

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

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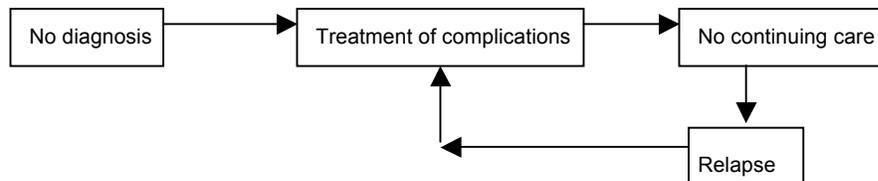
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A. Underlying Concepts of ASAM Criteria in a Health Care Reform Environment

1. Generations of Clinical Care

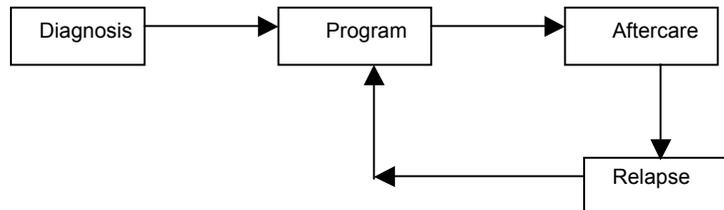
(a) Complications-driven Treatment

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

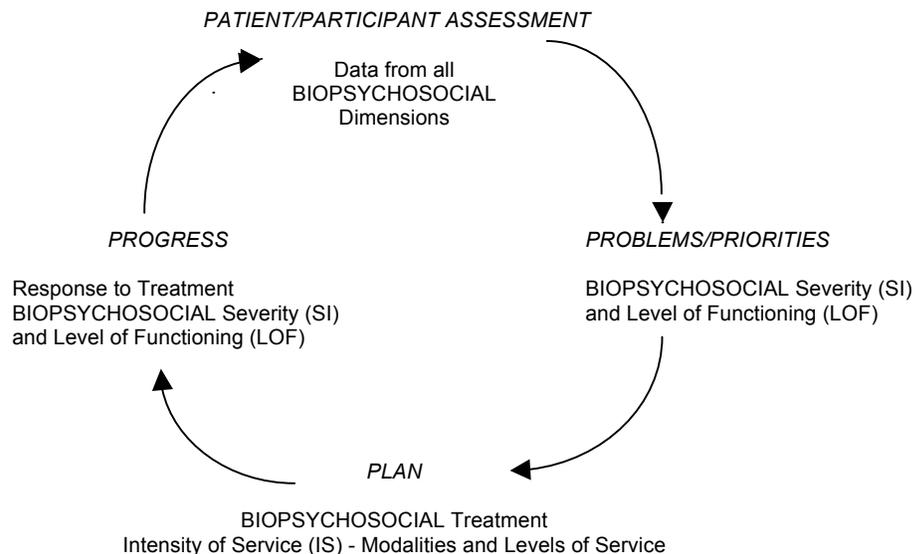


(b) Diagnosis, Program-driven Treatment

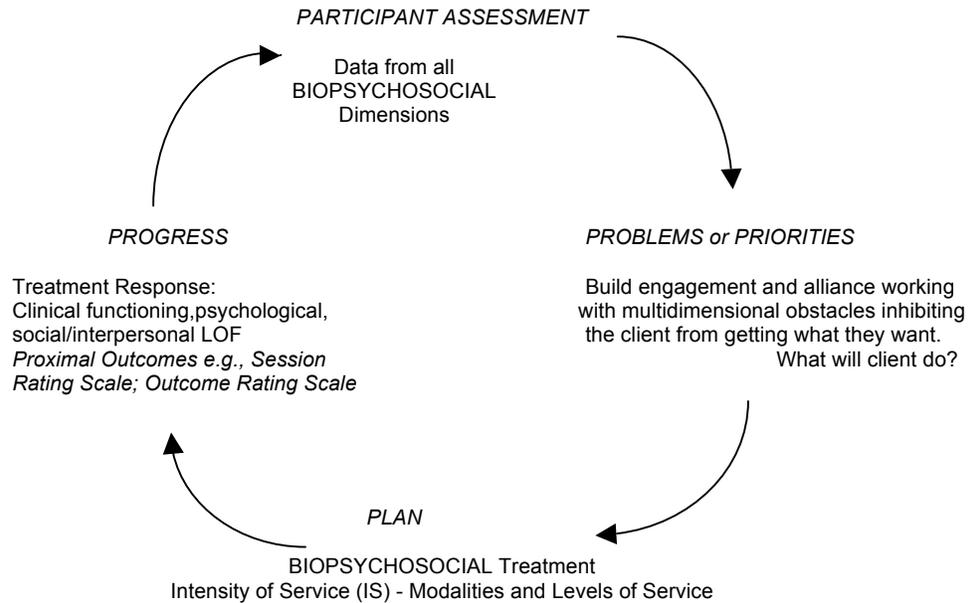
- ⤴ Diagnosis determines treatment
- ⤴ Treatment is the primary program and aftercare
- ⤴ Relapse triggers a repeat of the program



(c) Individualized, Clinically-driven Treatment



(d) Client-Directed, Outcome-Informed Treatment –Feedback Informed Treatment (FIT)



B. Skill-Building in ASAM Criteria - Assessment Dimensions and Levels of Care

(The ASAM Criteria 2013, pp 43-53)

The common language of six 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 - detox; 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. How to Organize Assessment Data to Match Level of Care

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?

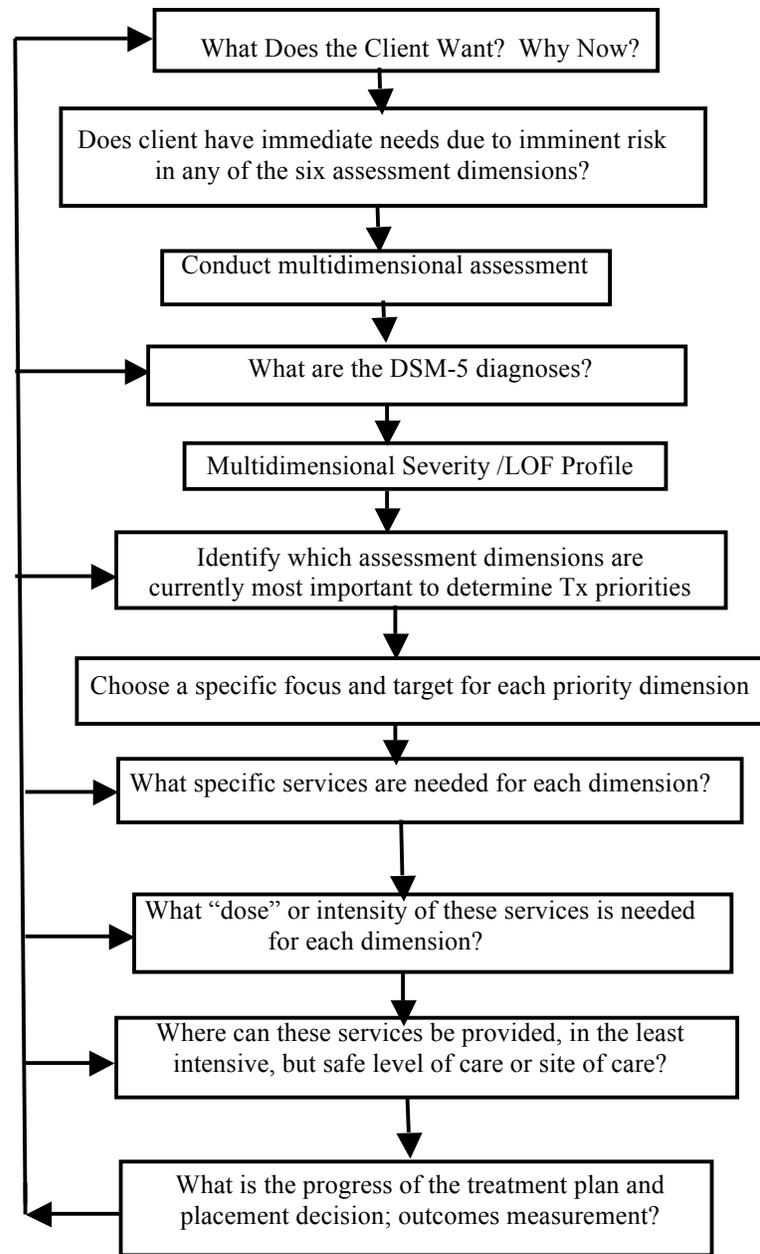
2. Assessing Severity and Level of Function (The ASAM Criteria 2013, pp 54-56)

To determine the multidimensional severity or level of function profile, consider each of the six ASAM 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.



(The ASAM Criteria 2013, p 124)

D. Engaging the Client in Participatory Treatment - Dimension 4 Issues

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.

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)

E. Care Management and Utilization Review Issues

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. Continued Service and Transfer/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.

3. 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-compliance 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.

F. Standardized Assessment – Assisted Clinical Decision-Making

- *The ASAM Criteria* book and *The ASAM Criteria Software* now branded as *Continuum*TM 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*TM - 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

G. Improving Care Management in an Era of Health Care Reform

1. Dealing with Disagreements over Treatment Plan and Level of 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

2. 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

3. 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

4. Payment

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

5. 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

6. 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

7. 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 provides 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	
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):	
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):	

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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.						
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM							
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM							
Clinically-Managed Residential Withdrawal Management	3.2-WM							
Medically-Monitored Inpatient Withdrawal Management	3.7-WM							
Medically-Managed Inpatient Withdrawal Management	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							
Clinically-Managed Low-Int. Residential Svcs.	3.1							
Clinically-Managed High-Intensity Population-Specific Residential Services	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	
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	
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):	
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):	

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 on Welfare

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.

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