). While there has been increased attention on Evidence-Based Practices (EBP), more focus on patient engagement and outcomes-driven services is still needed.

- Engaging with “Informed Consent”
  Treatment adherence and outcomes are enhanced by patient collaboration and shared decision-making. To engage people in treatment, person-centered services encompass clear information to patients. This requires informed consent, indicating that the adult, adolescent, legal guardian, and/or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities and the risks of treatment versus no treatment.

- Clarifying “Medical Necessity”
  This concept is central to judgments for third-party payers and managed care organizations to determine appropriateness of care. Because substance use, addictive and mental disorders are biopsychosocial in etiology and expression, treatment and care management are most effective if they, too, are biopsychosocial. The six assessment dimensions identified in The ASAM Criteria encompass all pertinent biopsychosocial aspects of addiction and mental health that determine the severity of the patient’s illness and level of function. “Medical necessity” encompasses all six assessment dimensions so that a more holistic concept would be “Necessity of Care,” or “clinical appropriateness.”

- Harnessing ASAM’s Definition of Addiction
  There is a “short version” definition of addiction (shown below), as well as a “long version” definition (available at http://www.asam.org/for-the-public/definition-of-addiction), which serves as more of a description of the condition. In April of 2011, these two versions were unanimously adopted as official ASAM statements.

  Short version: “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.”

  Notice how this “short version” definition uses the singular term “addiction” to describe a condition that is “primary” and “chronic.” So although this definition explains how compulsive, impulsive, or out-of-control substance use can be present, addiction can also involve impaired control over behaviors (such as gambling) that do not involve psychoactive substance use.
C. What’s New in *The ASAM Criteria* (The ASAM Criteria 2013, pp 11-14)

- *The ASAM Criteria* now expands on prior understanding and applications to serve a wider and more diverse population.

**Application to Adult Special Populations** (The ASAM Criteria 2013, pp 307 -356)

- Older Adults
- Parents or Prospective Parents Receiving Addiction Treatment Concurrently with their Children
- Persons in Safety Sensitive Occupations
- Persons in Criminal Justice Settings

Other key highlights of this new edition include, but are not limited to:

- Synchronization with *The ASAM Criteria Software*, such that the definitions and specifications in this text for the dimensions, levels of care and admissions decision rules serve as the reference manual for *The ASAM Criteria Software*, released by SAMHSA.

- Incorporation of the latest understanding of Co-occurring Disorders Capability (formerly termed Dual Diagnosis Capability), and what might better be termed “complexity capability,” to acknowledge the range of service needs beyond just addiction and mental health treatment. The need for persons with substance use disorders to be assessed and treated for co-occurring infectious diseases is but one clear example of this concept. Programs and practitioners increasingly understand the need for trauma informed care and primary health/behavioral health integration, as core features of all addiction treatment programs.

As the treatment field has learned more about the complexities of the people we serve, it increasingly is becoming more trauma-informed and responsive to the needs of people with co-occurring mental and substance use disorders. Services that are “co-occurring capable or enhanced” and “complexity capable” are described.

- Inclusion of the conceptual framework of Recovery Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented “chronic disease management” continuum, rather than as repeated, disconnected “acute episodes of treatment” for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay in which patients are “placed.”

- Updated Diagnostic Admission Criteria for the levels of care to be consistent with the American Psychiatric Association’s 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

- A new chapter on Gambling Disorder that is consistent with ASAM’s definition of addiction, asserting that the pathological pursuit of reward or relief can involve not just the use of psychoactive substances, but also the engagement in certain behaviors. The inclusion of a Gambling Disorder section also reflects shifts in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which includes Gambling Disorder in the Substance Use and Addictive Disorders chapter.

- A new chapter on Tobacco Use Disorder reflects a decision to address the treatment field’s inconsistencies in, and even ambivalence about, viewing this addiction as similar to alcohol and other substance use disorders.

- An updated opioid treatment section to incorporate new advances, named Opioid Treatment Services (addressing opioid antagonist pharmacotherapy in addition to opioid agonist pharmacotherapy). Previous editions and supplements of ASAM’s criteria have described care offered in what this edition is naming Opioid Treatment Programs (utilizing methadone to treat opioid use disorder in Level 1 and previously called Opioid Maintenance Therapy, OMT.) *The ASAM Criteria*, Third Edition, is the first to address the growing use of office-based opioid treatment (OBOT), utilizing buprenorphine products to treat opioid addiction.
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- Updates to better assess, understand and provide services for all six ASAM criteria dimensions to reflect current science and research. This can be seen in sections such as “Addressing Withdrawal Management” and Appendix B, “Special Considerations for Dimension 5 Criteria.” *Relapse, Continued Use, Continued Problem Potential - Dimension 5 (The ASAM Criteria 2013, pp 401-410)*

D. **How to Organize Assessment Data to Match Level of Care**

1. **Developing the Treatment Contract** *(The ASAM Criteria 2013, page 58)*

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What?</td>
<td>What does client want?</td>
<td>What does client need?</td>
</tr>
<tr>
<td>How?</td>
<td>How will s/he get there?</td>
<td>How will you get him/her to accept the plan?</td>
</tr>
<tr>
<td>Where?</td>
<td>Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment? What is indicated by the placement criteria?</td>
</tr>
<tr>
<td>When?</td>
<td>When will this happen?</td>
<td>When? How soon? What are realistic expectations?</td>
</tr>
<tr>
<td></td>
<td>How quickly?</td>
<td>What are milestones in the process?</td>
</tr>
<tr>
<td></td>
<td>How badly does s/he want it?</td>
<td></td>
</tr>
</tbody>
</table>

**Carl**

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn’t think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he has not been using any drugs. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl’s 24 y.o. sister, has custody of Carl following his mother’s death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl says he is holding for a friend.
What Does the Client Want? Why Now?

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

Conduct multidimensional assessment

What are the DSM-5 diagnoses?

Multidimensional Severity /LOF Profile

Identify which assessment dimensions are currently most important to determine Tx priorities

Choose a specific focus and target for each priority dimension

What specific services are needed for each dimension?

What “dose” or intensity of these services is needed for each dimension?

Where can these services be provided, in the least intensive, but safe level of care or site of care?

What is the progress of the treatment plan and placement decision; outcomes measurement?

(The ASAM Criteria 2013, p 124)
2. **Assessing Severity and Level of Function** *(The ASAM Criteria 2013, pp 54-56)*

To determine the multidimensional severity or level of function profile, consider each of the six ASAM ASAM Criteria dimensions as regards pertinent assessment data organized under the three H’s - History, Here and Now, How Worried Now.

The *History* of a client’s past signs, symptoms and treatment is important, but never overrides the *Here and Now* of how a client is presenting currently in signs and symptoms. e.g., if a person has by History had severe alcohol withdrawal with seizures, but has not been drinking Here and Now at a rate or quantity that would predict any significant withdrawal; and as you look at them, they are not shaky or in withdrawal so you are not Worried about severe withdrawal - then there is no significant Dimension 1 severity.

The *Here and Now* presentation of a client’s current information of substance use and mental health signs and symptoms can override the *History* e.g., if a person has never had serious suicidal behavior before by History; and in the *Here and Now* is indeed depressed and impulsively suicidal, you would not dismiss their severe suicidality just because they had never done anything serious before. Especially if you talked with them now and you are *Worried* that they could not reach out to someone if they became impulsive, then the Dimension 3 severity would be quite high.

*How Worried Now* you are as the clinician, counselor or assessor determines your severity or level of function (LOF) rating for each ASAM dimension. The combination of the three H’s: History; Here and Now; and How Worried Now guides the clinician in presenting the severity and LOF profile.

3. **Continued Service and Discharge Criteria** *(The ASAM Criteria 2013, pp 299-306)*

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

**Continued Service Criteria**: It is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
   or
2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
   and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient’s new problems can be addressed effectively.

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient’s existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

**Discharge/Transfer Criteria**: It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;  
   or
2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;  
   or
3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

E. Readiness to Change - Dimension 4

1. Definitions of Compliance and Adherence

Webster’s Dictionary defines “comply” as follows: to act in accordance with another’s wishes, or with rules and regulations. It defines “adhere”: to cling, cleave (to be steadfast, hold fast), stick fast.

2. Stages of Change and How People Change

* 12-Step model - surrender versus comply; accept versus admit; identify versus compare

* Transtheoretical Model of Change (Prochaska and DiClemente):

  - **Pre-contemplation**: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible “problem” and possibilities for change.

  - **Contemplation**: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

  - **Preparation**: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

  - **Action**: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

  - **Maintenance**: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

  - **Relapse and Recycling**: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.
Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

* Readiness to Change - not ready, unsure, ready, trying: Motivational interviewing (Miller and Rollnick)

F. Relapse/Continued Use/Continued Problem Potential - Dimension 5 (The ASAM Criteria 2013, pp 401-410)

A. Historical Pattern of Use
   1. Chronicity of Problem Use
      • Since when and how long has the individual had problem use or dependence and at what level of severity?
      2. Treatment or Change Response
      • Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity
   1. Positive Reinforcement (pleasure, euphoria)
   2. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity
   1. Reactivity to Acute Cues (trigger objects and situations)
   2. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses
   1. Locus of Control and Self-efficacy
      • Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?
      2. Coping Skills (including stimulus control, other cognitive strategies)
      3. Impulsivity (risk-taking, thrill-seeking)
      4. Passive and passive/aggressive behavior
      • Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.
2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.
3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.
1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and “doing time” rather than “doing treatment and change,” explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute recurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about “triggering” others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such “triggering” with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.
G. **Improving the System of Care to Implement The ASAM Criteria**

1. **Case Presentation Format** *(The ASAM Criteria 2013, pp 119 -126)*

Before presenting the case, please state why you chose the case and what you want to get from the discussion.

I. **Identifying Client Background Data**

- Name
- Age
- Ethnicity and Gender
- Marital Status
- Employment Status
- Referral Source
- Date Entered Treatment
- Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
- Current Level of Service (if this case presentation is a treatment plan review)
- DSM Diagnoses
- Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. **Current Placement Dimension Rating** *(See Dimensions below 1 - 6)*

1. 
2. 
3. 
4. 
5. 
6. 

(Give brief explanation for each rating, note whether it has changed since client entered treatment and why or why not)

This last section we will talk about together:

III. **What problem(s) with High and Medium severity rating are of greatest concern at this time?**

- Specificity of the problem
- Specificity of the strategies/interventions
- Efficiency of the intervention (Least intensive, but safe, level of service)

2. **The Coerced Client and Working with Referral Sources**

The mandated client can often present as hostile and resistant because they are at “action” for staying out of jail; keeping their driver’s license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Unfortunately, clinicians/programs often enable criminal justice thinking by blurring the boundaries between “doing time” and “doing treatment”. For everyone involved with mandated clients, the 3 C’s are:

- **Consequences** – It is within criminal justice’s mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.
Compliance – The offender is required to act in accordance with the court’s orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with “doing time” in a treatment place.

Control – The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles/concepts to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change; keep our collective eyes on the prize “No one succeeds unless we all succeed!”

3. **Working Effectively with Managed Care** *(The ASAM Criteria 2013, pp 119 -126)*

- Clinical discussion, not game playing - Improve communication between consumers, clinicians, providers, payers, managed care, utilization reviewers and care managers
- Use Case Presentation Format to concisely review the biopsychosocial data and focus the discussion
- Follow through Decision Tree to Match Assessment and Treatment/Placement Assignment to guide the clinical discussion
- Identify where the points of disagreement are: severity rating; priority dimension or focus of treatment; service needs; dose and intensity of services; placement level
- Offer alternative clinical data: severity rating and rationale; priority dimension or focus of treatment; service needed; dose and intensity of services; placement level
- Appeal if still no consensus

4. **Dealing with “Resistant” Providers/Payers Who Are at Different Stages of Change**

- Individualized Staff Development Plans based on what the clinician wants
- Individualized Agency Development Plans – expectations for progress and change
- Individualized Payer Development Plan – reaching consensus on criteria, “Medical Necessity”, design of Benefit Plans
- Incentives and leverage to facilitate continuing change and development
5. **Personnel**

- Better training in biopsychosocial theories, modalities of treatment, assessment and documentation skills
- Increased interdisciplinary functioning and team work
- Increased individualized treatment and thorough case management
- Increase curiosity and research

6. **Programs**

- Flexible lengths-of-service in all levels of service
- Overlapping levels of care - better continuity and efficiency
- Expanded intensities of service
- More modalities of treatment - biopsychosocial
- Innovative program structure - milieu; individualized treatment

7. **Payment**

- Reimburse or fund all levels of service
- Increase incentives for less costly care
- Fund thorough case management

8. **Public/Private Sectors**

- One quality and system of care
- One common set of criteria - clinically-based not program-based
- Increase interdependence - improve incentives and equalize over/under capacities

9. **Top Ten Ways You Know You’re a Program-Driven Service When……..**

1. You know the patient’s anticipated discharge date upon admission e.g., 7/1 + 28 = 7/29
2. You read a treatment plan and it sounds much the same as the next chart
3. There are five to nine problems each with three to five objectives, interventions or strategies
4. The treatment plan is still being developed three to five days after admission
5. You say things like “the full program’ or ‘must complete the program”
6. The “P = Plan” part of the “DAP” or “SOAP” progress note says: “Continue present course of treatment” or “Continue treatment regimen” or “Continue treatment objectives”
7. The treatment plan is preprinted
8. You see the same numbers in more than one chart e.g. 28 days; 24 sessions; or three months
9. Assessment indicates the patient is mandated for care, but is not sure they have a drug problem, yet the treatment plan is the same as for the patient who is sure they have a problem and want recovery.
10. There are preprinted progress notes.

10. **Gathering Data on Policy and Payment Barriers** *(The ASAM Criteria 2013, p 126)*

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client’s needs can be a data point that sets the foundation for strategic planning and change

- Finding efficient ways to gather data as it happens in daily care can provide hope/direction for change
PLACEMENT SUMMARY

| Level of Care/Service Indicated | Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client’s current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter |
| Level of Care/Service Received | ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service |
| Anticipated Outcome If Service Cannot Be Provided | Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify): |

H. The ASAM Criteria Software Decision Engine - Continuum™

- The ASAM Criteria book and The ASAM Criteria Software now branded as Continuum™ are companion text and application
- The text delineates the dimensions, levels of care, and decision rules that comprise The ASAM Criteria
- 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 now branded as Continuum™ - Value Proposition

For Patients:
- Improves Patient Outcomes

For Payers:
- Improved Patient Outcomes > Lower Long-Term Costs
- Standardizes prior approval process (utilization management)
- I.T. can facilitate/automate approval process (U.M.)
- Decreases expensive & unnecessary overtreatment
- Improves inter-rater reliability

For Providers
- Facilitates reimbursement process through fewer disputes, less administrative burden, & faster turnaround on payment
- Provides training to new counselors
- Generates sophisticated reports & analyses

For more information:
www.asamcontinuum.org
**Immediate Need Profile:** Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” in the following table: *(The ASAM Criteria 2013 page 66)*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication and/or Withdrawal Potential</td>
<td>1(a) Currently having severe, life-threatening, and/or similar withdrawal symptoms?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Biomedical Conditions/Complications</td>
<td>2 Any current severe physical health problems e.g., bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory, or motor abilities not related to intoxication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Emotional/Behavioral/Cognitive Conditions/Complications</td>
<td>3(a) Imminent danger of harming self or someone else e.g., suicidal ideation with intent, plan, and means to succeed; homicidal or violent ideation; impulses and uncertainty about ability to control impulses, with means to act on)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. as above</td>
<td>3(b) Unable to function in activities of daily living or care of self with imminent, dangerous consequences (e.g., unable to bathe, feed, groom, and care for self due to psychosis, organicity, or uncontrolled intoxication with threat to imminent safety of self or others as regards death or severe injury)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Readiness to Change</td>
<td>4(a) Does patient appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary? e.g., severe addiction, but patient feels controlled use still OK; psychotic, but blames a conspiracy)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. as above</td>
<td>4(b) Patient has been coerced, mandated or required to have assessment and/or treatment by mental health court or criminal justice system, health, or social services, work or school, or family or significant others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Relapse/Continued Use/Prob. Potential</td>
<td>5(a) Is client currently under the influence and/or acutely psychotic, manic, suicidal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. as above</td>
<td>5(b) Is patient likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate secure placement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. as above</td>
<td>5(c) Is patient’s most troubling presenting problem(s) that brings the patient for assessment dangerous to self or others? (See examples in Dimensions 1, 2 and 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>6. Are there any dangerous family; significant others; living, work, school situations threatening patient’s safety, immediate wellbeing, and/or sobriety (e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures)?</td>
<td></td>
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</tr>
</tbody>
</table>

*Yes to questions 1, 2 and/or 3 require that the patient immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care.*

*Yes to questions 4a and/or to 4b alone, require the patient to be seen for assessment within 48 hours, and preferably earlier, for motivational strategies, unless patient is imminently likely to walk out and needs a more structured intervention.*

*Yes to question 5a assess further for need for immediate intervention (e.g., taking keys of care away; having a relative/friend pick patient up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention).*

*Yes to question 5b, 5c and/or 6, without any “yes” answer in questions 1, 2, or 3, require that the patient be referred to a safe or supervised environment (e.g., shelter, alternative safe living environment, or residential or subacute care setting, depending on level of severity and impulsivity).*
Rating of Severity/Function: Using assessment protocols that address all six dimensions, assign a severity rating of 0 to 4 for each dimension that best reflects the client’s functioning and severity. Place a check mark in the appropriate box for each dimension.

### Risk Ratings (The ASAM Criteria 2013, p 57)

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Intensity of Service Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) No Risk or Stable – Non-issue or very low risk issue. No current risk in this dimension. Any chronic problem mostly or entirely stabilized.</td>
<td>No need for specific services in this dimension.</td>
</tr>
<tr>
<td>(1) Mildly difficult issue - Minor signs and symptoms present. Any chronic issues or problems able to be resolved in a short period of time.</td>
<td>Low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings.</td>
</tr>
<tr>
<td>(2) Moderate - Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support system may be present.</td>
<td>Moderate intensity of services, skills training, or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.</td>
</tr>
<tr>
<td>(3) Significant – Serious issue or difficulty coping within a given dimension. Person considered to be in or near “imminent danger”.</td>
<td>Moderately high intensity of services, skills training, or supports needed. May be in, or near imminent danger.</td>
</tr>
<tr>
<td>(4) Severe – Issues of utmost severity. Patient presents with critical impairments in coping and functioning, with signs and symptoms, indicating an “imminent danger” concern.</td>
<td>High intensity of services, skills training, or supports needed. More immediate, urgent services may require IP or residential settings; or closely monitored case management services at frequency greater than daily.</td>
</tr>
</tbody>
</table>

### Placement Decisions

Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client’s functioning/severity and service needs.

<table>
<thead>
<tr>
<th>ASAM Criteria Level of Withdrawal Management Service</th>
<th>Level</th>
<th>Dimen. 1 Intox/Withdraw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amb. Withd. Mgt. without Extend. On-Site Monitor</td>
<td>1-WM</td>
<td></td>
</tr>
<tr>
<td>Amb. Withd. Mgt. with Extend. On-Site Monitoring</td>
<td>2-WM</td>
<td></td>
</tr>
<tr>
<td>Clinically-Managed Residential Withdraw. Managmt.</td>
<td>3.2-WM</td>
<td></td>
</tr>
<tr>
<td>Med.-Monitored Inpatient Withdraw. Management</td>
<td>3.7-WM</td>
<td></td>
</tr>
<tr>
<td>Med.-Managed Inpatient Withdrawal Management</td>
<td>4-WM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASAM Criteria Level of Care for Other Treatment and Recovery Services</th>
<th>Level</th>
<th>Dimen. 2 Biomed.</th>
<th>Dimen. 3 Emot/Beh Cognitive</th>
<th>Dimen. 4 Readiness to Change</th>
<th>Dimen. 5 Relapse,Cont. Use/Problem</th>
<th>Dimen. 6 Recovery Environ.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention / Prevention</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services / Individual</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Treatment (IOP)</td>
<td>2.1</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization (Partial)</td>
<td>2.5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinically-Managed Low-Int. Residential Svs.</td>
<td>3.1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinically-Managed High-Intensity Population-Specific Residential Services</td>
<td>3.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinically-Managed High-Intens. Residential Svs</td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically-Monitored Intens. Inpatient Treatment</td>
<td>3.7</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medically-Managed Intensive Inpatient Services</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>OTP</td>
<td></td>
<td></td>
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</tbody>
</table>

### PLACEMENT SUMMARY

**Level of Care/Service Indicated** - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client’s current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter.

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**Anticipated Outcome If Service Cannot Be Provided** – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify).
Tracy

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment.

The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and nurse from the psychiatric unit who came from the unit to evaluate the teen, both feel she needs to be in hospital given the animosity at home, the violent behavior and the question of intoxication. Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

Dimension 1, Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.

Dimension 2, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints

Dimension 3, Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.

Dimension 4, Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to treatment, but doesn’t want to be at home at least for tonight.

Dimension 5, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be a reoccurrence of the fighting and possibly violence again, at least with father.

Dimension 6, Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting

Severity Profile:  

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Services Needed:  

Site of Care: Ann

DSM-5 Diagnosis: Alcohol Use Disorder, severe; and Cannabis Use Disorder, moderate; Major Depression

Ann, a 32-year-old white, divorced female, came in for assessment for the first time ever. She has been abstinent for 48 hours from alcohol and reports that she has remained so far up to 72 hours during the past three months. When she has done this she states she has experienced sweats, internal tremors and nausea, but has never hallucinated, experienced D.T.’s or seizures.

She states she is in good health except for alcoholic hepatitis for which she was just released from the hospital one week ago. Her doctor referred her for assessment. She smokes up to 3 or 4 joints a day, but stopped yesterday. In addition to the above, Ann describes two past suicide attempts using sleeping pills, but the most recent attempt was three years ago and she sees a psychiatrist once a month for review of her medication. She takes Prozac for the depression and doesn’t report abuse of her medication.

Ann reported that she lives in a rented apartment and has very few friends since moving away after her divorce a year ago. She is currently unemployed after being laid off when the supermarket she worked at closed. She has worked as a waitress, check-out person and sales person before and says she has never lost a job due to addiction.

Ann appears slightly anxious, but is not flushed. She speaks calmly and is cooperative. Ann shows awareness of her consequences from chemical use, but tends to minimize it and blame others including her ex-husband who left her without warning. She doesn’t know much about alcoholism/chemical dependency, but wants to learn more. She has one son, age 11, who doesn’t see any problems with her drinking and doesn’t know about her marijuana use.
Wanda is a 46-year old divorced woman who was married at 18 to a male who was emotionally and physically abusive and lived at home less than half of the time of their eight-year marriage. The marriage was also characterized by infidelities by both her and her husband and regular and sometimes heavy marijuana and alcohol use. Two children resulted from this marriage, a son, Juan, now 26 and a daughter, Rosa, now 24. She has had no contact with either of these children for the last 12 years after she became pregnant and delivered a baby girl, Gloria, from an African-American father, whom she claims she met in a bar one night and doesn’t even know his name. She was referred for assessment by her caseworker.

In the last 20 years, since the divorce, her drinking and marijuana use have increased markedly and she would often spend her days at home alone with Gloria, drinking and smoking heavily and neglecting her daughter. On one occasion the authorities became involved and threatened to remove Gloria from the home. As a result, she began seeing a counselor and at her suggestion, she began attending AA and NA briefly. Her counselor retired from practice and Wanda discontinued recovery group meeting attendance. The issue of custody apparently ceased being an issue but Wanda does not know why.

She is the child of an alcoholic father whom she alternately idolized and feared and who was seductive but not openly sexual with her as she was growing up. He father was killed in barroom brawl when she was 30 years old. Her mother 67 years old, lives alone and is still in denial about Wanda’s father’s alcoholism. She is the younger of two female children and her older sister is a teetotaler and a pillar of her church. They have not had contact in about three years.

A year ago she again began attending AA and claims she enjoys it. She attends weekly. She now drinks about once a week without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about her current drinking. She had considered finding another counselor because of her dissatisfaction with her life but never translates this into action. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

She lives with Gloria in a rented apartment and spends most of her day watching television and considers herself a “soap opera addict.” She is in a relationship with a drug dealer although she claims not to use any of the cocaine or heroin that her boyfriend sells. She likes him because “he buys her things.” He also helps with the rent although he does not live there. Gloria is doing poorly in school and has been picked up for a shoplifting offense. On two occasions she told Wanda that she was spending the night with a girlfriend and this was later determined to be untrue. Wanda has no idea where she was each of those nights. They are in a constant struggle with Gloria calling her mother a “slob” and Wanda calls Gloria a “tramp.”

She has been on welfare for most of her adult life and sees nothing unusual or undesirable about it. She has never worked outside of a few brief stints earlier as a dishwasher (2 times, once for 2 weeks and once for 3 weeks) and as attendant in a car wash (1 month). Both jobs came to an end because of her failure to show up for work because of using, oversleeping or being hung over. She has no job skills and is not particularly interested in acquiring such skills or working. She is aware that her welfare benefits will be terminated if she doesn’t do something about work and feels that the State is being unfair.

Wanda said she has no medical problems although she states that she can’t wait for menopause because her periods are so painful and her bleeding so heavy. She later added that she has migraine headaches although has never seen a doctor about them. Her affect is slightly flattened but beyond that, she neither appears depressed nor does she claim to be depressed. She has never sought substance abuse or mental health treatment except for the earlier six-month period with the counselor.
LITERATURE REFERENCES

“Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria” Ed. David R. Gastfriend has released 2004 by The Haworth Medical Press. David Gastfriend edited this special edition that represents a significant body of work presented in eight papers. The papers address questions about nosology, methodology, and population differences and raise important issues to continually refine further work on the ASAM PPC. (To order: 1-800-HAWORTH; or www.haworthpress.com)


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