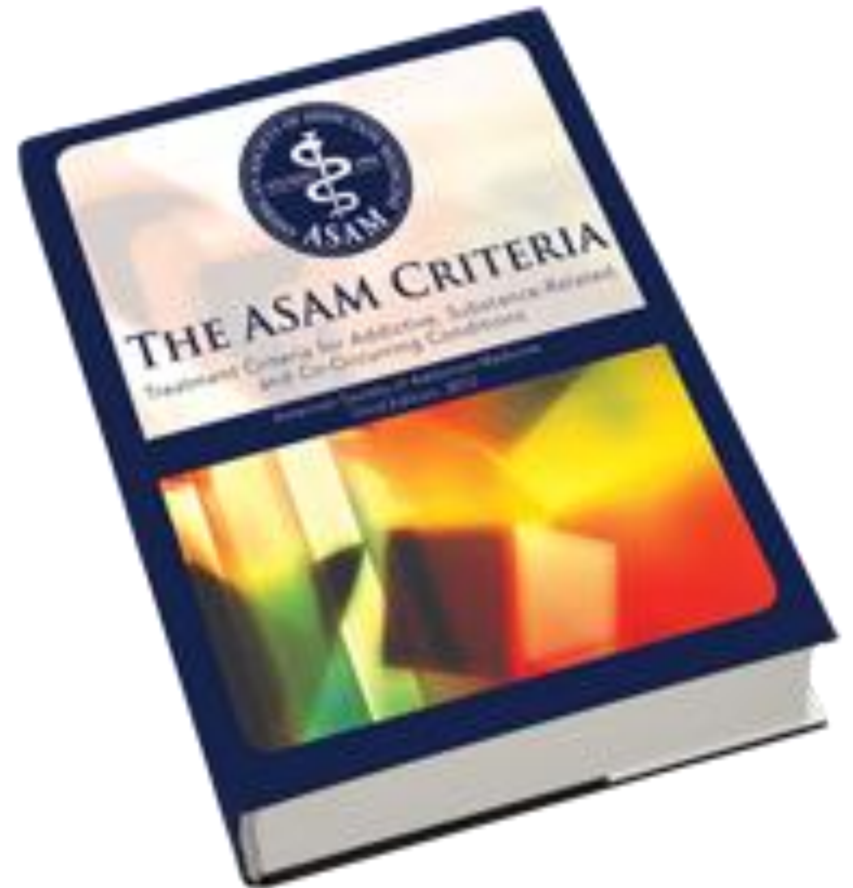
The ASAM Criteria
Introduction

[June 2017]

The ASAM Criteria

- The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions
- American Society of Addiction Medicine



What is ASAM?

ASAM is the American Society of Addiction Medicine. When managed care came on the scene in the 1980s various MCOs developed their own placement criteria. There were up to 50 separate sets of criteria and the difference between them varied greatly. In 1989 the current incarnation of ASAM was formalized and 2yrs later they released their first addition of the ASAM placement criteria.

What is The ASAM Criteria?

ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states.

- http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about

When is The ASAM Criteria Used?

ASAM criteria is used as a starting place for making decisions related to the course of treatment, taking into account a holistic view of the patient in view of the entire course of formalize treatment intervention over a continuum of care.

ASAM Definition of Addiction

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

Addiction is characterized by the inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

- http://www.asam.org/quality-practice/definition-of-addiction

Common Barriers for Implementation

- Rural Areas with lack of access to levels of care
- Family pressure with unrealistic expectations
- Criminal justice that focuses on length of stay or treatment as punishment
- SUD clinicians that view levels of care as separate modalities rather than as part of the continuum of care.
- Fragmented services

Disclaimers

- ASAM criteria is not intended to be encompass all possible SUD treatment modalities or specialized populations
- ASAM criteria is not dictated by court mandates for treatment
- ASAM criteria does not substitute for the judgment and discretion of the individual clinician
- ASAM criteria is a best practice guideline

Guiding Principles

Individualized Treatment

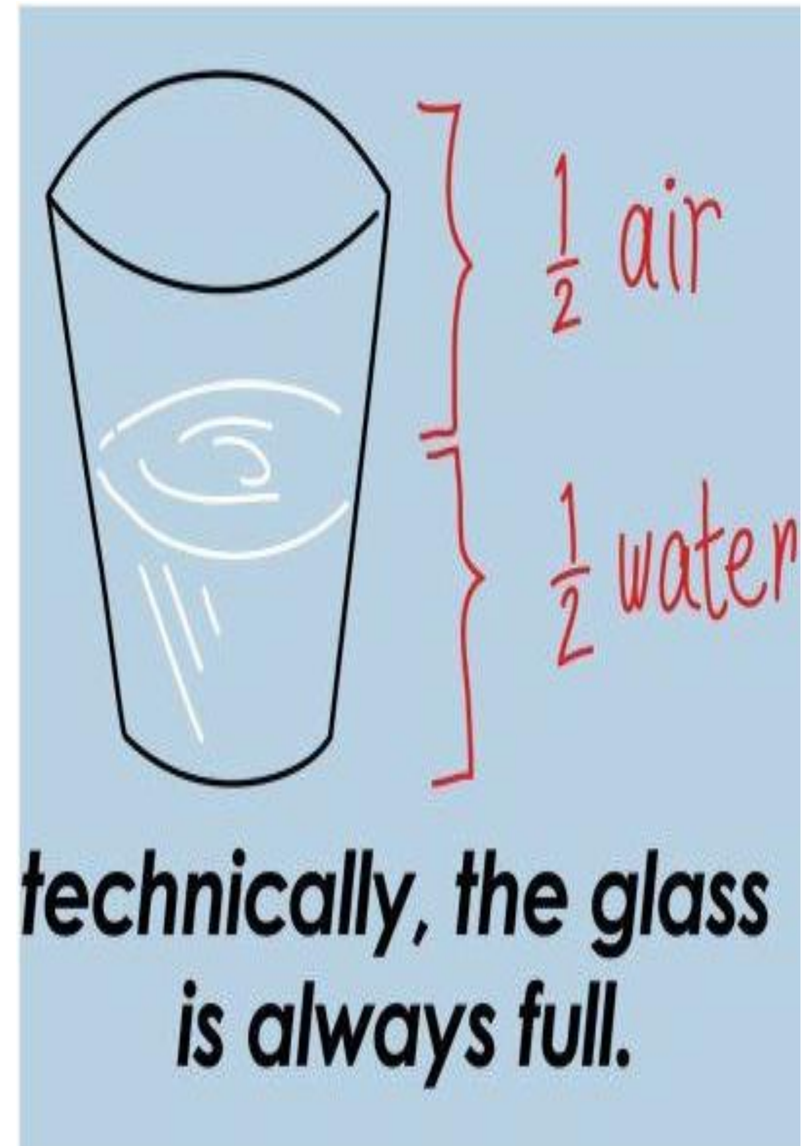
- It has the "goal of helping move practitioners toward individualized, clinically driven, participant-directed, and outcome informed treatment".
  - "What does the patient want?" "Why now?"
  - "What life areas or dimensions are most important in determining treatment priorities?“
  - "What specific services and service parameters are most appropriate?"
  - Moving away from fixed lengths of stay toward clinically driven interventions with expressed intention and evaluated results
  - "What is the outcome of the treatment plan and placement decision?"

Focus on the Continuum of Care

- The continuum of care is viewed as flexible and as a whole rather than as separate distinct modalities.
  - "For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient."

Strengths Based Approach

- Strengths/supports member can draw on
- Problems are opportunities
- Person Centered treatment focus



Focus on the Continuum of Care

- The continuum of care is viewed as flexible and as a whole rather than as separate distinct modalities.
  - "For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient."

Assessment and Reassessment

- Treatment outcomes are key. We are repeatedly cycling through assessment, adjusting the plan, and adjusting the placement or intervention
- Any treatment intervention, including an admission to a new level of care,
    1. MUST be the result of an assessment
    2. MUST be reevaluated for effectiveness

Focus on the Continuum of Care

- The continuum of care is viewed as flexible and as a whole rather than as separate distinct modalities.
  - "For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient."

Treatment Planning

- The treatment plan is developed in conjunction with the client and includes a comprehensive bio psychosocial assessment in addition to a comprehensive evaluation of the family.
- Treatment plan documentation includes both barriers to recovery and patient strengths
  - Psychosocial stressors, finances, housing, employment, etc
  - Skill and knowledge strengths and deficits.
  - strategies for dealing with negative stressors
  - Positive social supports, spiritual supports

Treatment Plan

- Treatment plan lists specific services to be delivered and behavioral responses expected
  - "I will attend all scheduled groups and afterward I will write what I learned in my journal"
- Less focus on immediately stabilizing the current symptomatology and more so on developing new insights and behaviors that move the client toward health. The decision to prescribe a type of service, transfer, or discharge is all geared toward moving a client toward health rather than simply stabilizing behavior

Treatment Plan Goals

- Goals need to be short-term, measureable, and achievable.
  - Stop using drugs --> NO!
  - Identify and implement 5 coping strategies --> Closer
  - When I have thoughts of using I will run one lap around the building -->Yes
    - Gives the client the ability to assess progress and effectiveness. Did it work? Yes, great! No, try it again or try something new

Treatment Reminders

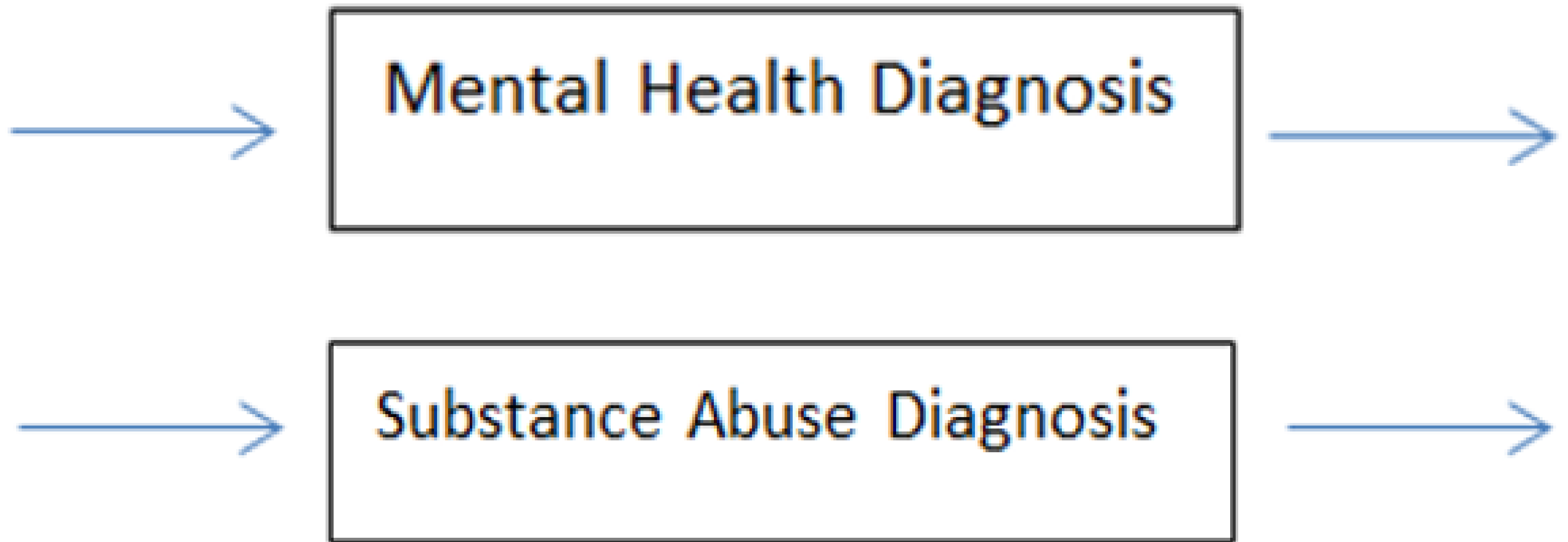
- Intensity of the intervention is paired with the intensity of the symptomatology.
- The individual is viewed as a whole person so an interdisciplinary treatment team is needed
  - In settings that do not offer comprehensive services, close coordination is a must
- The provider must inform the patient of all the options and the patient must choose to accept the treatment intervention, ideally the family is informed and accepts the intervention
- Medical necessity looks at the whole person to make an intervention recommendation rather than emphasizing any one area.

Focus The ASAM Criteria

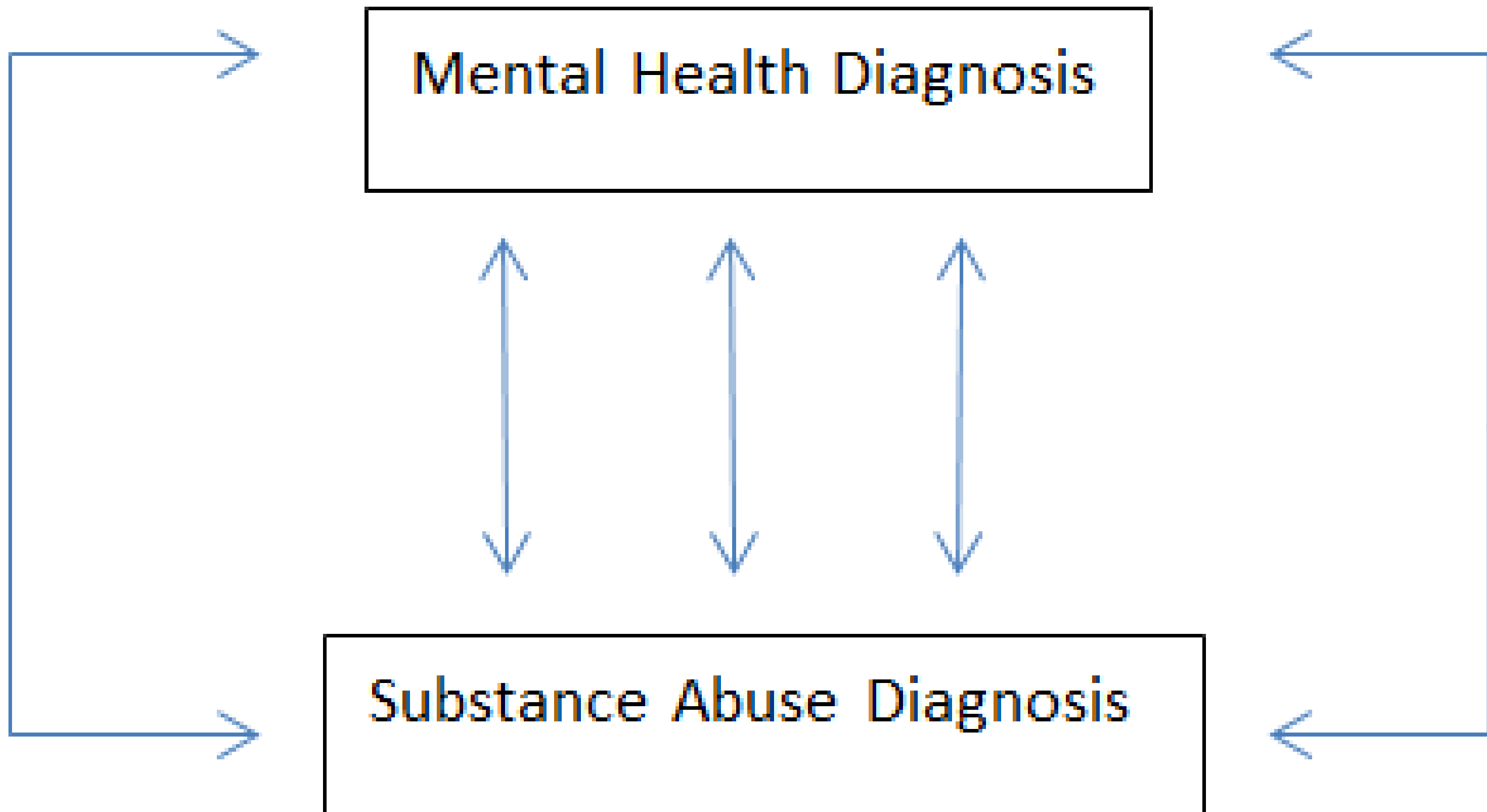
- Deemphasizes the placement and focuses more on a starting place for discussion. Gives a common frame of reference to conceptualize the client and the client's situation
- There was a concerted effort to improve the format of the manual to make it easier to understand and implement principles, processes and procedures across settings and in treating a variety of populations
- Access to web training is available with new manuals

Treatment Models

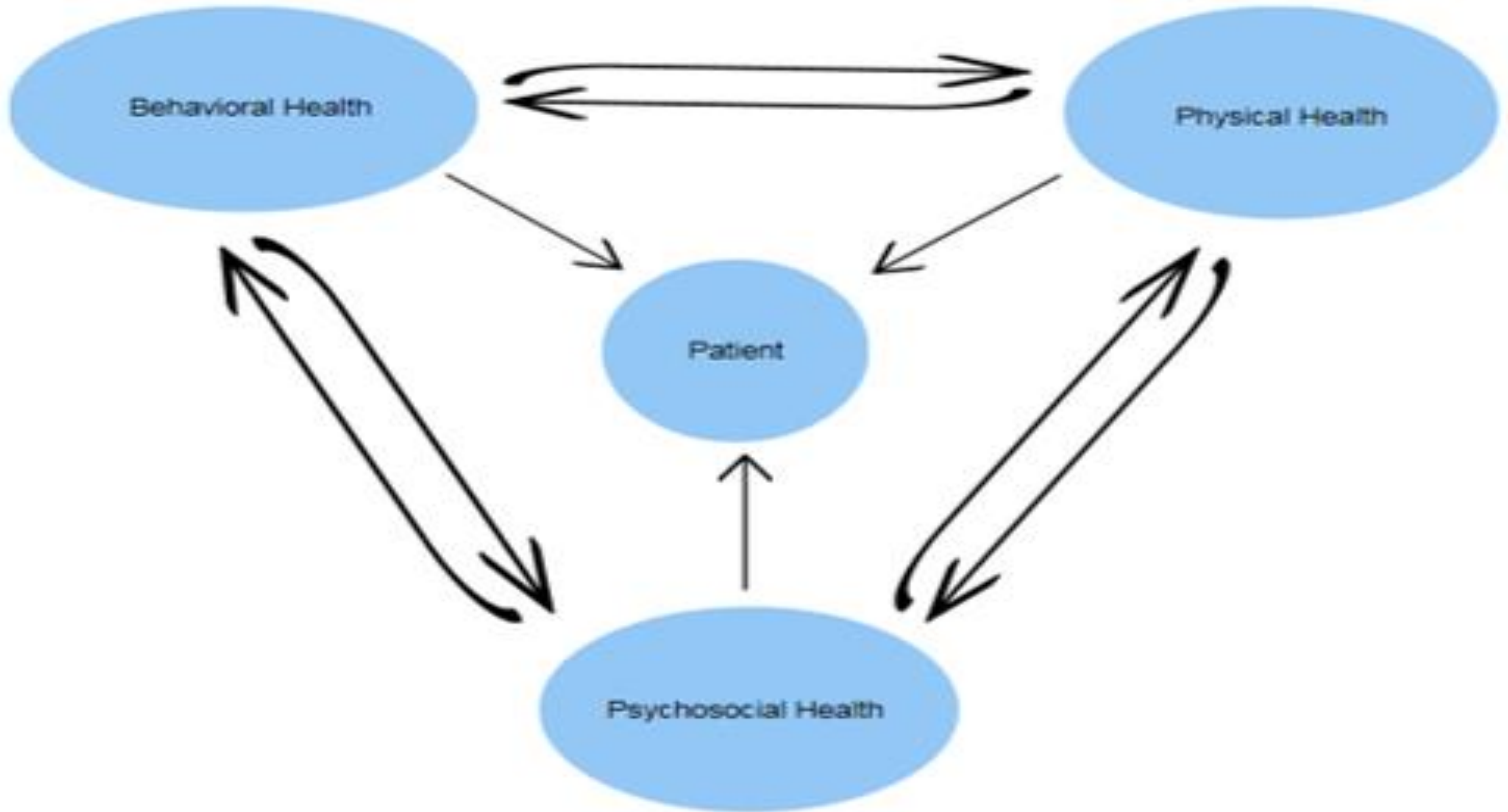
Dual Diagnosis



Co-Occurring Disorders



Integration



Application

Continuous Reevaluation

- All interventions are implemented based on assessment
- All interventions are Evaluated for Effectiveness

Multidimensional Assessment

Multidimensional Assessment: Dimensions 1-6

- Dim 1 – Intoxication and Withdrawal Potential
- Dim 2 – Biomedical Conditions
- Dim 3 – Emotional, Cognitive, Behavioral Conditions
- Dim 4 – Readiness to Change
- Dim 5 – Relapse Potential
- Dim 6 – Recovery Environment

Assessing for Stability

- Dim1-3 are vital for assessing the general stability of the patient. These must be considered first and trump all other considerations as they pertain to the safety of the patient

Multidimensional Assessment: Dim 1

- Dimension 1: Acute Intoxication/ Withdrawal Potential - Explore past and current experience of substance use and withdrawal.
  - Vitals, CIWA, COWS, UNCOPE, Current Symptomatology client is experiencing is important to validate results of assessments
  - Assessing for safety

Multidimensional Assessment: Dim 2

- Dimension 2: Biomedical conditions and complications - Explore medical history and identify any current medical complications
  - Assessing for medical stability
  - High BP may be a result of an ongoing medical condition but may be exacerbated by Alcohol withdrawal. Need to identify baseline and/or refer to medically monitored detox due to complication.

Multidimensional Assessment: Dim 2

- Are there medical conditions that need to be stabilized before a patient can be successful in recovery?
  - Severe injuries
  - Chronic pain that needs coordination
- Always asking how this is being addressed before, during or after but must be addressed in conjunction with substance abuse treatment.

Multidimensional Assessment: Dim 3

- Dimension 3: Emotional, behavioral, or cognitive conditions and complications - Explore patient thoughts, emotions and mental health issues.
  - Assess emotional and behavioral stability - SI/HI or Psychosis.
  - Will the patient be a danger to themselves or others?
  - Does internal stimulus interfere with their ability to engage?

Assessing for Recovery

- Dim 4-6 assess the patient's ability to engage in and maintain recovery.

Multidimensional Assessment: Dim 4

- Dimension 4: Readiness for change - Explore patient's readiness and interest in changing
  - Assess stage of change
    - Pre-contemplation - Don't want to change
    - Contemplation - Thinking about change
    - Preparation - ready to make changes
    - Action - making changes
    - Maintenance - changes made

Multidimensional Assessment: Dim 5

- Dimension 5: Relapse, continued use, or continued problem potential - Explore patient's unique relationship with relapse or continued use or problems.
  - Ask how much and how often they use
  - past patterns of abstinence
  - gage likely ability to maintain abstinence.

Multidimensional Assessment: Dim 6

- Dimension 6: Recovery/ living environment - Explore patient's recovery or living situation and surrounding people, places or things.
  - Get specific about danger of recovery environment.
  - Is there use in the home?
  - Does the family have the ability to secure medications?
  - Is family supportive of change?

Building a Risk Rating Profile

- A recommendation for treatment begins with the severity assigned to a case based on the Risk Rating Profile.
  - Each dimension is assigned a severity rating from the Risk Rating Matrix
  - The combination of risk and mitigating factors form the basis for each severity rating.

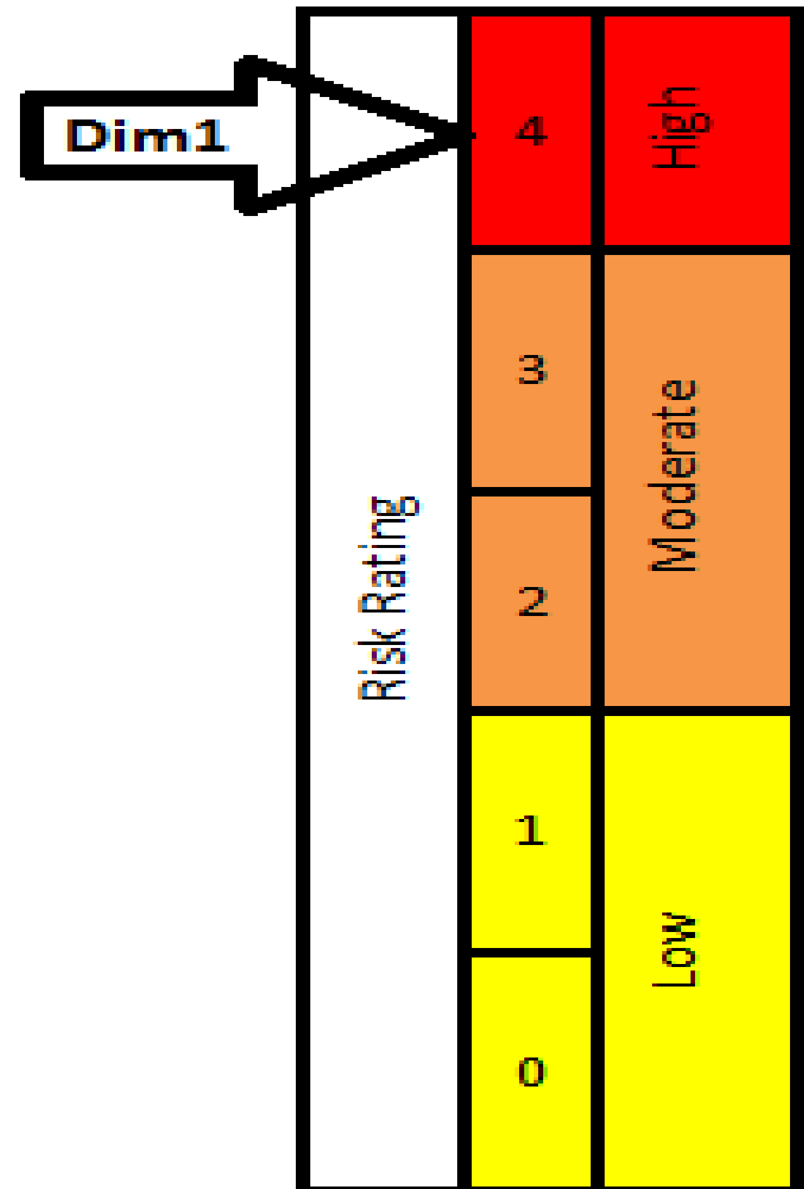
Building the Risk Rating Profile

Multidimensional Assessment: Risk Rating

Risk Rating Matrix – The ASAM Criteria pg74-104					
	Risk Rating: 0	Risk Rating: 1	Risk Rating: 2	Risk Rating: 3	Risk Rating: 4
Description	No immediate problematic symptoms.	Minimal symptoms which allow the patient to function at an adequate level to cause minimal interruptions to daily living	Moderate symptoms which cause a degree of discomfort or interference with daily life.	Moderate-high level of symptomatology. Very uncomfortable symptoms that interfere with ability to engage in recovery	High level symptoms, patient considered unstable.
Service Needed	No intervention	Low intensity intervention such as case management	Moderate level intensity, case management	Moderate-high level intervention, begin to consider higher levels of care.	Highest level of intervention available to address areas where patient is in imminent danger
	→ Low →		→ Moderate →		→ High →

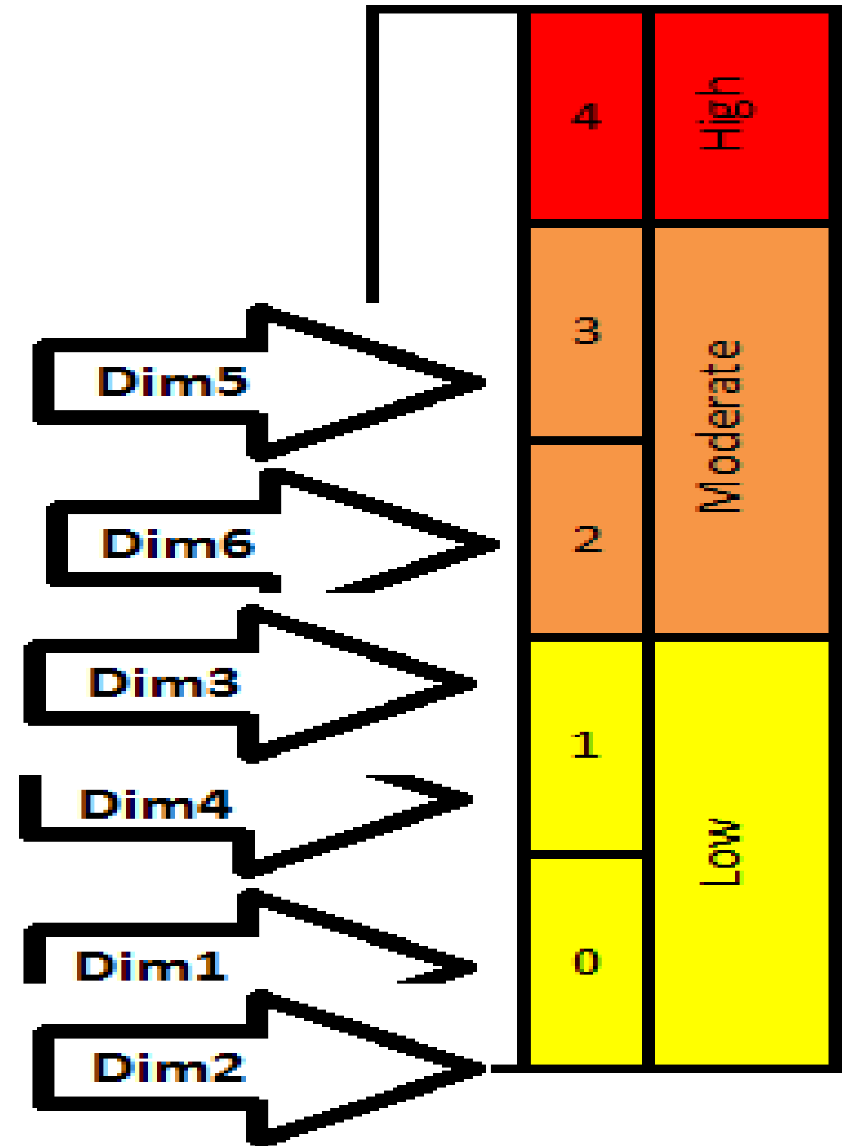
Application of the Risk Rating Matrix

Step 1: Assess for Safety – If any Dimension is rated as High it must be addressed in some way immediately



Application of the Risk Rating Matrix

Step 2: Determine the patient risk rating for all 6 dimensions.



Application of the Risk Rating Matrix

- Step 3: Identify the appropriate types of services needed to adequately and safely address the risk rating of each dimension.
- Step 4: Use the risk profile from steps 2 and 3 to develop a plan of care
- Step 5: Continue to reevaluate patient's ongoing service needs utilizing steps 1-4.

Placement on the Continuum of Care

Continuum of Care LLOC

LOC 0.5	LOC 1	LOC 1	LOC 2.1	LOC 2.5
Early Intervention	OP	OPT	IOP	PHP
assessment and education of at risk individuals who do not meet criteria for substance abuse treatment	Less than 9hrs of service per week adults, less than 6hrs per week adolescents for recovery or motivational enhancement	Daily or several times weekly opioid agonist medication and counseling available to maintain stability for those with severe opioid use disorder	9+ hours per week adults and more than 6hrs per week adolescents.	20+ hours per week not requiring 24hr care

Continuum of Care HLOC

LOC 3.1	LOC 3.3	LOC 3.5	LOC 3.7	LOC 4
RTC Minimal Clinical Monitored	RTC Specialized Clinical Monitored	RTC Clinical Monitored	RTC Medical Monitored	Inpatient Hospital
24hr structure with available trained personnel; at least 5hrs per week of clinical service	24hr care with trained counselors to stabilize imminent danger. Less intense milieu group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. **Not designated for adolescents.	24hr care with trained counselors to stabilize imminent danger and prepare for outpatient. Able to tolerate and use full active milieu or therapeutic community.	24hr nursing care with physician availability for significant problems in Dimensions 1, 2, 3 and 16hr counselor availability.	24hr nursing care and daily physician care for severe, unstable problems in dimensions 1, 2, or 3. Counseling available to engage patient in treatment.

Placement on the Continuum of Care

Placement along the continuum is considered in terms of the over all risk rating. If most dimensions are low then a lower level of care is indicated. If most dimensions are high then a higher level of care is indicated.

Note: A level of SUD treatment is an intervention designed to address a Substance Use Disorder. If substance use has been resolved there is no indication for treatment of a Substance Use Disorder.

LOC 0.5	LOC 1	LOC 2.1	LOC 2.5	LOC 3.1	LOC 3.3	LOC 3.5	LOC 3.7	LOC 4
Low		Moderate			Mod/High		High	

Key Points:
Continuum of Care

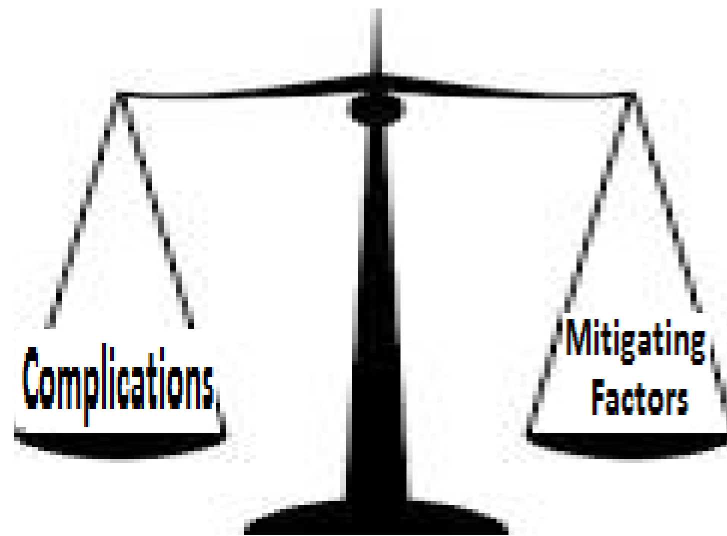
Key Points – Continuum of Care

- Levels of care are viewed as benchmarks along a continuum, point along a journey of recovery or levels of intervention rather than self contained treatment modalities.
- It is possible to stabilize outside the continuum of care via community support, ROSC, or mental health treatment
- Patient refusing a higher level of care should be offered an alternative lower level of care rather than turned away. Patient symptoms may stabilize with engagement at a lower level or motivation may significantly improve making the possibility of success at a higher level of care more likely.
- Myth of the Magical Milieu - Residential treatment is not a cure. It is a stop along the journey of recovery. It has set goals for intensive education and case planning but the process of recovery ultimately takes place outside of formalized treatment altogether.

Clinical Vignettes

Making a Determination

Making a determination is a matter of weighing complications vs. mitigating factors to determine the least intensive intervention where the patient can be successful and safe. Match the risk rating for each dimension to an equally intense intervention. Note: a high dimension in any dimension requires intervention but NOT necessarily an SUD intervention.



Allen

Allen is a 58YO male who meets DSM5 diagnostic criteria for Alcohol use disorder, mild. Wx potential is noted as currently mild, the CIWA is 3 with no more than mild Wx Sx noted by Hx.

Allen's Complication

Allen presented to the ER with his wife who is an LVN and stating she is concerned about his BP. Allen noted his last drink was 3 days ago and current pattern of use is 6+ drinks daily. Current BP noted as 140/100. Allen notes High BP by Hx that is not well controlled by medication. Allen noted he has been off BP medication for approx 3mo.

Allen's Mitigating Factors

Dim 3-6 are mild as Allen has no significant MH concerns (Dim3), is highly motivated to engage in community AA meetings (Dim4), has been drinking only 3mo following long period of abstinence, notes that he is able to utilize previous relapse prevention skills and reconnect with recovery supports within his recovery environment. Allen's wife has been on the phone with Allen's parents who are going through the house to remove any alcohol before Allen and his wife return home(Dim 5-6)

Is it Withdrawal or Medical?

Allen has a history of Hypertension and his current vitals are noted as high after 3 days of abstinence with no other significant Withdrawal Symptoms noted. We can reasonably conclude High BP is related to Dim 2, medical considerations as opposed to autonomic arousal that could markedly increase to crisis levels if Allen were intoxicated or experiencing other Symptoms of withdrawal. Dim 2 raises the overall level of concern and must be addressed but in this case can be addressed with medical intervention, no SUD intervention is needed to address Dim 1.

Allen Determination

- We conclude that Dim1 is stable.
- Dim2 is being addressed with medication administered at the ER.
  - Recheck shows blood pressure decreasing.
- Recommendation for follow up with his PCP within a few days is given to refill medications and recheck blood pressure.
- Dim3-6 are all rated as mild.

A determination for ASAM Level 1 is made to address relapse.

Wait, What's the issue?

Rosa is a 16YO female who presented to the ER escorted by police responding to domestic disturbance following 911 call from mother. Mother reported that Rosa went into a "wild rage" threatening the family. She became verbally and physically aggressive, reportedly throwing a chair which resulted in property damage. When police arrived on the scene the patient collapsed on the floor in sobs and would not respond to parents or police. Mother noted that Rosa had started hanging out with the wrong crowd during the previous semester at school and her behavior had progressively deteriorated. The patient admitted to smoking THC irregularly approximately 1x per mo with friends. Police decided to transport to ER to rule out substance induced episode.

Multidimensional Assessment

Dim1: None, No indication of intoxication in the ER, tox screen was negative for mind altering substances including THC.

Dim2: None, Patient has no complicating medical concerns

Dim3: Mod/High, during assessment with a nurse Rosa broke down crying indicating that she had been molested over a period of several years by a family member which escalated to rape several months ago. The parents were discussing visiting this family member at the time of the incident.

Multidimensional Assessment

Dim4: low, Patient was able to verbalize multiple reasons THC abuse was not positive, indicating that she did not plan to continue use.
Dim5: mild, Patient pattern of use is noted as minimal. UDS was negative for THC though patient admitted to smoking a few times approximately 1 time per month over the past 6 months, last use is noted as approximately 5 weeks ago.
Dim6: mild, during a brief intervention the patient was able to tell parents about the molestation and subsequent rape. Parents appeared to exhibit the normal range of emotions and seemed supportive of the patient. Child Protective Services was notified to file a report.

Determination

Discussion:

What is an appropriate level of care?

1. ASAM level 3.3 RTC to address substance use and trauma in a safe and secure setting
2. ASAM level 1 OP to address THC use patient has admitted to
3. No formal SUD intervention with referral to MH OP and victim's assistance

Meth Monsters

Rochester is a 34YO male who presented to ER escorted by police. Rochester became aggressive with police when confronted about urinating in public. He indicated to ER nurse that he was killing monsters in the shadows. Labs showed positive result for Amphetamine and Methamphetamine. Rochester is noted to be a daily IV Meth user and is Hep C positive per previous contact with the hospital. He had a large abscess on his right wrist that was treated in the ER, antibiotics were administered and on going wound care was recommended. Rochester's vitals were stable though he became very difficult to rouse shortly after arriving in the ER.

Determination

Due to acute intoxication and subsequent withdrawal we are unable to initially determine whether psychosis is substance induced or ongoing. Rochester would not be safe to discharge immediately from a controlled environment. ASAM Level 3.7 is indicated for 24-48hrs in order to establish a base line. ASAM Level 3.2 is appropriate as an alternative depending on the availability of area services.

Reevaluation

Following approx. 18hrs of sleep Rochester was able to sit up in bed and complete additional screenings with the floor nurse. He was no longer experiencing psychosis and complained about his wrist hurting, OTC pain relievers were administered and additional wound care was completed including repacking the wound. Rochester indicated that he was homeless and needed a bus pass back to the shelter before they closed the doors for the night. When a recommendation for treatment was offered by the hospital discharge planner, he indicated that he was not interested in residential care but would consider outpatient since they offered free coffee and snacks.

Dimensions 1-6

Identify Dimensions:

Dim1

Dim2

Dim3

Dim4

Dim5

Dim6

What is the appropriate level of care?

Rochester is clearly appropriate to continue at ASAM level 3.3, however, he has refused this level of care. He has indicated an interest in outpatient because the offer coffee and snacks. Offer ASAM Level 1, outpatient, in an attempt to engage Rochester in services. Circumstances may change such that he may become more willing to engage at level 3.3 in future. The important piece is to engage him where he is willing to be engaged.

Thank you