
How to Implement The New ASAM Criteria- Skill Building in an Era of Health Care Reform

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A. 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. Assessment of motivation and goals 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.

4. 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.

5. Changes in the new edition include:
 - (a) Changing the designation of levels of care from Arabic numbers to Roman numerals.
 - (b) New sections on Gambling Disorder and Tobacco Use Disorder.
 - (c) Merging all the adolescent criteria into the adult criteria.
 - (d) Adding an assessment dimension on spirituality.

6. 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

7. 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.

8. The following terminology 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:

- | | T | F |
|--|-----|-----|
| 9. It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms. | () | () |
| 10. A diagnosis is necessary, but not sufficient to determine level of care. | () | () |
| 11. The level of care placement is the first decision to make in the assessment | () | () |
| 12. The Tobacco Use Disorder section encourages all programs to become tobacco-free. | () | () |
| 13. In criminal justice populations, it is important to ensure patients “do treatment” not “do time” just focused on how long they have to stay. | () | () |
| 14. The co-occurring disorders section added a “complexity capable” description. | () | () |
| 15. Clients in early stages of change need relapse prevention strategies | () | () |

B. Underlying Principles of Assessment and Treatment in *The ASAM Criteria*

1. **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

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	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
4. Readiness to Change	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
5. Relapse, Continued Use or Continued Problem Potential	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.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

2. 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

3. 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

ASAM Criteria Level of Withdrawal Management Services for Adults	Level	Note: There are no separate Withdrawal Management Services for Adolescents
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically-Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring
Medically-Managed Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability

ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	2.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	2.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	3.3	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
Clinically-Managed High-Intensity Residential	3.5	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
Medically-Monitored Intensive Inpatient	3.7	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	4	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
Opioid Treatment Services	OTS	Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone

C. Fidelity to the Spirit and Content of *The ASAM Criteria* (*The ASAM Criteria* 2013, pp 21-22)

Issues often persist in today’s “real world” of treatment, indicating that clinicians and programs still struggle with understanding the full intent of ASAM’s criteria. These ongoing issues include:

- Some programs still describe their services as a fixed length of stay program, as evidenced by description of the program as a “Thirty Day Inpatient Program or “24 session IOP.” Or if the program claims no fixed length of stay, check what clients say if you ask: “How long do you have to be here?” An answer involving fixed numbers of sessions or weeks reveals regression to a program-driven model.

Such programs also may reveal their length of stay rigidity through the language used. Wording like “extended residential” may refer to a fixed program, since length of stay should be decided by tracking severity, function and progress, not by a predetermined decision that the patient needs a certain extended length of stay in a residential setting. Likewise, “graduating” and “completing a program” also reveals a focus on a fixed plan and program, rather than on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being offered with increased intensity for a relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder.

- A misunderstanding of residential treatment. In *The ASAM Criteria*, admission criteria for residential treatment encompass such severity and imminent danger that a 24-hour treatment setting is necessary. Yet, individuals are sometimes assessed as requiring residential treatment and then placed on a waiting list. The patient may need a 24-hour living support, such as Level 3.1 plus some outpatient intensity of services (Levels 1, 2.1 or

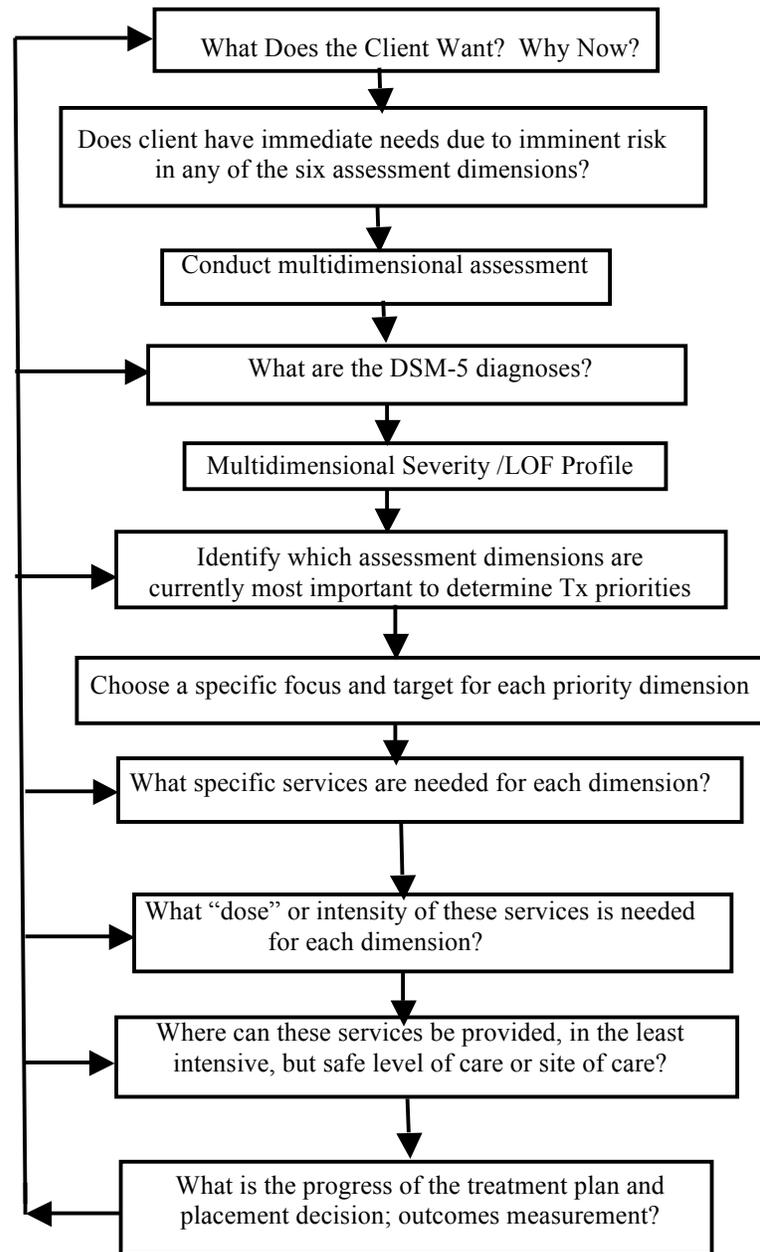
2.5). By definition, it is a misunderstanding of residential treatment to place a person on a waiting list.

- Funding limited to certain levels of care. States and counties that fund only a few levels of care, can discourage a seamless continuum of care. Licensure and contractual arrangements that keep levels of care in fixed programs can discourage or even forbid flexible overlapping of levels (e.g., a public sector entity may contract only for Level 3.7-WM which forces the program to staff for and document on every patient as if they are continually at a 3.7-WM severity). In fact, a patient may need that intensity of withdrawal management for only two days and could then be safely treated by seamlessly continuing in 3.2-WM or even overlapping 2-WM services within the structure of the withdrawal management facility.
- Limited levels of withdrawal management. Available levels of withdrawal management are often only 4-WM or 3.7-WM, which drives up cost and allows only brief lengths of stay in high-intensity settings. This leads to rapid relapse when the patient has not had their acute withdrawal adequately managed. An ambulatory level of care for withdrawal management might be both more clinically appropriate and less costly. Full use of the five levels of withdrawal management as described in *The ASAM Criteria* would allow longer lengths of stay for the same or less resources. Underutilization of ambulatory withdrawal management and a continuum of withdrawal management levels are due partly to benefit management design that often puts medical withdrawal management in a general health benefit split out from the behavioral health benefit. It is also due to provider and payer inexperience with ambulatory withdrawal management and hesitancy over risk management concerns.

D. How to Organize Assessment Data to Focus Treatment

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

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



(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/level of function profile, consider each of the 6 ASAM Criteria dimensions 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.

E. 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.

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

3. Positive Reinforcement (pleasure, euphoria)
4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

5. Reactivity to Acute Cues (trigger objects and situations)
6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

7. 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?
- 8. Coping Skills (including stimulus control, other cognitive strategies)
- 9. Impulsivity (risk-taking, thrill-seeking)
- 10. 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 reoccurrence 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. 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)

H. **Dimension 4 Issues**

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)

I. How To Apply The ASAM Criteria

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

There have been concerns raised from some quarters that ASAM's criteria do not apply readily to certain populations of persons with substance-related and co-occurring disorders. Heretofore, there have not been specific criteria for the following special populations, who may be in need of care for a substance-related condition, where usual assessment and treatment variables may require modification:

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

2. Persons in Criminal Justice Settings (*The ASAM Criteria* 2013, pp 350 -356)

SETTINGS - Settings can include:

- Jails (offenders who most often are sentenced to 2½ years or less, and non-sentenced offenders/detainees awaiting trial in a jail).
- Prisons (maximum, medium, or minimum security level).
- Pre-release such as work-release centers.
- Other criminal justice mandated supervised settings where movement is monitored and controlled.
- Community corrections-involved offenders on probation or parole. Many such offenders are given intermediate or alternative diversionary sanctions, intensive supervision (which may include electronic monitoring of their location or status), or are mandated to a community-based addiction treatment service stemming from a judge's order, a condition placed by a probation or parole officer, from an appearance before a specialty drug/mental health court, or as a step-down from a jail or prison.

3. 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: i

- ⤴ **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!”

4. 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

5. 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

6. Tobacco Use Disorder (*The ASAM Criteria* 2013, pp 367-392)

TH is a 50-year-old addiction counselor who works at a residential addiction treatment center. The center has decided that they are going to begin treating tobacco addiction along with all other addictions. The staff is not going to be able to smoke at all at work, and will not be allowed to come to work smelling of tobacco smoke. TH is in recovery from addiction to alcohol and pain medications. He has been sober for 23 years and always felt that tobacco was not part of his disease. He feels that he has extra rapport with patients since he goes out smoking with them on breaks. TH has often advised patients who wanted to stop smoking that they should wait at least a year before they even consider stopping, because “it is too hard to quit more than one thing at a time.” TH has been told by his doctor that his frequent bouts of bronchitis are directly related to his smoking, and that he needs to stop before he does permanent damage to his lungs. TH is about 40 lbs. overweight and fears that if he stops smoking, he will gain even more weight. He has never tried to quit, and is angry about his workplace forcing him to stop.

TH is in the precontemplation stage of change. He needs education about nicotine addiction and motivation for tobacco cessation. If TH will accept treatment, he may benefit from combination pharmacotherapy taking into account his concern about weight gain. Outpatient counseling (Level 1) is the most appropriate place to begin, with additional online resources and quit-line assistance. TH may find Nicotine Anonymous helpful, since he will be able to use the same philosophy and skills to quit tobacco that he used to enable recovery from alcohol and pain medications in the past. Group support at work will help motivate TH and enable his tobacco cessation attempts to be successful. TH’s primary care physician should monitor his tobacco cessation and weight, and give positive feedback about improvements in his bronchitis and lung function.

J. 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 and direction for change

PLACEMENT SUMMARY

<p>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</p>	
<p>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</p>	
<p>Reason for Difference - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify):</p>	
<p>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):</p>	

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY Page 1 of 2

Name: _____ Date: _____

Immediate Need Profile: Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” in the following table:

Dimension	Questions	Yes	No
1. Acute Intoxication and/or Withdrawal Potential	1(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal?		
1. as above	1(b) Currently having similar withdrawal symptoms?		
2. Biomedical Conditions/Complications	2 Any current severe physical health problems?		
3. Emotional/Behavioral/Cognitive Conditions/Complications	3(a) Imminent danger of harming self or someone else?		
3. as above	3(b) Unable to function and safely care self?		

. Yes to questions 1a, 1b, 2 and/or 3a, 3b requires that the caller/client immediately be referred for medical and/or mental health evaluation, depending on which dimension(s) involved.

4. Readiness to Change	4(a) Does client appear to need alcohol or other drug treatment/recovery, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK		
4. as above	4(b) Client been coerced, mandated or required to have assessment and/or treatment		

. Yes to questions 4a and/or to 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client’s stage of readiness to change.

5. Relapse/Continued Use/Prob. Potential	5(a) Is client currently under the influence or intoxicated?		
5. as above	5(b) Is client likely to continue to use or relapse in an imminently dangerous manner, without immediate care?		

. Yes to question 5a requires caller/client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24-hour structure or care.

6. Recovery Environment	6. Are there any dangerous family, sig. others, living/work/school situations threatening client’s safety, immediate well-being, and/or sobriety?		
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. Yes to Dimension 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be assessed for the need of a safe or supervised environment.

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	Intensity of Service Need	Dimensions					
		1.	2.	3.	4.	5.	6.
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.						
(1) Mild - Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings						
(2) Moderate - Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training, or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.						
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in, or near imminent danger.						
(4) Severe - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily.						

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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

ASAM Criteria Level of Withdrawal Management Service	Level	Dimen. 1 Intoxic/ Withdr.						
Ambul. Detox without Extended On-Site Monitor.	1-WM							
Ambul. Detox with Extended On-Site Monitoring	2-WM							
Clinically-Managed Residential Detoxification	3.2-WM							
Medically-Monitored CD Inpatient Detoxification	3.7-WM							
Medically-Managed Intensive Inpatient Detox.	4-WM							
ASAM Criteria Level of Care for Other Treatment and Recovery Services	Level		Dimen. 2 Biomed.	Dimen. 3 Emot./ Behav/ Cognitive	Dimen. 4 Readiness to Change	Dimen. 5 Relapse, Continued Use/Problem	Dimen. 6 Recovery Environ.	
Early Intervention / Prevention	0.5							
Outpatient Services / Individual	1							
Intensive Outpatient Treatment (IOP)	2.1							
Partial Hospitalization (Partial)	2.5							
Apartments /Clinically-Managed Low-Int. Res. Svcs.	3.1							
Clinically-Managed Med-Intens. Residential Svcs.	3.3							
Clinically-Managed High-Intens. Residential Svcs	3.5							
Medically-Monitored Intens. Inpatient Treatment	3.7							
Medically-Managed Intensive Inpatient Services	4							
Opioid Treatment Program	OTP							

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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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: Dimension: 1 2 3 4 5 6
Severity:

Services Needed:

Site of Care:

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 said he is holding for a friend.

Matt

Matt is a forty-two year old man. He reports completing the eleventh grade and obtaining his GED. Matt indicates he is married and has two children. He is currently incarcerated on the charge of Theft by Unlawful Taking.

Matt reports first drinking alcohol when he was 15 years old. Matt indicates he began to drink excessively at about 30 years old. He confirms drinking has been a problem in the past and describes drinking “sun up to sun down,” going to bars and after-hours clubs. He states that he continues to drink alcohol but only drinks one or two times per month, and has approximately two or three drinks at a time. Matt indicates he has been to AA meetings in the past, but doubts he has ever applied their principles to his life.

Matt reports his first use of marijuana at age 13. He describes marijuana as his drug of choice, and second to that he prefers to drink rum and cokes. Matt reports first using cocaine at age 27. He indicates only using cocaine three times in his life. He said he first used methamphetamine at age 30. Matt said his last use of alcohol and drugs as six months ago before being incarcerated.

Matt said he has never completed a Drug/Alcohol Treatment Program in his lifetime. Motivational enhancement for treatment could include focusing on how his substance use has affected his family, employment, and his physical health. Matt could benefit from a Cognitive Restructuring Class to increase self-awareness of the relationship between his thoughts and actions. A Twelve Step Program may also be effective for Matt in order to begin living with more principles.

Matt has a lengthy legal history including Possession of Marijuana (4 times), Driving Under the Influence (3 times), Driving Under Suspension (4 times, 15 year. Suspension), Possession of Controlled Substance-Meth (18-36 Months).

Ann

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

Ann, a 32-year-old 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.

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